STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525371	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Nursing & Rehab	1300 West Silver Spring Dr Glendale, WI 53209

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility was not administered in a manner that enabled it to use its resources effectively to ensure residents attained or maintained their highest practicable physical, mental, and psychosocial well-being. This deficient practice had the potential to affect all 85 residents residing in the facility at the time of the survey.*The facility did not provide skin care treatments based upon accepted standards of practice and assessments. Residents sustained avoidable deterioration in wounds as a result of not being thoroughly assessed, care planned for interventions to prevent decline, and ongoing monitoring with revisions to the care plan. Wounds became infected and necrotic. Hospitalizations were required. One resident required a left above knee amputation and a right below knee amputation as a result of the wounds not being provided care and treatment according to acceptable standards of practice, assessments and individualized needs. Cross-reference F684.*The facility did not prevent residents from developing avoidable pressure injuries. The facility did not ensure assessments and treatments were provided based on current standards of practice and individual resident needs. The facility did not ensure each resident had their clinical condition evaluated, defined interventions were implemented based upon individual needs and standards of practice, and the interventions were monitored and revised as indicated to prevent decline in the pressure injures. Residents developed multiple, avoidable pressure injuries that became infected and required hospitalizations and antibiotic treatment. Cross-reference F686.*The facility failed to ensure the medical director was coordinating the care of the residents in the facility. During the survey, regulatory care concerns were identified with pressure and non-pressure wounds not being care for according to professional standards of practice. The facility medical director deferred any wound concerns to the wound physician, did not know who the wound physician was, and was unaware the facility did not have systems in place to ensure ongoing assessment, care and treatment for individuals with wounds and those at risk for the development of wounds. Residents sustained serious injury and impairment as a result of the medial director's failure to coordinate care in the facility. One resident lost both lower extremities to amputation as a result of wound care not provided in accordance with acceptable standards of practice. A second individual sustained multiple surgeries and infections as a result of the facility not having coordinated medical care. Medical Director-QQ did not coordinate the overall medical services within the facility to ensure residents reached their highest practicable level of well-being.*The facility's leadership were aware of procedural changes that were implemented by Operator-FFF were not based on clinical standards of practice. The facility leadership did not implement procedures to ensure the care and treatment of the residents met clinical standards of practice and resident needs. During the time the procedural changes were implemented the facility did not maintain a full time Director of Nursing. Cross-reference F727. Systemic failures occurred at the facility during this time in the areas of clinical care and management of resident care, quality of life, and resident choices. *The facility's Governing Body/Administration did not ensure they maintained an effective Quality Assurance and Performance Improvement Program as it did not identify systemic concerns in the facility related to pressure and non-pressure skin concerns due to clinical procedural changes being implemented that were not based (continued on next page)

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

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	on standards of practice, a lack of coordination of care from the medical director, and lack of clinical oversight of a full time Director of Nursing. Cross-reference F867.A total of 39 deficiencies have been cited as a result of the recertification and complaint survey investigations including the concerns identified at F835 - Administration.The facility's failure to ensure the building was administered in a manner that enabled it to use its resources effectively and efficiently to allow residents to attain or maintain the highest practicable level of physical, mental, and psychosocial well-being created a finding of immediate jeopardy that began on 4/1/25. On 9/17/25, at 1:30 PM, Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were informed of the immediate jeopardy. The immediate jeopardy was not removed prior to exit from the survey when the facility failed to implement the immediate jeopardy removal plans they submitted prior to exit from the survey.Findings include:The Facility Assessment Tool updated 5/2025 and reviewed at QAPI 5/2025, documents, Part I: Our Resident Profile: (Name of Facility) typically accepts residents or continues to provide care for residents that may develop, the following common diseases, conditions, physical and cognitive disabilities, or combinations of conditions that requires complex medical care and management. Each resident is assessed and reviewed on an individual basis. Potential admissions with atypical diseases and/or conditions are reviewed and considered individually, as is set forth below.Integumentary System: Skin Ulcers, Injuries Musculoskeletal Systems: Fractures, Osteoarthritis, other forms of ArthritisInfectious Diseases: Skin and Soft tissue Infections, . Urinary Tract Infections, Infections with [NAME]-Drug-Resistant-Organisms, Septicemia, .Part 2: Services and Care We Offer Based on our Residents' Needs:Skin Integrity: Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds).Infection Prevention and Control: Identification and containment of infection, prevention of infections. Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies: Administration (e.g., Administrator, . QAPI, .)Nursing Services (e.g., DON .) .Medical/Physician Services (i.e., Medical Director, Attending Physician, Physician Assistant, Nurse Practitioner, .) .On 9/16/25, at 1:05 PM, Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B informed Surveyor previous DON-DDD resigned their position on July 30, 2025. NHA-A stated previous DON-DDD had been on leave from the facility from 4/1/25-5/12/25. NHA-A stated they had asked Operator-FFF to provide clinical support for the facility during this time, but none was provided until 5/8/25 when a mock survey was conducted. NHA-A stated it was a terrible time without clinical support, and he was asking for the help. NHA-A stated he would call Operator-FFF for clinical decision making but no one was present in the building. NHA-A informed Surveyor Operator-FFF changed the entire wound care program, requiring far less of what was previously required. DON-B stated Operator-FFF minimized the process for wound care. DON-B stated responsibilities were taken away from the wound care nurse that were previously required and she felt there would be issues that would occur. Surveyor asked why Operator-FFF would be minimizing or changing wound care practices at the facility. DON-B stated Operator-FFF wanted to decrease the workload during the receivership because they were losing the facility. DON-B stated weekly wound logs that contained measurements and documented progress of pressure and non-pressure wounds were eliminated as well as fall investigation packets. DON-B stated she had worked at the facility previously but had resigned as the DON on 12/31/24 following a survey that identified deficient practice and concerns that did not align with her values. DON-B stated prior to her resignation they (the facility) had systems and checks and balances in place and then Operator-FFF dismantled so many practices. DON-B stated she was working on reestablishing procedures and putting out fires and trying to make things better. On 9/16/25, at 2:55 PM, Medical Director (MD)-QQ informed Surveyor he was not aware of systemic issues with the facility's wound treatment program and deferred all wound treatment to the wound physician. MD-QQ informed Surveyor he was not sure who the facility's wound physician was and was not made aware the facility did not have an RN (Registered Nurse) overseeing the facility's wound program for many weeks, treatments were not being completed, and concerns with wounds were not discussed with (continued on next page)

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F 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the medical director followed through on his responsibilities regarding the coordination of care and treatment the residents received in the facility. This has the likelihood to cause serious harm, injury, or impairment to all 85 residents currently residing in the facility.Medical Director (MD)-QQ was not aware of and did not ensure facility residents with wounds had care and treatment necessary to prevent and heal pressure and non-pressure injury wounds. Medical Director-QQ deferred all wound care and treatment to the facility's wound team and Wound MD (Medical Doctor). Following Medical Director-QQ's decision to defer all wound care to the contracted wound MD, Medical Director-QQ did not ensure the resident care policies were implemented and that there was ongoing coordination of the medical care in the facility in accordance with policies and procedures and accepted standards of practice for medical care. Cross-reference F684 and F686.Medical Director (MD)-QQ was not aware the facility had implemented wound care procedural changes that were not based on clinical standards of practice. During the implementation of the procedural changes the facility did not maintain a full time Director of Nursing to oversee the clinical care and treatment of the residents. Medical Director (MD)-QQ was not aware the facility did not maintain a full time Director of Nursing to oversee the clinical care and treatment of the residents. Cross-reference F727 and F867.Medical Director-QQ did not fulfill his role on the facility quality assessment and assurance (QAA) committee by failing to assist with administrative decisions including recommending, developing, and approving facility policies and procedures related to resident care, coordination of medical care and implementation of policies and procedures. Cross-reference F867.Medical Director-QQ did not work with the facility's clinical team to provide surveillance and develop policies and procedures to prevent the potential infection of residents as deficient practice was identified with the facility's overall surveillance program for tracking and trending the prevalence of infections in the facility, antibiotic stewardship, and vaccinations. Cross-reference F880.The facility's failure to ensure Medical Director-QQ fulfilled their responsibility for the implementation of resident care policies and the coordination of medical care in the facility created a situation of immediate jeopardy starting 9/9/2025. Surveyor notified Nursing Home Administrator (NHA)-A of the immediate jeopardy on 9/16/2025 at 2:00 PM. The immediate jeopardy was not removed prior to exit from the survey as the facility failed to implement their immediate jeopardy removal plan they established prior to exit on 9/30/2025.Findings include:The Medical Director Agreement signed by Medical Director-QQ on 1/1/24 documents: Responsibilities and Functions of Medical Director.A. Supervise and coordinate provisions of medical services and resident care in the Facility.B. Assist Facility in arranging for and/or providing as needed continuous physician coverage for medical emergencies and in development of emergency treatment procedures for residents/patients as needed.C. Review and sign all incident reports, identify hazards to health and safety, and provide recommendations to the Facility's Administrator to promote a safe and sanitary environment for residents, guest and personnel.E. Assist the facility in its review and response to any surveys, complaints, or inspections or any medical care or treatment issues or concerns.F. Conduct periodic formal meetings with the Facility's department heads and chairpersons of the Facility's committees. G. Participate in identifying the need for, developing, amending, recommending, approving, implementing and monitoring written policies governing resident care including policies related to admissions, transfers, and discharges; infection control; use of restraints; physician privileges and practices; and responsibilities of non-physician health care workers (e.g. nursing, rehabilitation therapies, and dietary services in resident care, emergency care and resident assessment and care planning). Medical Director shall also assist with policies related to accidents and incidents; ancillary services such as laboratory, radiology, and pharmacy; use of medications; use (continued on next page)

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F 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	and release of clinical information; and overall quality of care.H. Advise the Facility's Administrator as to the adequacy of the Facility's resident care services and medical equipment.K. Serve as a member of QAPI committee, no less than monthly, and other committees as reasonable requested by Facility.L. Participate in any Facility accreditation or certification process.M. Make routine visits to the Facility to meet with the Facility's Administrator and Director of Nursing, or their designee (s), to discuss various issues and problems including, but not limited to administrative, dietary, and housekeeping issues, specific resident care problems, and professional staff needs for education or consultants. Medical Director QAPI and Facility Wound Program Concerns:On 9/16/25, at 2:55 p.m., Surveyor interviewed Medical Director-QQ. Surveyor asked Medical Director-QQ how often he visits the facility. Medical Director-QQ stated he visits the facility every other week but his NP (nurse practitioner) visits two to three times a week. Surveyor asked if Medical Director-QQ participates in facility QAPI meetings, and he stated yes, he participates in QAPI. Medical Director-QQ stated recently the facility has gone through transitions with ownership and he has let Nursing Home Administrator (NHA)-A deal with all the changes that have occurred. Surveyor asked Medical Director-QQ, when a resident develops a pressure or non-pressure wound, what is his role. Medical Director-QQ stated he typically is not involved with wounds, especially complex wounds. Medical Director-QQ stated he defers all wounds to the facility wound team and the Wound MD (Medical Doctor). Medical Director-QQ stated he is only involved if there is an emergent situation where they can't reach the Wound MD and the resident needs orders to be sent to the hospital. Medical Director-QQ stated he wasn't sure who the facility Wound MD was. Medical Director-QQ then mentioned the name of a wound MD Surveyor noted the facility no longer works with. Surveyor explained to Medical Director-QQ the concerns regarding wound care in the facility. Specifically, R97 and R98 had developed pressure and non-pressure wounds that developed into serious concerns needing hospitalization and having significant impact on the resident's quality of life including systemic infections and/or amputation. Surveyor explained R97 and R98 were not receiving wound assessments in accordance with standards of care and there wasn't RN oversight for wound management for many weeks. Surveyor explained treatments were not being completed. Medical Director-QQ stated he was not aware of any issues regarding wound management. Medical Director-QQ reiterated he defers to the wound team. Medical Director-QQ stated wound concerns were not discussed with him or in QAPI meetings. Cross-reference F867, F684, and F686.Medical Director QAPI and Infection Prevention and Control Concerns:On 09/10/2025, at 8:36 AM, Surveyor spoke with Infection Preventionist (IP)-I, regarding the requested Infection Prevention surveillance and program documentation. Per IP-I the Director of Nursing (DON)-B is on the phone with the (name of the electronic medical record) company, there are a couple things they are still trying to get that was requested.On 09/10/2025, at 9:51 AM, Surveyor interviewed DON-B and was told that the IPC (Infection Prevention and Control software) within (name of the electronic medical record) is disabled. To be able to add orders or update cases need to enable IPC. When DON-B goes to reports and tries to historically print records, just gets a blank screen. DON-B put date range in to report and nothing shows. DON-B had been employed previously at facility until the end of December. Documentation in binders up through December is available. DON-B looked, and the previous owners disabled IPC on 8/7/25. The new management company involved is trying to get legend or access so information can be provided. Per DON-B IPC is a module that you buy extra from (name of the electronic medical record) and it has been disabled.On 9/15/25, at 9:00 AM, Surveyor interviewed DON-B and IP-I, over the weekend they used the Physician Order Report for residents with an antibiotic to create surveillance logs. The new ownership company needs to sign a contract with (name of the electronic medical record) for the IPC add on and even then there is no promise the previous data will be available. On 9/15/25, at 9:00 AM, Surveyor continued the interview asking Director of Nursing (DON)-B and Infection Preventionist (IP)-I regarding the antibiotic stewardship program and was told they follow the McGeer's criteria (The McGeer criteria are a set of clinical guidelines used for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525371	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Nursing & Rehab	1300 West Silver Spring Dr Glendale, WI 53209

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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 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	infection surveillance in long-term care facilities, focusing on identifying potential infections and guiding antibiotic stewardship.)Surveyor reviewed the monthly surveillance for January through present of 2025. Surveyor noted no antibiotic use documentation or McGeer criteria assessments in the medical record or surveillance log.On 9/16/25, at 2:24 PM, Surveyor interviewed IP-I and confirmed McGeer's is the criteria used to assess antibiotic use. Surveyor asked how they check a resident on an antibiotic meets the criteria to be on it. Per IP-I the previous DON would type it in the sheets when we talked about residents on antibiotics at the 24-hour meeting. Surveyor noted these sheets did not become part of the resident's permanent medical record. During the survey Surveyors requested the vaccination record for 4 sampled residents regarding review of the facility's practice in administering the pneumococcal vaccination to residents who were eligible to receive such vaccination. R6, [AGE] years old, has no documentation of Pneumococcal vaccine being offered. R33, [AGE] years old, has no documentation of Pneumococcal vaccine being offered. R65, [AGE] years old, has no documentation of Pneumococcal vaccine being offered. R75, [AGE] years old, has no documentation of Pneumococcal vaccine being offered. On 09/16/2025, at 9:00 AM, Surveyor interviewed Director of Nursing (DON)-B who stated she was working on immunization information that was requested, would also look in Wisconsin Immunization Record (WIR). On 9/16/2025, at 11:00 AM, Surveyor followed up with DON-B and no Pneumococcal vaccination information was located, still wants to look one more place.Additionally during the survey Surveyors requested the vaccination records for 5 sampled residents and 1 staff person to review the facility's practices in ensuring administration of the COVID-19 vaccination. R6's medical record does not contain any documentation as to whether R6 was offered, received, or declined the COVID-19 immunization. R33's medical record does not contain any documentation as to whether R33 was offered, received, or declined the COVID-19 immunization. R40's medical record does not contain any documentation as to whether R40 was offered, received, or declined the COVID-19 immunization. R65's medical record does not contain any documentation as to whether R65 was offered, received, or declined the COVID-19 immunization. R75's medical record does not contain any documentation as to whether R75 was offered, received, or declined the COVID-19 immunization. Staff member (CNA-JJ) reviewed had no documentation of COVID-19 vaccination being offered, received or declined.Surveyor noted there is no indication through the QAPI process or facility practice the facility's infection prevention and control program and policies and procedures were based upon or implemented in accordance with current standards of practice and that Medical Director-QQ had directed and reviewed the facility's infection control program as the Medical Director of the facility. This included establishing a system to track, trend and provide overall surveillance of infections within the facility, ensuring the facility had an effective antibiotic stewardship program to prevent unnecessary use of antibiotics and ensuring the facility had an active immunization program in the facility. Cross-reference F880, F881, F883, and F887.On 09/16/2025 at 1:05 PM Surveyor asked NHA-A what the role of the Medical Director in the facility is. NHA-A stated the role of Medical Director- QQ is to participate in the QAPI meetings and provide feedback. NHA-A stated Medical Director- QQ oversees the Nurse Practitioners (NP's) seeing residents at the facility. Medical Director- QQ is the support for when there are issues or concerns with other physicians.Surveyor asked what the responsibility of Medical Director-QQ regarding the overall wellness and clinical care for the residents is; specifically, how were the NP's or Medical Director- QQ not aware of the severity of R97 and R98's wounds and other clinical concerns and systemic issues regarding care. DON-B stated, the NP's and Medical Director- QQ need to have the facility apprise them of any resident wounds as the NP's and/or Medical Director- QQ is not doing a full physical comprehensive assessment when visiting the residents unless they are aware of a particular situation. DON-B stated NP's and/or Medical Director- QQ is relying on the facility wound team to address wounds. Surveyor noted it is the role of the Medical Director to establish and coordinate the overall clinical program in the facility based upon current standards of practice. Surveyor also noted Medical Director-QQ is also the attending physician for many of the facility (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	residents.On 9/17/2025, at 8:03 AM, Surveyor interviewed NHA-A who stated the facility held QAPI meetings in January, February, March, and April of 2025, and an ad hoc QAPI meeting in July following a State survey. NHA-A confirms there was no QAPI meeting held during prior DON-DDD's leave of absence. NHA-A was unable to provide attendance sign in sheets for the meetings held in January, February, March and April of 2025. The QAPI agendas provided do not address the procedural changes implemented in wound care, the facility's plans for clinical coverage without a fulltime DON, nor a discussion with the Medical Director related to these areas of concern and how they would impact resident care and treatment at the facility. The facility's failure to ensure the medical director followed through on his responsibilities regarding the coordination of care and treatment the residents received in the facility led to a reasonable likelihood for serious harm, thus creating a finding of immediate jeopardy. The facility submitted an immediate jeopardy removal plan alleging removal of the immediate jeopardy as of 09/24/2025 with the implementation of the following plan. * Any unresolved nursing concerns were immediately escalated to the attending physicians and addressed.* Documentation was updated to reflect interventions, physician responses, and outcomes.* A comprehensive review of all current residents' charts was completed to ensure no nursing concerns requiring physician follow up were missed.* Any identified issues were immediately addressed and documented.* A new Medical Director s identified and oriented to facility policy and CMS requirements for physician oversight.* Nursing staff were re-educated on the chain of command for escalating medical concerns and expectations for timely physician responses.* Administrator and DON will review communication logs and physician notifications daily to ensure all nursing concerns are addressed promptly. * All facility policies and procedures will be reviewed with new Medical Director on 9/24/25 and the medical director will be involved in the plan of correction for the noncompliance.* The facility established a pan for audits and reporting to QAPI until substantial compliance is achieved. The implementation of this plan was not able to be verified upon exit from the survey leaving the immediate jeopardy at F841 to be ongoing at the time of survey exit on 9/30/2025.

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	525371	A. Building B. Wing	09/30/2025

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents received treatment and care, based on a comprehensive assessment, in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) for non-pressure injuries, changes of condition, neurological checks after unwitnessed falls, or physician follow up visits for 3 (R97, R98, and R73) of 20 sampled residents. R97 developed an infection in a surgical wound and developed other non-pressure wounds that were not comprehensively assessed by a Registered Nurse (RN) or treated despite physician orders. Due to the severity of the wounds and infections that developed, R97 required both left and right above the knee amputations. R98 developed non-pressure wounds (as well as pressure wounds) that were not comprehensively assessed or monitored and did not have ordered treatments applied consistently. R98 was admitted to the hospital with Fournier's Gangrene, severe sepsis, cellulitis of finger, and scrotal erythema requiring surgical intervention and IV antibiotics. The facility's failure to comprehensively assess non-pressure wounds, implement interventions based on the clinical condition and risk factors, and provide care consistent with professional standards of practice created a finding of immediate jeopardy that began on 1/09/2025. Surveyor notified Nursing Home Administrator/NHA-A and Director of Nursing (DON)-B of the immediate jeopardy on 9/16/2025 at 11:49 AM. The Immediate Jeopardy was not removed at the time of exit from the survey. Additional deficient practice was identified regarding R73. *R73 had unwitnessed falls on 6/25/2025, 7/1/2025, and 7/3/2025. Neurological checks were not completed. R73 was evaluated in the hospital after the fall on 7/1/2025 and had an order to be followed up in one week by the primary care physician. R73 did not see the Nurse Practitioner until 7/30/2025 and the documentation from the visit did not refer to a follow-up/evaluation of R73's falls. Findings include: The facility policy and procedure titled Wound Management documents: Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse. 3. Dressing changes may be provided outside the frequency parameters in certain situations. 4. Dressing will be applied in accordance with manufacturer recommendations. 5. Treatment decisions will be based on: a. Etiology of the wound: i. Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic, moisture or incontinence related skin damage. ii. Surgical. iii. Incidental (i.e. skin tear, medical adhesive related skin injury). iv. Atypical (i.e. dermatological or cancerous lesion, pyoderma, calciphylaxis). b. Characteristics of the wound: i. Pressure injury stage (or level of tissue destruction if not a pressure injury). ii. Size – including shape, depth, and presence of tunneling and/or undermining. iii. Volume and characteristics of exudate. iv. Presence of pain. v. Presence of infection or need to address bacterial bioburden. vi. Condition of the tissue in the wound bed. vii. Condition of the peri-wound skin. c. Location of the wound. d. Goals and preferences of the (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident/representative. 7. Treatments will be documented on the Treatment Administration Record. 8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: a. Lack of progression towards healing. b. Changes in the characteristics of the wound (see above). c. Changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights. According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. 1.) R97 was admitted to the facility on [DATE] with diagnoses of diabetes, lupus, agranulocytosis (low white blood cells to help fight infection), heart failure, acute kidney failure, anxiety, and depression. R97's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R97 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and had impairment to both arms and legs. No skin concerns were documented on the MDS assessment. R97 had a Guardian. R97's Activities of Daily Living Care Plan was initiated on 11/29/2019 and had interventions in place on 12/24/2024 of transferring with a full mechanical lift with total assistance of two people, bed mobility, dressing, bathing, hygiene, grooming, showers, etc. with extensive assistance of one person, and toileting check and change with total assistance of two people. R97's Skin Integrity Care Plan was initiated on 12/9/2019 with the interventions to float heels, have a cushion in the wheelchair, a pressure reducing mattress, and turn and reposition every two hours and as needed. R97 had the following treatments in place:-Skin prep to the left heel every shift for protection initiated 1/16/2020.-Zinc oxide paste to the buttocks every shift related to pressure injury of the sacral region Stage 4 initiated 6/26/2020.-Skin prep to the right posterior thigh daily initiated 9/30/2024. On 12/24/2024 at 12:28 PM in the progress notes, nursing indicated R97 had a fall while being assisted out of bed by staff. R97 complained a knee pain and was transferred to the hospital. R97 was in the hospital from [DATE] to 12/31/2024. The hospital documented R97 sustained a (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	fracture to the left tibia and fibula from the fall which was surgically repaired. The discharge instructions on the After Visit Summary included to follow up at the orthopedic clinic on 1/9/2025 at 11:00 AM and to keep the dressing on the surgical incision until the follow up visit. On 12/31/2024 at 2:07 PM in the progress notes, wound Licensed Practical Nurse (LPN)-I documented a late entry on 2/18/2025 documenting R97's skin check was completed and R97 had an immobilizer to the left leg. R97 had a skin issue to the right rear thigh in the form of a blister that was not evaluated, and an Aquacel dressing that was intact and was not to be removed until the follow up orthopedic appointment. LPN-I documented R97 refused to have the right rear thigh blister examined. Surveyor noted a Registered Nurse (RN) did not assess R97's skin upon readmission to the facility. On 12/31/2024 at 3:28 PM in the progress notes, LPN-I documented a late entry clarification on 6/30/2025 documenting the Aquacel dressing to the left above the knee amputation was not to be removed until the follow up orthopedic appointment. Surveyor noted R97 did not have an amputation at that time. R97's treatment orders of skin prep to the left heel and right posterior thigh and the zinc oxide paste to the buttocks continued from pre-hospitalization. On 1/2/2025, R97 was seen by the Wound Physician. The Wound Physician documented R97 had a pressure injury to the left heel. No other wounds were documented. On 1/2/2025 on the Skin Check form, LPN-I documented R97 had wounds to the left heel, the left lateral foot, the left medial ankle, and left dorsal foot with blisters that were inhouse acquired, as well as a surgical wound to the left lateral knee. The wounds were not assessed by an RN or the Wound Physician. LPN-I documented the Wound Physician saw R97 to evaluate and treat the left heel pressure injury and the other wounds needed to be assessed or evaluated. There was no further documentation regarding the non-pressure wounds. On 1/3/2025 at 9:13 AM in the progress notes, the dietician documented R97 had a significant weight loss and had a pressure injury to the left heel. No other wounds were documented by the dietician for the dietary assessment to create a complete picture of the dietary needs of R97. No documentation was found of R97 going to the orthopedic clinic on 1/9/2025 for the follow up appointment. No documentation was found of an assessment of R97's surgical wound or left foot wounds after The skin check form dated 1/2/2025. LPN-I started a weekly wound log on 1/26/2025 that had measurements of the left lateral surgical wound. This wound log was not part of R97's medical record and was not verified or assessed by an RN. No wound descriptors were written on the log. The log was weekly until 6/7/2025. On 1/30/2025, R97 went to the orthopedic clinic. The orthopedic clinic documented on the Report of Consultation R97 was one month status post the left tibia fracture surgical repair on 12/27/2024. R97 had significant wound breakdown for not being seen on 1/9/2025 in the office. Wound debridement was done in the office and the wound required twice daily packing with 4 x 4 gauze and betadine. The orthopedic clinic ordered R97 to be followed at the wound care clinic immediately and an antibiotic, Keflex 500 mg, to be given four times a day for 14 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525371	A. Building B. Wing	09/30/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted no assessments had been done by the facility of the surgical wound to the left outer knee. Orders were to leave the dressing in place until the first follow up appointment which R97 did not attend (on 01/09/25.) This resulted in R97 developing a wound requiring debridement and antibiotics for infection. Surveyor noted R97's record does not include any documentation to explain why R97 was not seen in the wound clinic on 1/9/2025 or if there was consultation with the clinic on that date if R97 was not able to keep their appointment. On 1/30/2025 at 10:58 AM in the progress notes, wound LPN-I documented R97 returned from the orthopedic appointment for the left tibia fracture follow up visit and has a wound to the left extremity. Sutures were removed at the office and R97 has a new order for wound care and antibiotics for the wound. At 1:57 PM in the progress notes, LPN-I documented the wound to the left lateral knee was irregular in shape measuring 14.5 cm x 2 cm x 1.5 cm with a pink and moist wound bed. The wound was not assessed by an RN. On 1/31/2025 at 7:25 AM in the progress notes, wound LPN-I documented the left lateral knee wound treatment was completed by LPN-I and the wound bed is 80% pink granulation and 20% slough. The peri wound was pink at the proximal end and brown discoloration to the distal wound. The immobilizer to the left leg was in place and the skin was checked for breakdown. Prevalon boots were in place for off-loading. On 2/3/2025 at 10:15 AM in the progress notes, wound LPN-I documented R97 was noted to have a fluid filled blister to the left dorsal foot measuring 8 cm x 2 cm x 0.1 cm. The Nurse Practitioner (NP) was notified and a treatment of skin prep to the left dorsal foot blister daily was obtained. The wound was not assessed by an RN. On 2/6/2025, R97 was seen by the in-house wound physician. The wound physician assessed the left dorsal foot blister documenting the etiology as lymphedema. The blister measured 2.5 cm x 8.1 cm x 0 cm. The wound physician did not assess the left lateral knee surgical wound. On 2/6/2025, R97 was seen in the orthopedic clinic where the left lateral surgical wound was debrided and the treatment of packing the wound with betadine gauze continued. On 2/13/2025, R97 was seen by the in-house wound physician. The lymphedema wound of the left dorsal foot measured 2.5 cm x 7.5 cm x 0.1 cm with 20% necrotic tissue, 50% slough, and 30% granulation tissue. This was the first documentation the blister was no longer intact. The treatment was changed by the wound physician. On 2/18/2025 at 12:13 PM in the progress notes, wound LPN-I documented R97 was seen in the wound clinic with a new order to start a wound vac to the left lateral knee surgical wound. The wound clinic ordered treatment of betadine to the left medial ankle and heel eschar daily. Surveyor unable to determine if the left medial ankle wound and the left dorsal foot wound were the same and labeled differently by the wound clinic. On 2/19/2025 at 7:21 AM in the progress notes, wound LPN-I documented the wound vac was applied to the left lateral knee surgical wound. The wound measured 13 cm x 3 cm x 1.5 cm with 10% granulation and 90% adipose tissue with no tunneling or undermining. The wound was surgically debrided at the wound clinic. R97 was also seen at the clinic for the left lateral ankle blister and left dorsal foot. A new treatment was obtained by the wound clinic and initiated. (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted no documentation was available in R97's medical record from the wound clinic with assessments of the wounds and the wounds were not assessed in the facility by an RN. LPN-I opened weekly wound assessment documents, but those assessments were never verified or signed by an RN. On 2/20/2025, the in-house wound physician discharged R97 from services due to R97 being followed for wounds at the wound clinic. On 2/26/2025 at 11:05 AM in the progress notes, wound LPN-I documented R97 had wounds to the left lateral knee, the left lateral foot, and the left dorsal foot. LPN-I documented the wound base tissue types but no measurements. The wounds were not assessed by an RN. On 2/26/2025 at 10:57 PM in the progress notes, nursing documented a conversation was had with the NP related to R97 needing to be assessed by psych services. R97 was noted to be crying on occasion about the left foot and the fear that the wounds will not heal and need to be amputated. Nursing documented R97's crying was related to pain. Psych services were obtained. On 3/4/2025 at 8:00 AM in the progress notes, wound LPN-I documented R97 went to the wound clinic for wounds to the left lateral knee, left heel, left lateral foot, left dorsal foot, and left medial ankle. At 10:50 AM in the progress notes, LPN-I documented the blister to the left lateral foot was newly discovered during wound care and measured 4.5 cm x 2.5 cm x 0.1 cm. LPN-I notified the NP, the Director of Nursing (DON), and R97's Guardian. The wound documentation was not verified or signed by an RN. On 3/6/2025 at 9:16 PM in the progress notes, nursing documented R97 had a new order for amitriptyline 50 mg every evening for neuropathy pain. R97 complained of bilateral feet feeling like they are on fire. On 3/13/2025 at 10:12 PM in the progress notes, nursing documented R97 was yelling out earlier in the shift related to pain to the left foot. Pain medication was administered at 1:15 PM and not effective. The NP was contacted and ordered to increase the biofreeze gel from three times daily to every six hours. The psych NP was in house and at bedside to assess R97 with no new orders for psychotropic medications. The physician was notified and received a new order to add an additional dose of amitriptyline 25 mg for neuropathy pain in the morning and to give ibuprofen 800 mg with acetaminophen 1000 mg twice daily for 14 days. On 3/15/2025 at 10:17 PM in the progress notes, nursing documented R97 continued calling out when R97 has pain from left heel open areas. R97 was encouraged to keep heel floated to relieve pressure and promote comfort. Scheduled medications and creams were helpful for pain. The treatment to the left leg and left heel/foot was completed. On 3/19/2025 at 8:00 AM in the progress notes, wound LPN-I documented R97 went to the outpatient wound clinic for the left lateral knee wound, the left heel, the left dorsal foot, and the left lateral foot. Wound care was not completed by LPN-I that shift. At 11:12 AM in the progress notes, nursing documented R97 was being admitted from the wound clinic to the hospital for possible left lower extremity wound infection, osteomyelitis, etc. with wounds probing down to bone and/or left lower extremity hardware. The hospital admission note on 3/19/2025 documented R97 presented to the emergency room with a (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	worsening presentation of the wound in the left lower extremity. R97 was at a scheduled wound care visit with clinician note citing that R97's chronic wound probes to the hardware and bone in several locations, had malodor, and had increased depth and necrosis. R97 also had increased malaise. There was also a note of a right foot wound with increased pain, edema and necrosis. R97 was started on antibiotics due to the concern of osteomyelitis. The physical exam documented an open wound on the left anterior knee, tender, non-draining without any pus or blood noted, the right foot has a wound on the heel with eschar present and the left foot has wounds on the medial and lateral sides with eschar, along with a large wound on the left heel with an overlying eschar. All wounds were painful to palpation. Surveyor noted pictures of the listed wounds but no wound picture of the right heel. No documentation was found of R97 having a wound to the right heel prior to the hospital admission. R97 was readmitted to the facility on [DATE]. R97 had orders for intravenous antibiotics for the wound infection after surgical removal of hardware to the left knee. On 4/9/2025 at 1:00 PM in the progress notes, wound LPN-I documented R97 returned to the facility with wounds. The left lateral knee surgical wound measured 13 cm x 4 cm x 3 cm with exposed bones, ligaments, tendon, and granulation and adipose tissue. The distal end of the wound was open and superficial, and 11 sutures were intact and approximate. The wound vac was applied per order. The left lateral foot wound measured 5 cm x 6 cm x 0.1 cm with 90% eschar and 10% granulation with scant serous drainage. The right dorsal foot skin was dry with 100% eschar that measured 4 cm x 2 cm x 0.1 cm. Surveyor noted LPN-I may have documented on the left dorsal foot rather than the right dorsal foot. The left posterior calf had an open area that measured 1 cm x 1 cm x 0.1 cm with no drainage. R97's skin was not assessed by an RN. Treatments were obtained for the left lateral knee wound and the left dorsal foot wound. No treatment was obtained for the left lateral foot. On 4/11/2025, an Infection of MRSA (Methicillin-resistant Staphylococcus aureus) to the Left Thigh Wound Care Plan was initiated. On 4/16/2025 at 2:00 PM in the progress notes, wound LPN-I documented R97 complained of pain to the right inner thigh. R97 thought it was a boil. LPN-I observed and noted the right inner thigh has an abrasion from the brief being too small and too tight. The wound was irregular in shape and superficial measuring 6 cm x 4 cm x 0.1 cm with a pink moist wound bed. The NP was notified, and a treatment was obtained. The wound was not assessed by an RN. LPN-I educated staff to use larger briefs when caring for R97. On 4/18/2025 at 9:03 AM in the progress notes, wound LPN-I documented during wound care to the left lateral knee surgical wound, the wound bed had 15% bone exposed with sutures present. LPN-I notified the NP to come and assess the wound. At 9:15 AM in the progress notes, LPN-I documented the NP arrived to assess R97's left lateral knee surgical wound with partial bone exposed and sticking outward. The NP ordered R97 to be evaluated in the emergency room. On 4/18/2025 in the NP notes, the NP documented R97 was seen for a follow up on the left lateral knee surgical wound with delayed healing. The NP received a phone call that morning about a complication to the wound with a bone sticking outward per the wound nurse and that had not been the case before. There had been bone, but it was not exposed like that and definitely not sticking out. Now it looks like the bone got fractured and the rough end of the bone was sticking out and the other end of the bone was not visible. R97 was recently at the hospital and the plan was to try to heal the wound with a wound vac and the next step would be an amputation above the knee. R97 agreed to the amputation and requested to be sent out to the hospital. R97 reported a lot of pain to the left leg. R97 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525371	A. Building B. Wing	09/30/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	denied any trauma or any fall in the past few days. R97 was hospitalized from [DATE] to 4/22/2025 for a left surgical above the knee amputation. R97 was readmitted to the facility on [DATE]. On 4/22/2025 on the Clinical admission form in the Skin section, the form prefilled with previous wounds, such as the left medial ankle, the left heel, the left lateral foot and the left dorsal foot with blisters as well as the front left knee surgical wound and the right medial thigh abrasion. Those wounds were present prior to R97's hospitalizations but were not present after readmission due to the left above the knee amputation. No RN assessed R97's skin. On 4/22/2025 at 10:50 AM in the progress notes, wound LPN-I documented R97's readmission skin check had a left above the knee amputation with a wound vac to the area that was not to be removed until follow up on 4/30/2025 at the orthopedic clinic. No other skin concerns were documented. On 4/30/2025 at 2:21 PM in the progress notes, wound LPN-I documented R97 returned from the orthopedic clinic appointment with the wound vac still in place to the left above the knee amputation surgical site with a new order to discontinue the wound vac on 5/4/2025 and replace with a dressing to be left in place until the following appointment on 5/9/2025. At 4:07 PM in the progress notes, nursing documented R97 had a new order for the antibiotic Cephalexin 500 mg four times daily for 14 days for an infection to R97's wounds. On 5/29/2025 at 8:27 AM in the progress notes, wound LPN-I documented R97 had an abrasion to the left upper arm that measured 2.5 cm x 1 cm x 0.1 cm with a pink wound bed. A treatment order was obtained. The wound was not assessed by an RN. No weekly wound assessments of the left above the knee amputation surgical wound or the left upper arm abrasion were documented. On 6/18/2025, R97 was sent to the hospital and admitted for acute renal failure. On 7/9/2025 on the hospital discharge summary, the physician documented R97 had wounds to the sacrum, the right anterior and posterior thigh, right hip, left posterior thigh, the right lower leg and the right ankle/foot. Discharge wound treatment orders for the right anterior and posterior thigh ulcers, the right hip ulcer and the left posterior thigh ulcer were to be washed with soap and water, dried well, skin prep to the crusted anterior thigh wounds, and Melgisorb AG with dry cover dressing to draining wounds on the posterior and lateral aspects daily and as needed. On 7/9/2025 on the Clinical admission form in the Skin section, the form prefilled with previous wounds, such as the left medial ankle, the left heel, the left lateral foot and the left dorsal foot with blisters, the front left lateral knee surgical wound, the right medial thigh abrasion, the left upper arm abrasion and the right lateral top of the foot abrasion. Those wounds were present prior to R97's hospitalizations but the left leg wounds were not present after readmission due to the left above the knee amputation. No RN assessed R97's skin. On 7/9/2025 at 4:04 PM in the progress notes, nursing documented R97 was readmitted with wounds to the coccyx, the right buttock, the right leg, and the right foot. No assessment was completed. The treatment of zinc to the left arm continued from pre-hospitalization. No treatments were initiated from (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the hospital discharge orders. On 7/10/2025 at 8:38 AM in the progress notes, nursing documented R97 was sent to the hospital for evaluation of rectal bleeding. R97 was admitted to the hospital at that time. On 7/12/2025 at 8:20 PM in the progress notes, nursing documented R97 was readmitted to the facility. No skin assessment was completed or documented. No treatments were initiated to the wounds that were documented from the hospital on 7/9/2025. On 7/21/2025, treatment orders were started for the right anterior and posterior ulcers and the left posterior ulcer to wash with soap and water, skin prep to the crusted anterior thigh wounds, and multisorb AG with dry cover dressing daily. This was the order from the discharge summary on 7/9/2025, 13 days after R97 discharged from the hospital. The order did not denote where the ulcers were located and misspelled the treatment. The wounds were never assessed or documented. On 7/22/2025 at 12:16 PM in the progress notes, nursing documented during wound care, the nurse observed increased drainage that was green in color and R97 verbalized pain. The NP was contacted and on order was obtained for the antibiotic doxycycline 100 mg twice daily for 10 days and to get a wound culture. Surveyor noted the documentation did not specify which wound had the green drainage. On 7/23/2025, R97 was seen by the in-house Wound Physician (WP)-O. This was the first assessment of any wounds since 2/13/2025 when R97 was last seen by the in-house wound physician. This is not the same wound physician that had cared for R97 on 2/13/2025. WP-O documented R97 had a non-pressure wound to the right shin/foot that measured 11.19 cm x 8.78 cm x 0.2 cm with 1-25% slough and 51-75% eschar and a non-pressure wound to the right thigh that measured 11.68 cm x 15.08 cm x 0.2 cm with 1-25% granulation and 51-75% eschar. No documentation was found of green exudate by the wound physician. On 7/23/2025, R97 had a treatment order for the right lower leg/ankle to paint with betadine daily. On 7/24/2025, R97 had treatment orders for the right lower leg/ankle to paint with betadine, once dry, apply ABD pad and kerlix daily, and the right medial/anterior thigh to paint with betadine daily. On 7/26/2025, R97 had a treatment to pain the left gluteal wound with betadine and leave open to air daily. Surveyor noted R97 did not have any documentation of a wound to the left gluteus. On 7/30/2025 at 1:26 PM in the progress notes, wound LPN-I documented R97 was seen by WP-O for the right foot, right ankle, and the right thigh wound. WP-O noted gangrene and dusky color to the right great toe and noted maggots in the ankle wound. R97 was sent to the hospital for further evaluation and treatment. On 7/30/2025 on the wound physician assessment note, WP-O documented ulcers were noted on the anterior aspect of the right thigh with 100% slough, moderate purulent exudate that was malodorous, the right distal leg/foot was a large wound extending into the ankles from the lower half of the leg from the front and back, and the distal foot and all toes were noted to be cyanotic (blue) with maggots noted in the wound bed. WP-O was unable to clean the maggots at the time of the evaluation and increased malodor was also noted. R97 was presenting with grossly necrotic wounds on the right lower extremity. The decision was made to send R97 to the emergency room for further evaluation (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525371	A. Building B. Wing	09/30/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and treatment, which might include an amputation of the right lower extremity. Imaging documentation was deferred as the wounds were extensive, much larger than they were at the last visit, grossly necrotic and due to the fact that we were not able to clean the wounds of maggots at the bedside. On 7/30/2025, R97 was admitted to the hospital. The hospital physician documented R97 had chronic appearing wounds on the right lower extremity extending up to the thigh. The wounds were scabbed and oozing with no surrounding redness. The right foot was foul smelling with green drainage, maggots, and deep wounds with muscle exposure. On 8/7/2025, R97 had a right above the knee amputation. R97 did not return to the facility. In an interview on 9/10/2025 at 3:34 PM, Surveyor asked DON-B and wound LPN-I why there were no weekly assessments of wounds. DON-B stated in May 2025; LPN-I was given the guidance by the management team that LPN-I did not have to do weekly wound assessments. DON-B stated if Surveyor reviews R97's medical record, the weekly assessments were done from January to May 2025. LPN-I stated no one was signing the assessments so they are still open. Surveyor asked LPN-I if an RN looked at any of the wounds when LPN-I was either doing treatments or measuring the wounds. LPN-I stated no. DON-B stated the in-house wound physician, and the wound log LPN-I made have the assessments. Surveyor shared the concern R97 went to the wound clinic and none of those assessments are in R97's record and the wound log is not part of R97's record. DON-B agreed. In an interview on 9/15/2025 at 8:05 AM, Surveyor asked wound LPN-I what the process was for the facility to assess resident wounds. LPN-I stated the wound team, consisting of the wound physician, the NP, LPN-I, an RN from the wound agency, and the unit managers, look at all the wounds weekly. LPN-I stated after DON-B left employment on 12/31/2024, LPN-I informed the new DON that the DON needed to sign LPN-I's wound assessments until LPN-I was certified. LPN-I stated the DON never followed through with signing anything; that is why all the assessments in R97's record are still open. LPN-I stated R97 was not seen by the wound team because R97 had a surgical wound so the wound clinic preferred R97 go there for care. Surveyor asked LPN-I how often R97 went to the wound clinic. LPN-I stated some months it was every other week and then it depended on how the wound was progressing. LPN-I stated WP-O saw R97 on 7/30/2025 for a second encounter, first seeing R97 the week before, and WP-O determined the right thigh wound was caused by R97's lupus. LPN-I stated LPN-I was on vacation from 7/18/2025-7/23/2025 so had not seen R97's wound for 9 days and did not know who was covering for LPN-I when LPN-I was gone. LPN-I stated the DON knew LPN-I was on vacation that week but did not know if anything was done with wounds. Surveyor asked LPN-I if LPN-I observed maggots in R97's wound on 7/30/2025. LPN-I stated LPN-I was with WP-O and they both observed maggots in the ankle wound. In an interview on 9/15/2025 at 1:41 PM, Surveyor asked LPN-Z if LPN-Z recalled R97. LPN-Z stated LPN-Z took care of R97 after the left leg was amputated. Surveyor asked LPN-Z what wounds LPN-Z could recall that R97 had at that time. LPN-Z stated R97 had a wound on the right thigh on the front but could not recall if there was a treatment to the area. LPN-Z recalled a treatment to the right foot, but stated the wound care nurse did the treatment during the week. Surveyor asked LPN-Z what the fac

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	525371	A. Building B. Wing	09/30/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents with pressure injuries or at risk for pressure injuries received necessary treatment and services consistent with professional standards of practice to prevent the development of pressure injuries and to promote healing for 5 of 5 residents (R98, R97, R10, R4, and R2) reviewed for pressure injuries. *R98 was admitted to the facility with a history of a stage 2 pressure injury to the right buttock. On 7/3/2025, nursing documented R98 was not able to get wound treatment or measurements completed but does not indicate what wounds required treatment or measurement. On 7/13/2025, nursing documented R98 has a pressure injury to the right lateral coccyx. On 7/16/2025, R98 was assessed by the wound physician and found to have unstageable pressure injuries to the right ischium and sacrum/right buttock. On 7/23/2025, R98 now also has a deep tissue injury to the right heel, and an unstageable pressure injury to the left heel. On 8/2/2025, R98 was sent to the emergency room for concerns of infection and R98's admission diagnoses included: Two necrotic decubitus ulcers on the left and right buttocks, draining yellow discharge and very foul odor, severe sepsis, Fournier's gangrene in male (a rare, life threatening infection that rapidly destroys soft tissues in the genital, perineal and perianal areas), stage 4 pressure injury to the left buttock, stage 4 to the right buttock, deep tissue injury to the right heel, and unstageable pressure injury to the left heel. On 8/2/2025, R98 underwent surgical debridement and findings included: Two necrotic decubitus ulcers on the left and right buttocks, draining yellow discharge and very foul odor and necrotic tissue to the bilateral buttocks with significant fat and muscle necrosis. R98's left buttock wound tracked down to the bone, and right buttock wound tracked down to subcutaneous fat. *R97 did not have comprehensive skin assessments upon readmission to the facility on [DATE], 4/9/2025, 4/22/2025, 7/9/2025, and 7/12/2025. R97 developed a Deep Tissue Injury to the left heel on 1/2/2025 that became Unstageable, an Unstageable pressure injury to the left lateral heel/foot on 2/17/2025, a blister to the left lateral foot on 3/4/2025 with no etiology of the wound or staging, and a Stage 2 pressure injury to the coccyx on 5/20/2025 that had previously been a Stage 4 pressure injury that healed in 2020. Ordered wound treatments were not implemented timely; the treatment to the left lateral foot ordered on 2/18/2025 was not implemented until 2/24/2025 and the treatment orders for the sacral wound ordered on 7/9/2025 were not implemented until 7/20/2025. Treatments were ordered for wounds that were not assessed or documented; R97 had an order for a treatment to the sacrum on 4/9/2025 with no documentation of a wound present and an order for a treatment to the left gluteal wound on 7/26/2025 with no documentation of a wound present. Wounds were not comprehensively assessed weekly by an RN in the facility after 2/13/2025 when R97 stopped being seen by the wound physician. During the survey, systemic failures were identified in the wound care and preventative interventions the facility was providing. The facility did not have established policies and procedures for wound care that were reviewed and approved by the medical director to ensure they were based upon current standards of practice. The facility did not have a system to ensure risk factors were appropriately assessed and addressed. The facility did not have an established system to monitor and assess wounds based upon standards of practice. Surveyors notified nursing home administrator (NHA)-A, director of nursing (DON)-B, wound licensed practical nurse (LPN)- I, and regional nurse consultant (RNC)-L on 9/16/2025, at 11:50 AM. The immediate jeopardy was not removed prior to survey exit on 9/30/2025. (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Additional resident examples not at the scope and severity of immediate jeopardy include:* R4 developed a facility acquired stage three pressure injury to the sacrum.* R10 developed a facility acquired stage three pressure injury to the sacrum and was observed not wearing heel boots per care plan interventions during the survey.* R2 has a history of having a deep tissue injury to the heel. During survey R2 was observed to have R2's heel directly on the bed and not being offloaded. R2 was observed not wearing heel boots during the survey per R2's care plan intervention for prevention of pressure injury development. R2's pressure injury care plan was not revised to reflect patient specific interventions. Findings include: The facility policy titled Wound Management with a reference date of 2019 documents: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidenced-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and Compliance Guidelines:1. Wound treatments will be provided in accordance with physician orders, including cleansing method, type of dressing, and frequency of dressing change.2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse.5. Treatment decisions will be based on:a. Etiology of the wound .b. Characteristics of the wound .c. Location of the wound.6. Guidelines for dressing selection may be utilized in obtaining physician orders .c. The facility will follow specific physician orders providing wound care.7. Treatments will be documented in the treatment administration record (TAR).8. The effectiveness of the treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include:a. Lack of progression towards healing.b. Changes in the characteristics on the wound. 1.) R98 was admitted to the facility on [DATE] and has diagnoses that include end stage renal disease dependent on renal dialysis, nicotine dependence, diabetes mellitus, degenerative disk disease of lumbosacral area with worsening back pain, muscle wasting with atrophy/weakness, endocrine, nutritional, and metabolic disease. R98's admission minimum data set (MDS) dated [DATE] indicated R98 has intact cognition with a Brief Interview for Mental Status (BIMS) score of 15 and the facility assessed R98 as requiring total assistance with 1 staff member for toileting hygiene and moderate assist with 1 staff member for repositioning. R98 was frequently incontinent of urine and always incontinent of bowel and wore an adult brief for protection. R98 used a bed pan while in bed for R98's toileting needs. R98 was non ambulatory and required a Hoyer lift with two staff assist for transfers into a wheelchair, R98 was able to self-propel while in the wheelchair. The facility assessed R98 on 6/13/2025 to be a mild risk for pressure injury development with a Braden score of 18. Surveyor reviewed R98's hospital discharge paperwork dated 6/13/2025 that documented R98 was admitted into the hospital on 6/6/2025 with worsening back pain and inability to stand. Hospital staff documented on 6/8/2025, R98 had a stage 2 pressure injury to the right buttock; no comprehensive assessments were documented in the hospital discharge paperwork. R98's care plan was initiated on 6/13/2025 for: Pressure at risk due to Assistance required in bed mobility with the following interventions:- Conduct weekly skin inspection.- Assist and encourage turning and repositioning every 2-3 hours.Interventions initiated 6/17/2025:- Diabetic foot check every evening.- Prevalon boots while in bed, may remove with care and therapy. R98's Pressure injury Care Area Assessment (CAA) dated 6/17/2025 documents:-Resident at risk for skin breakdown due (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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	525371	A. Building B. Wing	09/30/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	unstageable5.83 cm x 5.25 cm x 0.1 cm, small serous drainage, 1-25% granulation tissue (new, pink/red tissue that forms as wounds heal), 51-75% slough.On 7/16/2025, the following treatments were initiated for R98's right ischium and sacrum/right buttock unstageable pressure ulcers:- Protect peri wound (around the wound) with skin prep.- Cleanse pressure area with 1/2 strength Dakin's solution.- Apply Santyl to wound bed.- Cover with bordered gauze.- Change daily and as needed (PRN). Surveyor reviewed R98's July MAR/TAR and noted staff did not initial treatments were being completed as ordered for 7 out of 15 days in July until staff initiated the treatment on 7/16/2025. On 7/23/2025, R98 had a wound assessment with wound physician-O with the following wound assessments:1. Right ischium pressure ulcer, unstageable,1.44 cm x 3.2 cm x 0.2 cm, small serous drainage, 76%-100% slough.2. Sacrum/right buttock pressure ulcer, unstageable.2.19 cm x 1.98 cm x 0.1 cm, small serous drainage, 1-25% granulation tissue, 51%-75% slough.3. Right heel suspected deep tissue injury (DTI)2.19 cm x 1.98 cm x 0.1 cm, purple in color, attached edges.Treatment ordered: cleanse with saline solution, apply skin prep twice a day (BID) and PRN.4. Left heel pressure ulcer, unstageable.0.61 cm x 0.52 cm x 0.1 cm, 100% eschar tissue (dry, dead tissue)Treatment ordered: cleanse with betadine daily and PRN. Surveyor reviewed R98's July and August MAR/TARs and noted the right heel and left heel treatment orders did not get initiated until 8/1/2025 with the following order:-Paint left and right heel with betadine and leave open to air daily and PRN Surveyor noted the right heel treatment initiated on 8/1/2025 was not the same treatment to be initiated when ordered on 7/23/2025 by wound physician-O. On 7/30/2025, at 13:23 (1:23PM), in the progress notes wound LPN-I documented (R98) was seen by wound team for multiple wounds: . sacrum wound, left and right heel eschar. (R98) is to be on bed rest except dialysis days. On 7/30/2025, R98 had a wound assessment with wound physician-O with the following wound assessments:1. Right ischium pressure ulcer, unstageable.2.24 cm x 2.11 cm x 0.1 cm, small serous drainage, 76%-100% slough. 2. Sacrum/right buttock pressure ulcer, Stage 3.2.65 cm x 2.35 cm x 0.1 cm, small serous drainage, 1-25% granulation tissue, 51-75% slough. 3. Right heel DTI.2.63 cm x 2.35cm x 0.1 cm, purple, attached edges Surveyor noted there was no assessment documented on R98's left heel on 7/30/2025. On 7/30/2025, R98's care plan was initiated for: Pressure ulcer actual: sacrum, left medial thigh (documented as trauma), unstageable right buttock, unstageable right and left heel. Assistance required in bed mobility, bed fast, bowel incontinence with the following interventions:- Evaluate need for pain reliever prior to cleaning and dressing changes.- Notify practitioner if symptoms worsen or do not resolve.- Provide pressure reducing wheelchair cushion.- Provide pressure reduction/relieving mattress.- Treatments as ordered.- Weekly wound assessment. On 8/1/2025, at 14:50 (2:50PM,) LPN-R documented therapy department informed LPN-R (R98's) level (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	of consciousness (LOC) was not the same as usual. (R98) was not participating in therapy, was lethargic, trembling/shaking . STAT (immediate) labs and wound culture were ordered. Surveyor noted that the wound culture was ordered to be obtained from R98's left medial thigh wound that was documented as a trauma/non-pressure related injury. Cross-reference F684. Surveyor noted there was no further documentation regarding R98's status regarding the documented loss of consciousness for the remainder of R98's progress notes. On 8/2/2025, at 10:03AM, in the progress notes, LPN-R documented nurse practitioner updated on critical lab results. LPN-R informed by the dialysis center that (R98) is being sent to the hospital for further evaluation due to possible infection at the port site. On 8/2/2025, at 14:42 (2:42PM), in the progress notes, LPN-R documented . (R98) admitted to hospital with necrotic fasciitis (a subset of aggressive skin and soft tissue infections that cause muscle fascia and subcutaneous tissue necrosis) to wound and finger. Surveyor reviewed R98's hospital admission paperwork dated 8/2/2025 and noted the following documented:1. R98's admission diagnoses in the hospital on 8/2/2025 include: .- Fournier's gangrene in male (Primary, life threatening infection that rapidly spreads through the tissues of the genital and perineal areas).- Severe sepsis (infection that leads to widespread inflammation and organ damage).- Stage 4 pressure ulcer, left buttock.- Deep tissue injury of right heel.- Unstageable pressure injury of left heel.- Stage 4 pressure injury, right buttock. 2. R98's vital signs in the emergency room on 8/2/2025 at 11:32AM were documented:- Temperature, 98.5 degrees Fahrenheit- Heart rate, 117 (elevated)- Respirations, 16- Blood pressure, 99/62 (low)- Pulse oximetry, 99% R98's emergency room assessment and plan summary documented on 8/2/2025 included the following findings:- Two necrotic ulcers on the left and right buttocks, draining yellow discharge and has very foul odor.- Bilateral buttock pressure wounds with abscess and concern for possible progression to Fournier gangrene. Surgery consulted and will have incision and drain performed today (8/2/2025).- (R98) started on broad spectrum IV antibiotics, blood cultures sent for evaluation.- (R98) found to have infected sacral pressure wounds, abnormal labs.- Right buttock pressure ulcer was positive for Bacteroides (diverse group of bacteria that cause serious infection if enter other body tissues).- (R98) underwent bilateral buttock debridement that resulted in:- Right buttock: 6 cm x 3 cm, debrided down to subcutaneous fat.- Left buttock: 13 cm x 14 cm, debrided down to and including muscle.Findings: Necrotic tissue to bilateral buttocks, significant fat and muscle necrosis. Left buttock wound tracked down to the bone, right buttock wound tracked down to subcutaneous fat. On 9/10/2025, at 3:33PM, Surveyor interviewed DON-B and wound LPN-I who stated weekly skin sheets/assessments were being completed, however, in May 2025 wound LPN-I was given guidance from previous facility governing body to no longer document weekly skin assessments because the wound physician documentation and notes were enough. DON-B stated DON-B left the facility 12/31/2024 and the facility was doing weekly skin assessment sheets. DON-B came back to the facility in August 2025 and noted the weekly skin assessments were not being completed and restarted them to be completed by staff. DON-B and wound LPN-I were not sure why the weekly skin assessment sheets would have been stopped. Wound LPN-I and DON-B confirmed there are no weekly skin assessments for R98's pressure wounds other than what is documented in the progress notes (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and wound physician wound notes. Surveyor shared concern Surveyor is not able to tell exactly when R98's pressure injury concerns started. DON-B and wound LPN-I confirmed they both could not determine either based on what is documented. On 9/15/2025, at 8:06AM, Surveyor interviewed wound LPN-I who stated any nursing staff can document an assessment if there is a concern with a resident. Wound LPN-I stated staff will notify wound LPN-I if a resident has an area of concern and then wound LPN-I will assess the resident. Wound LPN-I stated the previous DON was notified wound LPN-I would need to have previous DON-DDD look at and sign off on the skin assessments for oversight. Wound LPN-I stated the previous DON never signed off on wound LPN-I's assessments or followed up on any concerns wound LPN-I brought forth. Wound LPN-I stated wound LPN-I was on vacation from 7/18/2025 – 7/23/2025 and was not sure what staff was following resident wounds during that time. Wound LPN-I stated nursing would do dressing changes per order, but not sure if anything else was done or what staff were managing/following resident wounds. On 9/15/2025, at 9:26AM, Surveyor interviewed LPN-P who stated nursing staff are to fill out a skin assessment if an area of concern is noted on a resident and that will signal to wound LPN that there is a concern with a resident. LPN-P stated the assessment should document the location of the wound, and the wound LPN will gather the wound description and measurements. Surveyor asked LPN-P if the wound LPN is not available what staff is to get the wound assessment and measurements. LPN-P stated that if a skin assessment is filled out it will signal whoever needs to look at it and they will get the assessment and measurements of the wound. LPN-P stated the physician should be called for notification of the concern and get orders if appropriate. LPN-P stated the resident should be put on the 24 hour report to be monitored. LPN-P was not sure if R98 was put on the 24 hour report on 7/13/2025 when R98's pressure injury was first noted. LPN-P could not recall if R98 was getting treatments prior or had any concerns with pressure injuries. On 9/15/2025, at 9:47AM, Surveyor interviewed LPN-R who stated LPN-R could not recall how R98 was acting on 8/1/2025 and 8/2/2025. LPN-R stated R98 had wounds on the buttocks but could not recall if R98 needed treatments or when those treatments were completed and by whom. LPN-R could not recall what lab work or what wound culture was needed on 8/1/2025 or if any further monitoring was done for R98 on 8/1 and 8/2 when LPN-R documented R98 had a change in level of consciousness. On 9/15/2025 at 2:19PM, Surveyor attempted to call wound physician-O two times. The call ended both times without an option to leave a voicemail. On 9/15/2025, at 2:30PM, Surveyor interviewed DON-B who stated all nursing staff can document wound assessments with the oversight or follow up of a registered nurse. DON-B stated a comprehensive assessment must be completed when an area of concern is noted and should document the location or the wound, measurement, description, who was contacted, and treatment initiated if applicable. DON-B stated the resident is then placed on the 24 hour board to make other staff aware that the resident is experiencing a concern and to monitor. DON-B stated DON-B was not DON at the time of R98's pressure wound concerns, but comprehensive assessments should have been completed when R98's pressure wound first appeared, the care plan should have been revised, and treatments initiated immediately. DON-B stated when R98 was experiencing a change in level of consciousness, R98 should have been monitored and charted on, DON-B stated R98 should probably have been sent to the emergency room on 8/1/2025 if not 8/2/2025 due to change in level of consciousness and not sent to dialysis. (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/15/2025 at 3:15PM, Surveyor shared serious concerns with NHA-A, DON-B, wound LPN-I, and regional nurse consultant (RNC)-L of the facility's failure to not evaluate R98's clinical condition and risk factors, not define and implement interventions consistent with resident needs, goals, and standards of practice in a timely manner, or monitor and evaluate the impact of interventions for R98's pressure injuries to the right ischium, sacrum/right buttocks, and the right/left heels resulting in R98 needing surgical intervention and IV antibiotics due to infection. In an interview on 9/16/2025 at 8:18 AM, DON-B and LPN-I met with Surveyor to review R98's wound management. DON-B stated after DON-B left on 12/31/2024 and before returning on 8/7/2025, there were multiple changes in management and things were not done as they should have been done. DON-B stated systems were in place prior to 1/1/2025 and are being put back into place now that DON-B is back in the facility as the DON. 2.) R97 was admitted to the facility on [DATE] with diagnoses of diabetes, lupus, agranulocytosis (low white blood cells to help fight infection), heart failure, acute kidney failure, anxiety, and depression. R97's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R97 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and had impairment to both arms and legs. No skin concerns were documented on the MDS assessment. R97 had a Guardian. R97's Activities of Daily Living Care Plan was initiated on 11/29/2019 and had interventions in place on 12/24/2024 of transferring with a full mechanical lift with total assistance of two people, bed mobility, dressing, bathing, hygiene, grooming, showers, etc. with extensive assistance of one person, and toileting check and change with total assistance of two people. R97's Skin Integrity Care Plan was initiated on 12/9/2019 with the interventions to float heels, have a cushion in the wheelchair, a pressure reducing mattress, and turn and reposition every two hours and as needed. R97 had the following treatments in place:-Skin prep to the left heel every shift for protection initiated 1/16/2020.-Zinc oxide paste to the buttocks every shift related to pressure injury of the sacral region Stage 4 initiated 6/26/2020.-Skin prep to the right posterior thigh daily initiated 9/30/2024. R97 was in the hospital from [DATE] to 12/31/2024. The hospital documented R97 sustained a fracture to the left tibia and fibula from a fall which was surgically repaired. On 12/31/2024 at 2:07 PM in the progress notes, wound Licensed Practical Nurse (LPN)-I documented a late entry on 2/18/2025 documenting R97's skin check was completed and R97 had an immobilizer to the left leg. R97 had a skin issue to the right rear thigh in the form of a blister that was not evaluated, and an Aquacel dressing that was intact and was not to be removed until the follow up orthopedic appointment. LPN-I documented R97 refused to have the right rear thigh blister examined. Surveyor noted a Registered Nurse (RN) did not assess R97's skin upon readmission to the facility. R97's treatment orders of skin prep to the left heel and right posterior thigh and zinc oxide paste to the buttocks continued from pre-hospitalization. On 1/2/2025, R97 was seen by the Wound Physician. The Wound Physician documented R97 had a Deep Tissue Injury (DTI) to the left heel that measured 4 cm x 4 cm with purple/maroon discoloration and was present on admission per nursing staff. (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/2/2025 at 10:06 AM in the progress notes, wound LPN-I documented R97 was seen by the wound physician to evaluate and treat the right heel DTI. A new treatment order for skin prep to the left heel was obtained and an order for Prevalon boots to bilateral feet for off-loading. Wound LPN-I made a late entry on 3/19/2025 documenting the facility acquired left heel DTI was Unstageable with 100% eschar and the skin was intact. Surveyor noted a DTI does not have the characteristic of eschar and the wound physician did not document the eschar. The treatment of skin prep to the DTI continued as previously ordered on 1/16/2020. R97 was seen by the wound physician on 1/9/2025, 1/16/2025, and 1/23/2025 with documentation of the left heel DTI continuing at the same measurements and appearance as the initial evaluation. R97 was to be encouraged to off-load pressure to the heels. On 1/30/2025, R97 went to an orthopedic clinic appointment so was not assessed by the wound physician. No assessment was completed by an RN. On 1/31/2025 at 7:25 AM in the progress notes, wound LPN-I documented immobilizer to the left leg was in place and the skin was checked for breakdown. Prevalon boots were in place for off-loading. R97's At Risk for Pressure Ulcer Care Plan was initiated on 2/4/2025 with interventions of heel boots (already in the Skin Integrity Care Plan), skin assessment to be completed per policy, and treatments as ordered. R97 was seen by the wound physician on 2/6/2025 and 2/13/2025 with documentation of the left heel DTI with measurements of 4 cm x 3.8 cm and the same appearance as the previous assessments.Wound LPN-I started a weekly wound log on 2/16/2025 that has measurements of the pressure injury. This wound log was not part of R97's medical record and was not verified or assessed by an RN. No descriptors were written on the log. The log was weekly until 4/12/2025. On 2/17/2025 at 12:28 PM in the progress notes, wound LPN-I made a late entry on 3/4/2025 documenting R97 had a facility acquired Stage 2 pressure injury to the left lateral foot measuring 4.5 cm x 2.5 cm x 0.1 cm with an intact fluid filled blister. The wound was not assessed by an RN and no treatment was obtained for the new area of concern. On 2/18/2025, R97 went to the outpatient wound clinic. At 12:13 PM in the progress notes, wound LPN-I documented the wound clinic had orders for the left lateral heel Unstageable pressure injury of applying iodoflex and gauze dressing three times weekly and the left heel eschar paint with betadine daily and leave open to air. The treatments entered on the Treatment Administration Record (TAR) were to cleanse the left heel with wound cleanser, iodoflex, which was equivalent to iodosorb paste, and a border gauze three times a week and to paint the left heel with betadine daily. Both treatments entered on the TAR were for the left heel and no treatment was entered for the left lateral heel/foot. On 2/20/2025, the in-house wound physician discharged R97 from services due to R97 being followed for wounds at the wound clinic.Surveyor noted no documentation was available in R97's medical record from the wound clinic with assessments of the wounds and the wounds were not assessed in the facility by an RN. LPN-I opened weekly wound assessment documents, but those assessments were never verified or signed by an RN. Surveyor noted the left heel and left lateral foot wounds became eschar and slough with eschar making them Unstageable per wound LPN-I's documentation in the progress notes. (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/24/2025, R97 had an order to cleanse the left heel and left lateral foot with wound cleanser, iodoflex to the wound bed, and border gauze to be changed three times a week, as was ordered after the wound clinic appointment on 2/18/2025. On 2/26/2025 at 10:57 PM in the progress notes, nursing documented a conversation was had with the NP related to R97 needing to be assessed by psych services. R97 was noted to be crying on occasion about the left foot and the fear that the wounds will not heal and need to be amputated. Nursing documented R97's crying was related to pain. Psych services were obtained. On 3/4/2025 at 8:00 AM in the progress notes, wound LPN-I documented R97 went to the wound clinic for wounds to the left lateral knee, left heel, left lateral foot, left dorsal foot, and left medial ankle. At 10:50 AM in the progress notes, LPN-I documented the blister to the left lateral foot was newly discovered during wound care and measured 4.5 cm x 2.5 cm x 0.1 cm. LPN-I notified the Nurse Practitioner (NP), the Director of Nursing (DON), and R97's Guardian. The wound documentation was not verified or signed by an RN. At 2:27 PM in the progress notes, nursing documented the wound clinic ordered R97 to wear Prevalon boots at all times, place a pillow under the calf to offload the heel, and turn and reposition frequently. Surveyor noted these interventions were in R97's Care Plan but the wound clinic felt the need to restate those interventions, and the left lateral foot had a wound prior to 3/4/2025 making it unclear if this was an additional wound to the left foot. On 3/6/2025 at 9:16 PM in the progress notes, nursing documented R97 had a new order for amitriptyline 50 mg every evening for neuropathy pain. R97 complained of bilateral feet feeling like they are on fire. On 3/13/2025 at 10:12 PM in the progress notes, nursing documented R97 was yelling out earlier in the shift related to pain to the left foot. Pain medication was administered at 1:15 PM and not effective. The NP was contacted and ordered to increase the biofreeze gel from three times daily to every six hours. The psych NP was in house and at bedside to assess R97 with no new orders for psychotropic medications. The physician was notified and received a new order to add an additional dose of amitriptyline 25 mg for neuropathy pain in the morning and to give ibuprofen 800 mg with acetaminophen 1000 mg twice daily for 14 days. On 3/15/2025 at 10:17 PM in the progress notes, nursing documented R97 continued calling out when R97 had pain from left heel open areas. R97

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure 3 (R58, R73, & R40) of 11 residents received adequate supervision and assistance devices to prevent accidents. 1.) R58 suffered a fall on 2/14/25 resulting in left sacrum fracture and right inferior pubic ramus fracture when interventions were not being implemented per R58's care plan. 2.) R73 had three unwitnessed falls, 6/25/2025, 7/1/2025, and 7/3/2025. The falls were not thoroughly investigated with a root cause analysis to determine appropriate interventions to prevent future falls. 3.) R40 did not receive supervision while smoking per R40's smoking care plan. Findings include: The facility's policy titled Falls Management Process dated 2011 with no revision date documents the following: . 1. In the event a resident has fallen and/or is found on the ground, a complete head-to-toe assessment must be performed prior to moving the resident unless life-threatening safety concerns are present. 4. if the resident is conscious, provide reassurance and comfort . resident is not to be moved until assessed for injury by a nurse unless life-threatening situation exists. 5. if able, ask the resident to explain what happened and what they were attempting to do at the time of the fall (helpful for root cause analysis later). 6. upon arrival of the nurse, a quick head-to-toe scan will be performed without unnecessary movement, palpating and examining all areas for breaks in the skin and/or other abnormal findings. 7. obtain vital signs: blood pressure, pulse, pulse oximetry, and respirations. 8. obtain neurological checks (neuro-checks) per policy for any unwitnessed fall or any fall with evidence of injury to the head. 9. if no obvious injury or only minor injury, move resident to a comfortable position. If significant injury, severe pain, or abnormal assessments observed, call 9-1-1. 11. the nurse will complete an event documentation report, fall risk assessment, pain assessment, and obtain witness statements. 12. the nursing supervisor will determine the most appropriate intervention, implement, and update care plan. 13. resident fall will be noted on 24 hour report for three days for post fall monitoring, assessing for (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	injury, full vital signs every 8 hours, and pain assessment. 14. the Director of Nursing will be notified immediately for falls resulting in injury and/or transfer. The facility's policy titled Falls Review Process dated 2011 with no revision date documents: Post Fall Director of Nursing/Designee will assess the resident and review fall documentation, including witness statements, resident interview, environment review of area where fall occurred, and equipment inspection. The event will be discussed and event documentation reviewed for completion in Interdisciplinary Team (IDT) meeting. Compare data from previous assessments. Discuss identified trends. Therapy referral and Medication Review initiated. Other referrals if applicable . Review Fall Risk Assessment for any potential new risk factors. Review plan of care/interventions to ensure all prior interventions are in place and still appropriate. Adjust/add interventions on the Plan of Care. Update and communicate interventions. Provide appropriate training for caregivers if appropriate. Educate resident/family if appropriate Discuss findings and interventions with the resident/patient/family for inclusion in the Interdisciplinary Plan of Care (IPOC). The facility's policy, titled Resident Smoking, dated 7/15/25, documents in part, . Policy: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. Policy Explanation and Compliance Guidelines: . 6. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, (sic) to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. 10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan. 1.) R58 originally admitted to the facility on [DATE] with diagnoses including major depressive disorder, other epilepsy (a neurological condition characterized by recurrent seizures), extrapyramidal and movement disorder (involuntary body movements), schizophrenia, and unspecified dementia, moderate, with other behavioral disturbance. R58 had a legal guardian. R58's Medicare 5 Day Minimum Data Set (MDS) dated [DATE] documented R58 had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition, R58 was always continent of bowel (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and bladder, R58 was independent with toileting hygiene, bed mobility, and sit to stand transfers, R58 required supervision for bed to chair transfers and toilet transfers, and R58 used a manual wheelchair and was independent with wheelchair mobility for 150 feet. The MDS documented R58 did not exhibit any behaviors of inattention, disorganized thinking, or altered level of consciousness. R58's care plan for potential for fall or seizure related injuries related to use of medication, cognitive deficits, impaired mobility, seizures, impaired vision, history of multiple falls, initiated 5/17/2013, documents the following interventions: . -call light or personal items available and in easy reach (date initiated: 8/17/2018, revision on: 9/26/2023) . -encourage resident to wear gripper socks (date initiated: 2/11/2025) . -encourage resident to request assistance to reach things out of reach. Keep shoes close. (date initiated: 10/30/2013, revision 12/2/2016) . -keep environment clean, well lit, and free of clutter, glare, and shadows (date initiated 5/17/2013, revision on 12/2/2016) . R58's care plan for self-care deficit related to cognitive deficits, impaired mobility, impaired vision, initiated 10/10/2013, documents the following interventions: . -transfer assistance of supervision (date initiated: 10/10/2013, revision on 2/12/2025) . -walking assistance of only with therapy (date initiated: 10/10/2013, revision on 2/12/2025) . -wheelchair locomotion: independent in wheelchair with anti roll back brakes (date initiated: 2/12/2025) . On 2/8/25, the facility completed a Fall Risk Evaluation for R58 with a score of 22.0, indicating R58 was a high risk for falls. Nursing progress note dated 2/14/25, at 4:19 AM, . resident found laying on left side and wheelchair flipped upside down. Resident stated . was going to the bathroom. Resident transported to the hospital per on-call nurse practitioner recommendation. The Post Fall Evaluation dated 2/14/25 documents the fall was not witnessed. Resident was attempting to self-toilet at the time of the fall. Wheelchair was not locked. Poor lighting in area: yes. Footwear at time of fall: bare feet. Bedside call light on when resident was found: no. Contributing factors note: poor lighting, unlocked wheelchair, and bare feet. Vitals (assessed at 4:30 AM): Blood pressure 135/97, pulse 132, pulse type: irregular – new onset. Pain score: 6. Surveyor did not note any documentation on the last time the resident was checked on or offered toileting assistance in the fall investigation provided. Surveyor noted facility staff did not provide supervision for R58 during bed to chair transfer or toilet (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	transfer at the time of the fall as per the care plan and assessment of R58. Surveyor reviewed hospital history and physical (H&P) document in R58's electronic health record (EHR) from hospital stay 2/14/25-2/18/25. The hospital course documents R58 presented to the emergency department (ED) from nursing home on 2/14/25 after [R58] tripped over foot and fell and had complaints of pain to lower back, head, and neck. Imaging studies in ED showed nondisplaced fracture of the left sacral ala (fracture in the bone at the base of the spine) and nondisplaced fracture of the lateral cortex of the right inferior pubic ramus (fracture in the bone in the lower part of the pelvis). Orthopedic surgery was consulted and recommended pain control and therapy, no surgical intervention was indicated, weight bearing as tolerated (WBAT). On 9/9/25, at 10:56 AM, Surveyor observed R58 in R58's wheelchair with no anti roll back brakes located on the wheelchair per R58's care plan initiated 2/12/25. On 9/10/25, at 1:03 PM, Surveyor observed R58 lying in bed with R58's wheelchair next to the bed with no anti roll back brakes located on the wheelchair. On 9/15/25, at 10:30 AM, Surveyor observed R58 in R58's wheelchair with no anti roll back brakes located on the wheelchair. On 9/16/25, at 1:39 PM, Surveyor observed R58 lying in bed with R58's wheelchair next to the bed with no anti roll back brakes located on the wheelchair. On 9/16/25, at 1:36 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-S who stated R58 requires setup assistance or reminders for dressing and toileting cares. CNA-S stated R58 has been using the same wheelchair for as long as CNA-S has been there. On 9/16/25, at 1:45 PM, Surveyor interviewed Med Tech (MT)-AA who stated staff encourage R58 to do as much as R58 can with cares, but staff checks to make sure R58 is cleaned up and has appropriate clothing on. MT-AA did not recall R58's fall on 2/14/25. On 9/16/25, at 2:16 PM, Surveyor spoke with Licensed Practical Nurse (LPN)-BB via phone call, LPN-BB was the nurse on duty at the time of R58's fall on 2/14/25. LPN-BB stated R58 fell and broke R58's pelvis. LPN-BB stated R58 had a recent fall prior to the fall on 2/14/25 and was given a wheelchair, and prior to using a wheelchair, R58 was completely independent and walked around the facility all day. LPN-BB stated R58 was supposed to ask for assistance to get into the wheelchair if needing to use the bathroom. LPN-BB stated at the time of the fall, R58 got up independently and did not use the call light. LPN-BB stated R58 appeared to be at R58's baseline in the days leading up to the fall on 2/14/25. LPN-BB stated the wheelchair that R58 was using at the time of the fall did not have any anti roll back brakes or auto-locking system in place. LPN-BB stated R58 was not wearing any gripper socks or footwear at the time of the fall. On 9/16/25, at 3:29 PM, Surveyor informed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A of the concern that R58 sustained a fall on 2/14/25 resulting in multiple fractures. No further information was given as to why supervision was not provided during transfer into R58's wheelchair, why R58 did not have anti roll back brakes on the wheelchair, why R58 was not wearing gripper socks, or why the light was not on in R58's room per R58's established care plan at the time of the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2.) R73 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following a cerebral infarction, depression, anxiety, chronic pain syndrome, and alcohol abuse. R73's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R73 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and the Falls Care Area Assessment (CAA) from R73's Annual MDS dated [DATE] documented R73 was at risk for falls due to impaired mobility, cognitive deficits, and the use of psychotropic medications; R73 was assisted with transfers and bed mobility. R73 did not have an activated Power of Attorney. R73's Physical Functioning Deficit Care Plan initiated 5/18/22 documents interventions of bed mobility with limited assistance of one and limited assistance to use bathroom from wheelchair to toilet with grab bars. Per the Care Plan, R73 transferred with the assist of one person to stand and pivot from admission until 2/19/25. The Care Plan was revised on 2/19/25 to use a full mechanical lift and revised back on 3/25/25 to a stand and pivot transfer. R73's At Risk for Falls Care Plan initiated on 5/5/22 had the following interventions in place on 6/25/25:-Bed in low position while in bed; level with wheelchair seat for transfers.-Call light and personal items available and in easy reach.-Clear and monitor environmental obstacles.-Do visual checks during regular rounding and ask if (R73) needs anything, if they would like to transfer to and from wheelchair/bed, offer to toilet, and before leaving show how to use call light and remind to use if anything is needed.-Dump seat in wheelchair.-Dycem to wheelchair.-Elevate head of bed before getting out of bed.-Encourage participation in activities to improve strength or balance.-Encourage to allow staff to lay (R73) in bed for naps.-Encourage rest periods if (R73) is feeling fatigued.-Observe for side effects of medications.-Offer a reacher and encourage to use.-Offer to lay (R73) down after meals.-Offer to lay (R73) down in bed before dinner.-Provide education and reinforce use of call light.-Stop sign – call don't fall – placed in room.-Therapy referral as ordered and as needed.-Wheelchair of appropriate size; uses leg rests for transport. On 6/25/25 at 9:54 PM in the progress notes, a Registered Nurse (RN) documented the RN was called to R73's room by staff. Upon entering the room, the RN saw R73 semi-sitting on the floor with the wheelchair on R73's back. R73 stated R73 slid onto the floor. The RN assessed R73 and R73 was assisted back to bed with a full mechanical lift. R73 was not in any distress but complained of pain to the back and hip area. The Nurse Practitioner was notified, and an order was received for an x-ray of the back and bilateral hips. The RN completed a Post Fall Evaluation form documenting R73's wheelchair was not locked at the time of the fall, R73 was not using a cane or walker as instructed and R73 was not wearing oxygen as prescribed at the time of the fall. The Interdisciplinary Team (IDT) met on 7/3/25 to review R73's fall on 6/25/25 and determined the cause of the fall to be R73 was fatigued causing R73's bottom to slide forward out of the wheelchair. The IDT documented all fall interventions were in place at the time of the fall, R73 is care planned for impulsivity and putting self on the floor. The IDT recommended continuing the current plan of care. Surveyor noted the RN determined R73's wheelchair was not locked, R73 was not using adaptive equipment when transferring, and was not using oxygen as prescribed. This was not incorporated in the IDT root cause analysis. No revisions were made to R73's Care Plan. On 7/1/25 at 1:53 PM in the progress notes, Licensed Practical Nurse (LPN)-P documented R73 had an unwitnessed fall. R73 told LPN-P R73 tried to walk to the bed. R73 stated R73 hit their head. R73 complained of right leg/hip pain and neck pain with movement. R73 did not lose consciousness. R73 was sent to the hospital for evaluation and treatment. LPN-P completed a Post Fall Evaluation form documenting the wheelchair was unlocked at the time of the fall, R73 was not using cane/walker as (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	instructed, and R73 was not wearing oxygen as prescribed at the time of the fall. LPN-P documented R73 did not ask for assistance prior to the fall. R73 returned from the hospital with no injuries noted and no new orders. No IDT notes were found for review of R73's unwitnessed fall on 7/1/25. No root cause analysis was completed or documented, and no changes were made to R73's At Risk for Falls Care Plan. Surveyor noted R73's falls on 6/25/25 and 7/1/25 had the same post fall evaluation concerns. The IDT did not meet until 7/3/25 to review R73's fall on 6/25/25 so no interventions were revised to prevent future falls. On 7/3/25 at 3:22 PM in the progress notes, an LPN documented R73 was found on the floor lying on the side after hearing R73 calling out for help. R73 stated they were trying to walk. R73 denied hitting the head. Water was on the floor and R73 stated R73 spilled the water when R73 fell. The LPN contacted the RN supervisor to assess R73 and no abnormal findings were discovered. The LPN completed a Post Fall Evaluation form documenting the wheelchair was not involved in the fall, R73 was not using a cane/walker as instructed, and R73 was not wearing oxygen as prescribed at the time of the fall. The IDT met on 7/3/25 to review R73's fall on 7/3/25 and determined R73 had been returning from therapy at the time of the fall and the wheelchair was behind R73. The IDT recommended R73 to be offered to lay down after therapy. Surveyor noted the LPN determined R73 was not using adaptive equipment when transferring and was not using oxygen as prescribed. This was not incorporated in the IDT root cause analysis. R73's At Risk for Falls Care Plan was revised on 7/3/25 with the intervention to offer R73 to be laid down after therapy. On 9/9/25 at 10:05 AM, Surveyor observed R73 lying in bed. R73's bed was in the low position. Surveyor asked R73 if R73 had fallen recently at the facility. R73 stated R73 fell once out of the wheelchair when R73 was trying to get into bed independently from the wheelchair. R73 stated R73 hit their head but did not get injured. On 9/10/25 at 3:49 PM, Surveyor asked Director of Nursing (DON)-B if there were any investigations for R73's falls. DON-B stated everything that was found for the falls had been provided which were the progress notes and the Risk Management tools used for Quality Assurance. Surveyor noted no interviews with staff that were working with R97 were obtained to help determine the root cause of the falls. On 9/11/25 at 9:42 AM, DON-B stated DON-B was aware the fall investigations were lacking in content. DON-B was not the DON at the time of R73's falls and the facility administration had identified the need for improvement with fall investigations. DON-B stated DON-B was aware that the fall packets that had been provided to Surveyor were not complete. On 9/15/25 at 3:15 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and DON-B the concern R73's three falls were not thoroughly investigated with a root cause analysis and the care plan was not revised with interventions to prevent future falls. On 9/17/25 at 8:21 AM, Surveyor observed R73 lying in bed eating breakfast. The head of the bed was elevated, and the bed was in a low position. R73's wheelchair had an air pocket-type cushion in place with Dycem under the cushion. Surveyor noted the cushion was not a dump seat as stated in the At Risk for Falls Care Plan. Surveyor had not observed R73 in the wheelchair during the survey. Surveyor asked R73 how often R73 gets out of bed and into a wheelchair. R73 stated sometimes R73 will get up for like therapy but otherwise stays in bed because that is where R73 likes to stay. On 9/17/25 at 8:26 AM, Surveyor asked LPN-Z what the facility process was when a resident has a fall. LPN-Z stated LPN-Z would assess the resident by getting vital signs and neurological checks and would notify the DON and have an RN assess the resident. LPN-Z stated the physician would be (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	notified as well as the Power of Attorney. LPN-Z stated if the resident is taking an anticoagulant, LPN-Z would call the ambulance. LPN-Z stated the nurse on the floor would fill out and complete all the paperwork that goes with a fall. On 9/17/25 at 8:36 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-CC and CNA-DD how R73 transfers. CNA-CC stated sometimes R73 uses a full mechanical lift but has the ability for assistance for a pivot transfer. CNA-CC stated R73 can lift their legs, but tends to slide down when in the wheelchair. CNA-DD stated R73 refuses to get out of bed and has not had therapy for about two weeks. Surveyor asked CNA-CC and CNA-DD if they do anything to prevent R73 from falling. CNA-DD stated they put a pillow on the side of the bed under the sheet to keep R73 from rolling out of bed and they keep the bed low. CNA-DD stated R73 does not try to put themself on the floor and does not try to get out of bed. Surveyor asked CNA-CC and CNA-DD if R73 had a special cushion in the wheelchair. CNA-DD stated therapy gave R73 a flat cushion, and R73 slides themselves down out of the chair and in bed, too. Surveyor shared with CNA-CC and CNA-DD that R73's care plan says R73 should have a dump seat in the wheelchair. CNA-CC and CNA-DD did not know what a dump seat was. On 9/17/25 at 8:44 AM, Surveyor interviewed DON-B and Assistant DON (ADON) LPN-C regarding the dump seat that is on R73's care plan. DON-B and ADON LPN-C did not know what a dump seat was. ADON LPN-C stated R73 has a regular cushion in the wheelchair. The facility's policy, titled Resident Smoking, dated 7/15/25, documents in part, . Policy: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. Policy Explanation and Compliance Guidelines: . 6. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, (sic) to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. 10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan. 3.) R40 was admitted to the facility on [DATE] with a diagnoses that include hemiplegia and hemiparesis following a cerebral infarction (stroke) affected right dominant side, congestive heart failure, vascular disease, depression and anxiety. R40's MDS (Minimum Data Set) annual comprehensive assessment dated [DATE], documents a BIMS (Brief interview for Mental Status) score of 10, on a scale of 0 to 15, indicating R40 has moderate cognitive impairment. R40 has an impairment in their range of motion (ROM) on one side for both upper and lower extremities. R40's Smoking and Safety assessment dated [DATE], documents, under Smoking and Safety Interaction: Does the Resident display any of the following? Checkmark is indicated for, Follows the facility policy on location and time of smoking. The remainder of the Smoking and Safety Assessment is incomplete. There are no check marks documented under Care Planning regarding: Smoking Care Plan and Smoking Cessation Care Plan nor Clinical Suggestions. R40's Smoking and Safety assessment dated [DATE], documents, under Smoking and Safety Interaction: Does the Resident display any of the following? Checkmark is indicated for, Follows the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	facility policy on location and time of smoking. The remainder of the Smoking and Safety Assessment is incomplete. There are no check marks documented under Care Planning regarding: Smoking Care Plan and Smoking Cessation Care Plan nor Clinical Suggestions. R40's Smoking and Safety assessment dated [DATE], documents, under Smoking and Safety Interaction: Does the Resident display any of the following? Checkmark is indicated for, Follows the facility policy on location and time of smoking. The remainder of the Smoking and Safety Assessment is incomplete. There are no check marks documented under Care Planning regarding: Smoking Care Plan and Smoking Cessation Care Plan nor Clinical Suggestions. Surveyor noted all of R40's Smoking and Safety Assessments, under Smoking and Safety Interaction: Does the Resident display any of the following? Limited or no ROM (Range of Motion) in arms and hands or unable to extinguish tobacco or marijuana safely - none is assessed. R40's Progress Note, dated 7/3/24, documents, in part .Visit Type: INITIAL CARDIAC PCC (sic) (Patient Centered Care) SOCIAL HISTORY(sic): Current smoker, denies alcohol use Tobacco: (patient screened on 07/03/2024) * In the PAST 12 MONTHS (sic), how often have you used tobacco or any other nicotine delivery product (i.e., e-cigarette, vaping or chewing tobacco)? Daily or Almost Daily * Smoking history: Over 10 years * Amount smoked per day: < (less than) 1/2 pack * Pack/years: +5 pack/year SMOKING CESSATION (sic): (Complete if patient identified as a current tobacco user), .Smoking and tobacco use cessation counseling was provided during the visit on 07/03/2024 for 5 minutes and the following items were discussed: * Patient is a current smoker, understands the negative health impacts, and options * Patient is not willing to attempt smoking cessation * Smoking cessation is important due to their health conditions of: CAD (coronary artery disease) * Methods of cessation that were discussed with the patient include: Nicotine patch, gum and lozenges * A quit date of August 2024 was discussed * Resources that were made available to the patient include: Verbal discussion. R40's Care Plan, date initiated 11/11/24, documents a Focus area to include R40 is at risk for smoking related injury related to: Smokes independently. The Goal documents, R40 will maintain Independence safely while smoking. Interventions include to assure smoking material is extinguished prior to patient leaving smoking area and complete smoking safety assessment per Living Center policy. On 09/10/25 at 12:50 PM, Surveyor interviewed R40 who stated R40 can smoke whenever R40 wants to and enjoys smoking a lot. Surveyor asked if there is any staff present while R40 smokes and R40 stated, no. R40 keeps R40's own cigarettes and lighter. On 09/09/25 at 1:15 PM, Surveyor observed R40 smoking along with 2 other resident smokers in the outside designated smoking area, referred to as the back patio. There was no staff supervision present. R40 was in wheelchair, wearing sweatpants, regular white socks with no shoes and a short-sleeved shirt. R40's right arm was in a sling and R40 was observed with a cigarette in left hand. Surveyor asked R40 if R40 wears a smoking apron or anything to protect him over his clothes when smoking and R40 stated, he does not know anything about it. 09/10/2025 2:15 PM Surveyor observed R40 smoking along with 3 other resident smokers on the back patio. There was no staff supervision present. R40 was in a wheelchair, wearing cotton sweatpants, regular white socks with no shoes and a short-sleeved shirt. R40's right arm was in a sling and R40 had a cigarette in left hand. R40's cotton sweatpants had a cigarette size burn hole in the left pant (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	leg. R40 stated he forgot how he got the cigarette burn in his pants. Surveyor asked how R40 puts out his cigarette and R40 stated, tosses on ground. Surveyor asked if anyone steps on the cigarette and R40 said, no, just toss it. Surveyor asked R40 who lights R40's cigarettes and R40 stated, I do. Surveyor observed R40 until R40 tossed their cigarette onto the ground and no staff member was present to extinguish it. 09/10/2025 at 2:05 PM, Surveyor interviewed Director of Nursing (DON)-B and asked DON-B what practice is followed for supervision while smoking with residents who are cognitively impaired. DON-B stated, facility does not base smoking supervision on a resident's cognition but rather on the smoking safety assessment. Surveyor asked how often the smoking safety assessments are completed and DON-B stated, upon resident admission and quarterly. Surveyor shared with DON-B that there are only 3 smoking safety assessments for R40 dated 11/11/24, 6/24/25 and 8/28/25 with incomplete assessment details/documentation. Surveyor stated there was not a smoking safety assessment completed upon admission on [DATE] and the first smoking safety assessment occurred on 11/11/24 with 4.5 months lapsing from admission. The subsequent smoking safety assessment occurred on 6/24/25 with 7 months lapsing in between. DON-B stated the facility is now completing the smoking safety assessments upon admission and quarterly. Surveyor shared R40 was observed to have a burn hole in their sweatpants and that there was no supervision or a staff member present to ensure R40's cigarette was extinguished. Surveyor stated, there is a concern R40's care plan is not being followed for smoking interventions. DON-B stated, she understood and is aware R40's care plan is not being followed. There was no additional information provided at this time.

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	525371	A. Building B. Wing	09/30/2025

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility did not use the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week and the facility did not ensure full time Director of Nursing (DON) coverage. This deficient practice has the potential to affect all 85 residents residing in the facility. *On 8/30/25, there was no RN who worked for 8 consecutive hours. *The Facility did not provide full time Director of Nursing (DON) coverage from 4/1/25 to 5/12/25 and again 7/31/25 until at least 8/4/25.Findings include: 1.) Surveyor reviewed nursing schedules and nurse staff postings for last 30 days from start of survey and noted the facility's nursing schedules and nurse staff postings did not indicate the presence of an RN in the facility on 8/30/25.Surveyor reviewed the Facility Assessment Tool under the staffing section licensed nurses providing direct care it is documented that there is RN coverage 24 hours per day. Surveyor noted that the regulation states a skilled nursing facility must ensure they have an RN providing services at least 8 consecutive hours a day, 7 days a week. On 09/15/2025, at 10:15AM, Surveyor interviewed Scheduler-H regarding an RN not being on the schedule for August 30th. On 09/15/2025, at 10:55AM, Scheduler-H confirmed that was a Saturday and there was no RN in the building. On 09/15/2025, at 2:30 PM, during the end of day meeting, with Nursing Home Administrator-A and Director of Nursing-B, Surveyor relayed concern that on 8/30/25 there was no RN in the building. No additional information was provided as to why the facility did not ensure that an RN was on duty for at least 8 consecutive hours a day, 7 days a week.2.) On 9/10/25, Surveyor requested documentation from facility of Director of Nursing (DON)-B hours worked and time spent in the building for nursing services.On 09/15/2025, at 10:25 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and was told that DON-B is a full-time employee, and they have an offer letter to prove it. Surveyor asked about DON-B working at (name of hospital) and was told they reduced their hours to PRN (as needed) when the DON position was accepted. There was a period when DON-B was working both jobs after DON-B gave notice to go from full time to PRN at (name of hospital). On 09/16/2025, at 1:05 PM, Surveyor interviewed NHA-A and DON-B regarding previous DON-DDD ending employment at the facility and was told they walked out on July 30, 2025. NHA-A also stated that previous DON-DDD was gone from 4/1/25 through 5/12/25 on a leave of absence. NHA-A stated that the previous governing body told NHA-A that they would provide clinical support but did not. NHA-A stated being able to call for clinical decision making but no one was present in the building. DON-B signed the offer letter on 8/4/25 and then had to fulfill notice of other job at (name of hospital) for 2 to 3 days a week for 2 to 3 weeks at 24 hours a week. DON-B worked around this schedule and put in full time work at this facility. Now DON-B is at the facility full time hours Monday through Friday, full days. The first day of the survey 9/9/25 DON-B had a planned day off, that's why they were not there.Surveyor noted that the facility was without full time DON coverage from 4/1/25 to 5/12/25 and again 7/31/25 until at least 8/4/25.

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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 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, interview, and record review, the facility did not store and prepare food in accordance with professional standards for food service safety potentially affecting all 85 residents that eat food prepared by the facility.*In the facility's main kitchen, observations of hair restraints for facial hair not being utilized, scoop used for flour was placed down in the flour bin, and not in the scoop holder and silverware not being stored in sanitary conditions.Findings include:The facility policy and procedure titled FOOD SAFETY REQUIREMENTS, dated 10/1/2022 documents: Policy, it is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. Policy Explanation and Compliance Guidelines: 1. Food safety practices shall be followed throughout the facility's entire food handling process. e. Equipment used in handling of food, including dishes, utensils, mixers, grinders and other equipment that comes in contact with food. 7. Staff shall adhere to save hygienic practices to prevent contamination of foods from hands or physical objects. d. Dietary staff must wear hair restraints (e.g., hairnet, at, and/or beard restraints) to prevent hair from contacting food.Flour scoop and silverware: On 9/09/2025, at 11:36 AM, Surveyor observed the main kitchen area. During observation of the main kitchen area Surveyor observed a red scoop sitting in a flour bin under the serving table. [NAME] Supervisor (CS)-LL stated the scoop should not be in there and there is a holder on the side of the flour bin that the scoop should be in. Dietary Director (DD)-G was present and observed the scoop in the bin as well. DD-G stated the scoop should never be left down in the flour and staff knows it needs to be in the holder. Surveyor questioned CS-LL about the silverware that was sitting next to the serving line if that is where they store the silverware and if it gets covered at any point. CS-LL stated Yes this is where it is stored and No, that the silverware does not get covered at any point, not even at the end of the night.Beard restraints:On 9/09/2025, at 11:51 AM, Surveyor observed the kitchen staff setting trays for lunch. Surveyor asked DD-G about the employees with facial hair not wearing beard hair restraints. DD-G informed Surveyor that the facility does not currently have those restraints, and that DD-G will get them ordered, 2 dietary aids and dietary director observed w/o beard nets at serving station while the lunch meal was being plated.On 9/09/2025, at 12:00 PM, Surveyor interviewed Dietary Aide (DA)-K who stated DA-K was never asked to put on a beard restraint even know DA-K currently has 2 inches of facial hair on DA-K's chin. DA-K is currently on the food line and setting trays for lunch. DA-K indicated being an employee in the kitchen since 2021 and DA-K has never worn a beard restraint. On 9/09/2025, at 12:00 PM, Surveyor interviewed Dietary Aide (DA)-J who stated DA-J has never seen a beard restraint here at this building. Surveyor asked DA-J if anyone here at the facility ever talked to DA-J about wearing one, DA-J stated No, or offered one to wear, No. DA-J was setting up trays with lunch food on the cart to go to the floor. DA-J had facial hair of 1 inch to chin area.On 9/11/2025, at 9:20 AM, Surveyor asked DD-G what the current staff is utilizing for beard restraints until there order arrives? DD-G informed Surveyor the facility is utilizing the head-hair restraints until the order comes in later today.On 9/11/2025, at 11:14 AM, Surveyor interviewed DA-MM, who indicated that at the end of the night DA-MM places the silverware over by the food line and does not need to place a cover or anything on top of the silverware during the night. DA-MM states it just gets set over there so it's ready for breakfast.Surveyor observed a sink right across from line area where silverware is being placed and stored throughout the night. Surveyor noted that after staff interview the silverware sits in this area while the staff is preparing the line for breakfast in the morning and has no cover to block from potential splashes.DD-G was observing the above-mentioned interaction between Surveyor and DA-MM, DD-G offered explanation to Surveyor. DD-G stated that DA-MM is a newer employee and doesn't know that the silverware needs to be covered. DD-G stated that kitchen staff are supposed to be covering, and DD-G covers the silverware (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525371	A. Building B. Wing	09/30/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	when DD-G is working at the end of the night, so DD-G indicated not knowing what is going on with staff statements.On 9/11/2025 2:10 PM, Surveyor informed DD-G and Nursing Home Administrator(NHA)-A, of the concerns with the food safety requirements including scoop down in the flour bin, hair restraint use and the sanitary storage during the overnight hours of the silverware utensils. NHA-A stated, the kitchen staff just went over this, the kitchen staff were aware that they need to cover the silverware, items should be placed down for drying, i just went around and educated again.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility did not ensure it completed accurate mandatory submission of staffing information based on payroll data in a uniform electronic format to the Centers for Medicare & Medicaid Services (CMS). This had the potential to affect all 85 residents residing in the facility. Staffing information for Quarter 3 (April 1 - June 30 2025) of the Payroll Based Journal (PBJ) was not accurately submitted to CMS.Findings include:The CMS Electronic Staffing Data Submission Payroll-Based Journal, Long-term Care Facility Policy Manual, dated June 2022, indicates: Chapter 1: Overview, 1.1 introduction .(U) mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS .1.2 Submission Timelines and Accuracy. Direct care staffing and census data will be collected quarterly and is required to be timely and accurate .Report Quarter: staffing and census data will be collected for each fiscal quarter. Staffing data includes the number of hours paid to work by each staff member each day within a quarter. Census data includes the facility's census on the last day of each of the three months in a quarter. The fiscal quarters are as follows: Fiscal Quarter, Date range: (quarter) 1 October 1-December 31, (quarter) 2 January 1-March 31, (quarter) 3 April 1-June 30, (quarter) 4 July 1-September 30 . Surveyor reviewed the PBJ Staffing Data Report, CASPER Report 1705D, for Fiscal year 2025 (run on 9/4/25) which indicated the Facility had excessively low weekend staffing and a one-star staffing rating for the 3rd Quarter (April 1-June 30). Surveyor reviewed the Facility's weekend schedules from April 2025 through June 2025. Surveyor noted licensed nurses and certified nursing assistants present on each shift, for each unit. Surveyor noted these schedules included call ins, agency staff and staff who picked up shifts. Surveyor noted there did not appear to be excessive call-ins.On 09/10/2025, at 1:17 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-SS regarding weekend staffing and was told they recently got more staff. Surveyor asked what this meant and CNA-SS said they added a couple aids to the schedule which has been helpful. Surveyor asked about long wait times for residents and was told only during busy times, especially in the mornings or at mealtimes. Surveyor asked if there are not enough aides on the weekend are baths/showers not given and was told that typically baths/showers are not scheduled on weekends on this unit, they are done during the week. Surveyor asked if staffing is ever low and residents get left in bed and was told only by the resident's choice. Maybe they cannot get up as soon as they like all the time but always given option to get up. Surveyor asked if beds go unmade when short staff and was told it is CNA-SS routine to make the bed when resident is out so no issue.'sOn 09/10/2025, at 1:21 PM, Surveyor interviewed CNA-TT regarding staffing and was told it is great. CNA-TT could not pinpoint a particular time period staffing was short, just depends on availability of staff. When asked about call lights going unanswered on the weekend, CNA-TT replied that they rarely work weekends.On 09/10/2025, at 1:25pm, Surveyor interviewed housekeeping-UU who has worked at the facility two months. Surveyor asked if it seems like there is enough nursing staff and was told yes, housekeeping-UU has noticed the aides on the units will go to other units and help each other. Surveyor asked about call light times and was told sometimes staff ignore them and that frustrates housekeeping-UU. Surveyor asked if it seems like residents get left in bed when short of staff and was told no the majority get up. Surveyor asked if the beds are made, and the response was yes.On 09/15/2025, at 10:15AM, Surveyor interviewed Scheduler-H who has worked for the facility since May. Surveyor asked if there were staffing issues when started the job and was told for the most part has been able to staff by the numbers given. Scheduler-H did not notice an issue with being short of staff after starting the job. Surveyor asked what happens when have a call in, they offer in house bonuses and use COVR (an app) for agency nurses and CNA. (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor asked what do when cannot find coverage and was told generally found with incentives offered.On 09/15/2025, at 10:25 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and asked about the Facility Assessment stating 12 nurses per day, but schedule shows 10 per day. NHA-A stated when the census is 100-112 then they have 12 nurses, census has not been that high so have been running with 10 nurses. Surveyor asked NHA-A why the facility could have triggered for excessively low weekend staffing and one star staffing from April to June. NHA-A looked over payroll reports and called payroll, the reason they triggered for low weekend and one star is that on the weekends they offer bonuses for managers to pick up. Payroll is supposed to code them as working the weekend for coverage and that was not happening in April, May and June.On 09/15/2025, at 2:30 PM, during the end of day meeting, with NHA-A and Director of Nursing-B, Surveyor shared concern that the facility did not report PBJ data correctly.No additional information was provided as to why the facility did not accurately submit staffing information for Quarter 3 (April 1 - June 30) of the Payroll Based Journal (PBJ).

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility's Quality Assurance Committee did not make a good faith effort to identify and correct systemic deficiencies prior to the survey. This deficient practice has the potential to affect all 85 residents at the facility. During a recertification survey conducted on 9/9/25-9/30/25, it was determined 39 deficiencies existed including the deficient practice at F865, QAPI (Quality Assurance and Performance Improvement) Program/Plan, Disclosure/Good Faith Attempt.Four of the 39 deficiencies have been identified as immediate jeopardies related to wound care at F684, pressure injury care at F686, responsibilities of the medical director at F841 and facility administration at F835. F684 and F686 at the immediate jeopardy scope and severity are also substandard quality of care.Widespread deficient practice was identified at F727 related to sufficient staffing including concerns with not having a full time Director of Nursing in the facility; F812 for food storage and procurement; F851 related to accurate submission of staffing for payroll based journal; F865 related to QAPI; F880 related to systemic concerns related to infection control; F881 for antibiotic stewardship; F887 for failure related to COVID-19 immunizations; F925 for facility wide concerns related to pest management; and F946 and F949 related to failures to ensure adequate clinical training programs for staff that work with all residents residing in the facility.At the time of the recertification survey (9/9/2025-9/30/2025) the facility was not in compliance with the regulations at F689 accidents and hazards, F684 quality of care, and F692 nutrition and hydration after it was determined these regulations were not corrected on a revisit survey completed 9/2/2025. Cross-reference survey event IDs: HBE5-H2 and L0G2-H2. On 7/3/2025 immediate jeopardy had been identified at F692 related to nutrition and hydration concerns. Cross-reference survey event ID L0G211. On 7/28/2025 a survey was completed that identified immediate jeopardy concerns at F692 for nutrition and hydration concerns. Cross-reference survey event ID HBE511.The facility failed to have a system to establish priorities for improvement activities that focuses on high risk areas of concern for the residents in the facility. The facility failed to have a system to address through QAPI to analyze and act upon data to develop improvement plans, and the facility failed to ensure the committee developed and implemented action plans to correct identified quality deficiencies and sustain compliance.Findings include:The facility policy entitled, QAPI Change Process, dated 1/1/25, documents in part, . POLICY: The facility has established and utilizes a systematic approach to performance improvement activities to ensure changes are effective and improvements are sustained. Definitions: Quality Assurance and Performance Improvement (QAPI) (sic) is the coordinated application of two mutually reinforcing aspects of a quality management system: Quality (QA) and Performance Improvement (PI). Quality Assurance (QA) (sic) is the specification of standards for quality of care, service and outcomes, and systems throughout the facility for assuring that care is maintained at acceptable levels in relation to those standards. Performance Improvement (PI) (sic) is the continues study and improvement of processes with the intent to improve services or outcomes, and prevent or decrease the likelihood of problems, by identifying opportunities for improvement, and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement.On 09/16/2025 at 1:05 PM, Surveyor interviewed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B regarding their QAPI program and the systemic issues concerning the facility. Surveyor asked NHA-A for QAPI plan, QAPI meeting minutes and staff sign in sheets not yet provided following the survey Entrance Conference. NHA-A stated previous DON-DDD took the QAPI plan, meeting minutes and sign in sheets when previous DON-DDD resigned on July 31, 2025. Surveyor asked NHA-A, Since July 31, 2025, when previous DON-DDD departed, has there been a QAPI meeting? NHA-A stated it has been difficult to hold a meeting with the State being at the facility as much as they have been. There was a meeting scheduled for today, 9/16/25, but it was cancelled. Surveyor asked NHA-A who attends the QAPI meetings and NHA-A stated, NHA, DON, Medical (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Director, Infection Preventionist (IP)/Wound nurse and other department heads. Surveyor asked NHA-A, what are the current performance improvement plans (PIPs) the facility is working on. NHA-A stated the facility is working on four PIPs to include wounds, falls, admissions and infections but they are just now being formulated and not in written format. DON-B stated the facility has identified the PIPS through audits and State surveys. DON-B stated the majority of time has been dedicated to the current State plan of correction (POC) (referring to the POCs associated with survey event IDs L0G211/LOG2-H2 and HBE511/HEB5-H2) and the facility will formalize the PIPs through the POC process.Surveyor noted, no other PIP has been identified in 2025 besides the four currently being formulated and not implemented or completed.Surveyor asked NHA-A if NHA-A was apprised of the serious clinical concerns occurring at the facility, particularly related to harm level quality care. NHA-A stated, the previous Director of Nursing (previous DON-DDD) was in charge of the clinical aspects of the building and NHA-A should have been apprised of all clinical concerns but was not. NHA-A stated he did not realize the clinical issues were this bad, particularly with two residents, (referring to R97 and R98) with wounds resulting in immediate jeopardy. Cross-reference F684 and F686). NHA-A stated the department heads met every morning and afternoon to discuss clinical issues, or any other areas of concern and no issues were brought up to the level of harm, especially issues with lack of wound care and practices. NHA-A stated NHA-A trusted clinical leaderships' report during morning and afternoon meetings as accurate and NHA-A stated, there were always minor concerns brought to his attention but never the kind of issues brought forth with this survey.Surveyor asked NHA-A about the concerns regarding clinical leadership and the determination there were periods of time with no full time DON in the facility. Cross-reference F727.NHA-A stated DON-B resigned December 31, 2024, and previous DON-DDD became the DON effective 1/1/25. NHA-A stated, stated previous DON-DDD was on a leave of absence from 4/1/25 through 5/12/25. NHA-A stated the Regional Office for the Operator-FFF told NHA-A Operator-FFF would provide on-site clinical coverage during previous DON-DDD's leave of absence but did not. NHA-A stated Operator-FFF could be accessed by telephone, but no one was present at the facility until 5/8/25 when staff from Operator-FFF showed up to complete a mock survey. NHA-A stated this was a terrible period without clinical support and NHA-A had asked for the help but did not receive. NHA-A stated previous DON-DDD returned on 5/13/25 and his last day at the facility was 7/31/25. NHA-A stated the previous Assistant Director of Nursing's last day was also 7/31/25.NHA-A stated, NHA-A rehired DON-B and DON-B signed an offer letter on 8/4/25. DON-B stated, DON-B had to fulfill a 2-3 weeks' notice with their employer following the facility DON job offer. DON-B approximately worked 24 hours a week at her previous job and worked these hours around DON-B's full-time position at facility. DON-B state DON-B is now at facility Monday through Friday, full-time, standard business hours.Surveyor asked what the responsibility of the Infection Preventionist/Wound Licensed Practical Nurse (IP/Wound LPN)-I for the oversight of wound care and development of R97 and R98's wounds. DON-B stated that Operator-FFF changed the entire wound care program following DON-B's original departure on 12/31/24, requiring far less of what was previously required and minimized the process for wound care. DON-B stated that IP/Wound LPN-I knew that by taking away wound care responsibilities that were required previously, issues would occur. DON-B stated, Operator-FFF dismantled so many practices and now with DON-B returning to the facility since rehire on 8/4/25, DON-B is working on establishing procedures, putting out fires and trying to get things better.Surveyor asked why Operator-FFF would change wound care practices to practices that do not meet standards of quality care. DON-B stated Operator-FFF wanted to decrease the workload during receivership because Operator-FFF was losing the facility. DON-B stated, Operator-FFF eliminated weekly wound logs that contained wound measurements and the progress of wounds. No RN was following wound care. DON-B stated, Operator-FFF also eliminated the Falls investigation packet. Cross-reference F689.Surveyor asked NHA-A what the role of the Medical Director in the facility is. NHA-A stated the role of Medical Director- QQ is to participate in the QAPI meetings and provide (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	feedback. NHA-A stated Medical Director- QQ oversees the Nurse Practitioners (NP's) seeing residents at the facility. Medical Director- QQ is the support for when there are issues or concerns with other physicians.Surveyor asked what the responsibility of Medical Director-QQ regarding the overall wellness and clinical care for the residents is; specifically, how were the NP's or Medical Director- QQ not aware of the severity of R97 and R98's wounds and other clinical concerns and systemic issues regarding care. DON-B stated, the NP's and Medical Director- QQ need to have the facility apprise them of any resident wounds as the NP's and/or Medical Director- QQ is not doing a full physical comprehensive assessment when visiting the residents unless they are aware of a particular situation. DON-B stated NP's and/or Medical Director- QQ is relying on the facility wound team to address wounds. Surveyor noted it is the role of the Medical Director to establish and coordinate the overall clinical program in the facility based upon current standards of practice. Surveyor also noted Medical Director-QQ is also the attending physician for many of the facility residents. Cross-reference F841.On 09/17/2025 at 8:03 AM Surveyor interviewed NHA-A and DON-B. Surveyor asked NHA-A and DON-B how the facility identifies systemic issues. DON-B stated, through the QAPI process and Interdisciplinary Team (IDT) meetings and then discuss as team. Then facility determines which department is affected, create root cause analysis to develop solutions and monitor with frequency and duration for effectiveness.Surveyor asked NHA-A and DON-B if the facility establish priorities for its improvement activities that focus on high-risk, high-volume or problem-prone areas, as well as health outcomes, resident safety, choice, autonomy and quality of care. DON-B stated yes, for example, right now facility will be addressing wounds. Surveyor noted this was as a result of care concerns identified to be immediate jeopardy by the Surveyors during the current recertification survey rather than the QAPI committee identifying the concern through analysis of facility data.Surveyor asked NHA-A and DON-B if the facility tracks adverse events and medical errors, analyze their causes, implement preventive actions and mechanisms that include feedback and learning throughout the facility. DON-B stated yes, through risk management.On 09/17/2025 at 11:36 AM, Surveyor interviewed NHA-A and DON-B and confirmed previous DON-DDD was on a leave of absence from 4/1/25 -5/12/25. NHA-A stated the acting DON was supposed to be previous clinical consultant-GGG from the Regional Office through previous vice president of operations (VPO)-HHH, but she was never present in the building until Operator-FFF had representatives showed up on 5/8/25. NHA-A stated, the facility did not notify the State of an acting DON. NHA-A confirmed previous DON-DDD resigned as of 7/31/25 and there was a gap in DON coverage until DON-B was hired on 8/4/25. Surveyor asked who the acting DON was from 7/31/25 to 8/4/25 and NHA-A stated, they did not have anyone else. NHA-A stated NHA-A hired DON-B as quickly as he could.Surveyor notes, NHA-A produced QAPI meeting templates with minutes, originally thought to been taken by previous DON-DDD indicating there was a monthly QAPI meeting in January, February, March and April of 2025 and an ad hoc QAPI meeting in July 2025 following a State survey. NHA-A confirmed there was no QAPI meeting during previous DON-DDD's leave of absence, leaving no DON in facility from 4/1/25 -5/12/25. There also were no QAPI meetings following previous DON-DDD's return from leave of absence (5/13/25) until an ad hoc meeting was held on 7/1/25 after receiving an immediate jeopardy citation. The facility cannot provide confirmation of compliance that the required attendees participated in the QAPI process/meetings even for any documents provided as there are no sign in sheets for the QAPI meetings held in January, February, March and April of 2025. None of the QAPI meeting minutes address the systemic clinical changes including revisions to the overall wound care program, discontinuing the falls investigation procedure following DON-B's original departure on 12/31/24. There is no PIP for 2025 that has been implemented and/or corrected, only PIPs in initial development.No further information was provided as to why the facility's Quality Assurance Committee did not make a good faith effort to identify and correct systemic deficiencies for residents prior to identification by the survey team throughout the survey activity this past year.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the Facility did not establish and maintain an Infection Prevention and Control Program (IPCP) based upon current standards of practice, designed to provide a safe environment and to help prevent the development and transmission of communicable diseases and infections. This deficient practice has the potential to affect all 85 residents. * The IPCP did not have documentation of an effective water management program (WMP). * The IPCP 2025 surveillance logs were lacking pertinent information and documentation. * The Facility Assessment lacked infection prevention and water management information. * R75 did not have contact isolation initiated when infection was discovered. Findings include: The facility's policy titled, Infection Prevention and Control Program, implemented 10/1/22 documents, in part: This facility has established and maintains 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 infections as per accepted national standards and guidelines. Policy Explanation and Compliance Guidelines: 1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases. 2. All staff are responsible for following all policies and procedures related to the program. 3. Surveillance: a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee . 5. Isolation Protocol (Transmission-based Precautions): a. A resident with an infection or communicable disease shall be placed on transmission-based (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	precautions as recommended by current CDC (Centers for Disease Control) guidelines. b. Residents will be placed on the least restrictive transmission-based precaution for the shortest duration possible under the circumstances. 16. Water Management: a. A water management program has been established as part of the overall infection prevention and control program. b. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. c. The Maintenance Director serves as the leader of the water management program. he facility's policy titled, Water Management Program, dated 1/01/2025 documents, in part: It is the policy of this facility to establish water management plans for reducing the risk of Legionellosis and other opportunistic pathogens . in the facility's water systems based on nationally accepted standards . Policy Explanation and Compliance Guidelines: 1. A water management team has been established to develop and implement the facility's water management program, including facility leadership, the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and Director of Nursing. a. Team members have been educated on the principles of an effective water management program, including how Legionella and other water-borne pathogens grow and spread. b. The water management team has access to water treatment professionals, environmental health specialists, and state/local health officials. 2. The Maintenance Director maintains documentation that describes the facility's water system. 3. A risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. 5. Based on the risk assessment, control points will be identified . 8. The water management team shall regularly verify that the water management program is being implemented as designed. Auditing assignments will reflect that individuals will not verify the program activity for which they are responsible. 9. The effectiveness of the water management program shall be evaluated no less than annually. 14. Documentation of all the activities related to the water management program shall be maintained with the water management program binder for a minimum of 3 years. (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Water Management Program: The 6/24/21 CDC Toolkit titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings identifies the key elements of a water management program for healthcare facilities to include: 1. Establish a water management program team 2. Describe the building water systems using text and flow diagrams 3. Identify areas where Legionella could grow and spread 4. Decide where control measures should be applied and how to monitor them 5. Establish ways to intervene when control limits are not met 6. Make sure the program is running as designed and is effective 7. Document and communicate all the activities The 6/24/21 CDC Toolkit documents, program team members should possess certain skills that are needed to develop and implement your water management program. The team should also include: -Someone who understands accreditation standards and licensing requirements -Someone with expertise in infection prevention -A clinician with expertise in infectious diseases -Risk and quality management staff The Facility's WMP dated August 15, 2025, documents that the Program Team for (the name of facility) consists of the Administrator and Director of Maintenance. The staff names listed were of individuals no longer employed at the facility. Additionally, Surveyor noted the Infection Preventionist is not listed as part of the team. On 09/15/25, at 10:25 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B regarding the Water Management Committee not being identified in the Facility Assessment. Per DON-B there is no committee, just the maintenance department and they review information with IP (infection preventionist) and monthly report to QAPI (Quality Assurance Performance Improvement). On 9/16/25, at 11:07 AM, Surveyor interviewed Director of Maintenance (DOM)-GG about the water management plan. DOM-GG wasn't sure how much information they would have as they have only been on job three months and got no training. DOM-GG shared that if a room is not occupied, they test the water temperature and run the water 5-10 minutes. Surveyor asked about testing/monitoring controls for Legionella in the water and was told DOM-GG would need to start that. Surveyor asked if there were committee meetings held regarding water management and was told none as of yet. Surveyor asked about conferring with IP and was told that was not done.In the Water Management (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	what is tested and where. Documentation of IP Surveillance On 09/10/2025, at 8:36 AM, Surveyor spoke with Infection Preventionist (IP)-I, regarding the requested Infection Prevention surveillance and program documentation. Per IP-I the Director of Nursing (DON)-B is on the phone with the (name of the electronic medical record) company, there are a couple things they are still trying to get that was requested. On 09/10/2025, at 9:51 AM, Surveyor interviewed DON-B and was told that the IPC (Infection Prevention and Control software) within (name of the electronic medical record) is disabled. To be able to add orders or update cases need to enable IPC. When DON-B goes to reports and tries to historically print records, just gets a blank screen. DON-B put date range in to report and nothing shows. DON-B had been employed previously at facility until the end of December. Documentation in binders up through December is available. DON-B looked and the previous owners disabled IPC on 8/7/25. The new management company involved is trying to get legend or access so information can be provided. Per DON-B IPC is a module that you buy extra from (name of the electronic medical record) and it has been disabled. On 9/15/25, at 9:00 AM, Surveyor interviewed DON-B and IP-I, over the weekend they used the Physician Order Report for residents with an antibiotic to create surveillance logs. The new ownership company needs to sign a contract with (name of the electronic medical record) for the IPC add on and even then there is no promise the previous data will be available. Surveyor noted IP-I was certified on 9/7/25 with completion of the Nursing Home Infection Preventionist Training Course by the CDC. Surveyor reviewed the surveillance logs provided by the Facility for 2025 and found no January facility map showing where infections were in building or the Line List Template used for other 2025 months. For February surveillance documentation there is a facility map with wound/skin notated in room [ROOM NUMBER] of D wing and Line List Template recording a fungal infection located in the binder. Surveyor randomly selected four residents that had a diagnosis that should be included on surveillance documentation and 2 of the 4 were not included. In February, R6 was admitted to Aurora [NAME] Medical Center on 2/8/25 with Influenza A and septic shock. R6 should have been documented in February surveillance records with Influenza A diagnosis, Surveyor was unable to locate documentation of R6's diagnosis within the February surveillance record. For August surveillance documentation there is a facility map and Clinical Physician Orders report documenting the surveillance cases. The second randomly selected (not recorded) resident that should have been included in the surveillance log is R1 who went to (name of hospital) on 8/3/25 and was diagnosed with pneumonia. On 9/16/25, at 11:00 AM, Surveyor interviewed DON-B regarding January surveillance not being (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, the facility did not ensure they implemented their antibiotic stewardship program potentially affecting all 85 residents in the facility.Review of the facility infection surveillance logs for residents on antibiotics indicated antibiotic use without documentation of appropriate use of the antibiotic.Findings include:The facility's policy titled, Infection Prevention and Control Program, implemented 10/1/22 documents, in part: 6. Antibiotic Stewardship:a. An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program.b. Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program.c. The Infection Preventionist, with oversight from the Director of Nursing, serves as the leader of the antibiotic stewardship program.d. The Medical Director, consultant pharmacist, and laboratory manager will serve as resources for the antibiotic stewardship program.The facility's policy titled, Antibiotic Stewardship Program, last reviewed 4/8/2025 documents, in part: 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:i. Nursing staff shall assess residents who are suspected to have an infection and complete an SBAR (Situation, Background, Assessment, Recommendation) form prior to notifying the physician.ii. Laboratory testing shall be in accordance with current standards of practice.iii. The facility uses the (CDC's NHSN Surveillance Definitions) to define infections.iv. Criteria specific to each state are used to determine whether or not to treat an infection with antibiotics.v. All prescriptions for antibiotics shall specify the dose, duration, and indication for use.vi. Reassessment of empiric antibiotics is conducted after 2-3 days for appropriateness and necessity, factoring in results of diagnostic tests, laboratory reports, and/or changes in the clinical status of the resident.vii. Whenever possible, narrow-spectrum antibiotics that are appropriate for the condition being treated shall be utilized.b. Monitoring antibiotic use:i. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness.ii. Antibiotic orders obtained from consulting, specialty, or emergency providers shall bereviewed for appropriateness.iii. Random audits of antibiotic prescriptions shall be performed to verify completenessand appropriateness (process measure) .v. At least one outcome measure associated with antibiotic use will be tracked monthly, as prioritized from the facility's infection control risk assessment and other infection surveillance data. Examples include: tracking C. difficile infections, antibiotic resistance, adverse drug events related to antibiotic use, or costs related to antibiotic use.8. Documentation related to the program is maintained by the Infection Preventionist, including, but not limited to:a. Actions plans and/or work plans associated with the program.b. Assessment forms.c. Antibiotic use protocols/algorithms.d. Data collection forms for antibiotic use, process, and outcome measures.e. Antibiotic stewardship meeting minutes.f. Feedback reports.9. Records related to education of physicians, staff, residents, and families.h. Annual reports.On 09/10/25, at 9:51 AM, Surveyor interviewed Director of Nursing (DON)-B and was told that the IPC (Infection Prevention and Control software) within (name of electronic healthcare record) is disabled. To be able to add orders or update cases need to enable IPC. When DON-B goes to reports and tries to historically print records, just gets a blank screen. DON-B put date range in to report and nothing shows. DON-B had been employed previously at facility until the end of December. Documentation in binders up through December is available. DON-B looked, and the previous owners disabled IPC on 8/7/25. The new management company involved is trying to get legend or access so information can be provided. Per DON-B IPC is a module that you buy extra from (name of electronic healthcare record) and it has been disabled.Surveyor noted without access to IPC unable to locate or determine if a resident was assessed for appropriate use of the antibiotic.On 9/15/25, at 9:00 AM, Surveyor interviewed Director (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility did not ensure medical records contained documentation related to COVID-19 immunizations for 5 (R6, R33, R40, R65 and R75) of 5 residents reviewed for immunizations and employee records contained documentation related to COVID-19 immunizations for 1 of 1 staff reviewed.*R6's medical record does not contain any documentation as to whether R6 was offered, received, or declined the COVID-19 immunization.*R33's medical record does not contain any documentation as to whether R33 was offered, received, or declined the COVID-19 immunization.*R40's medical record does not contain any documentation as to whether R40 was offered, received, or declined the COVID-19 immunization.*R65's medical record does not contain any documentation as to whether R65 was offered, received, or declined the COVID-19 immunization.*R75's medical record does not contain any documentation as to whether R75 was offered, received, or declined the COVID-19 immunization.*Staff member (CNA-JJ) reviewed had no documentation of COVID-19 vaccination being offered, received or declined. Findings include:The facility's policy titled, Infection Prevention and Control Program, implemented 10/1/22 documents, in part: 8. COVID-19 Immunization:a. Residents and staff will be offered the COVID-19 vaccine when vaccine supplies are available to the facility.c. Education about the vaccine, risks, benefits, and potential side effects will be given to residents or resident representatives and staff prior to offering the vaccine. d. Residents or resident representatives will have the opportunity to accept or refuse a COVID-19 vaccination, and change their decision based on current guidance. e. Staff will have the opportunity to receive the COVID-19 vaccination or apply for a religious or medical exemption to the vaccine for facility consideration as per current guidelines and facility policy. f. Documentation will reflect the education provided and details regarding whether or not the resident or staff received the vaccine. The facility's policy titled, Vaccine Information Statements, implemented 3/1/19 documents, in part: Prior to the administration of any vaccine, a copy of the most current, relevant CDC Vaccine Information Statement (VIS) will be provided to any child or adult receiving the vaccine or such information will be provided to the legal representative who has the authority to consent to the immunization of a minor child or incompetent adult. Intent of Policy: It is the intent of this policy to provide instructions for the use of CDC's Vaccine Information Statements (VIS) as required under the National Childhood Vaccine Injury Act (42 U.S.C. S3o0aa-26) as well as our current State law(s) governing immunization requirements. (Refer to CDC's VIS statement entitled Instructions for Using Vaccine Information Statements.) Policy Explanation and Compliance Guidelines: 1. Prior to the administration of each vaccine, the person receiving the immunization, or his/her legal representative, will be provided with a copy of CDC's current vaccine information statement relative to that vaccine. 2. Vaccine Information Statements (VIS) will, as appropriate, be supplemented with visual presentations or oral explanations to assist vaccine recipients in understanding the benefits and potential side effects of such vaccinations. 3. A notation will be made in each resident's medical record at the time vaccine information materials are provided indicating: a. The edition date of the Vaccine Information Statement provided, and b. The date the VIS was provided.4. Individuals receiving vaccines, or their legal representative, will be required to sign a consent form prior to the administration of such vaccine(s). The completed, signed, and dated record will be placed in the individual's permanent medical record. The facility's policy titled, COVID-19 Vaccinations, implemented 1/2/2025 documents, in part: Policy: It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering our residents and staff the COVID-19 vaccine. Policy Explanation and Compliance Guidelines: 1. It is the policy of this facility, in collaboration with the medical director, to have an immunization program against COVID-19 disease in accordance with national standards of practice. 2. (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	COVID-19 vaccinations currently in use include the updated 2024-2025 mRNA COVID-19 vaccines such as the Pfizer-BioNTech or Moderna brands and the protein subunit vaccine Novavax 2024-2025 formula. 3. The number of updated 2024-2025 COVID-19 vaccine doses and individual needs is based on age and vaccination history. For people who are not moderately or severely immunocompromised (See Table 1).: ii. People ages 5-64 years: Should receive 1 dose of an age-appropriate 2024-2025 COVID-19 vaccine. (People ages 12-64 years who are unvaccinated and receive the 2024-2025 Novavax COVID-19 vaccine for initial vaccination should receive 2 doses of 2024-2025 Novavax COVID-19 vaccine.) iii. People ages 65 years and older: Should receive 2 doses of any 2024-2025 COVID-19 vaccine, spaced 6 months (minimal interval 2 months) apart. (People ages 65 years and older who are unvaccinated and receive Novavax COVID-19 vaccine for initial vaccination should receive 2 doses of 2024-2025 Novavax COVID-19 vaccine followed by a third dose of any 2024-2025 COVID-19 vaccine dose 6 months (minimal interval 2 months) after the second dose.). 11. COVID-19 vaccinations will be offered to residents when supplies are available, as per CDC and/or FDA guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period, or refuses to receive the vaccine. 12. Following assessment for potential medical contraindications, COVID-19 vaccinations for residents may be administered in accordance with physician-approved standing orders. 13. The facility may administer the vaccine directly or the vaccine may be administered indirectly through an arrangement with a pharmacy partner or local health department. 14. The facility will educate and offer the COVID-19 vaccine to residents, resident representatives and staff and maintain documentation of such. 15. The facility will maintain documentation related to staff COVID-19 vaccination and include at a minimum: a. Education to the staff regarding the risks, benefits, and potential side effects of the COVID-19 vaccine; b. The offering of the COVID-19 vaccine or information on obtaining the COVID-19 vaccine; c. The COVID-19 vaccine status of staff and related information as indicated by NHSN. 17. Residents or their representatives and staff will sign the consent form prior to administration of the COVID-19 vaccine. This information will be retained in the resident's medical record or the staff's medical file. 19. Residents or resident representatives retain the right to accept, refuse or change their decision about COVID-19 immunization. If refused, the residents will adhere to the protocols set forth by specific facility policy. 20. The facility will abide by staff vaccination requirements or medical or religious exemptions based on state, local or employer guidance as indicated. (Insert any state, local or employer specific guidance as needed.) 21. The resident's medical record will include documentation of the following: a. Education to the resident or resident representative regarding the risks, benefits, and potential side effects of the COVID-19 vaccine; b. Each dose of the vaccine administered to the resident, or; c. If the resident did not receive the COVID-19 vaccine due to medical contraindication or refusal. 1.) R6's Annual Minimum Data Set (MDS) with an assessment reference date of 7/11/25, documents a Brief Interview for Mental Status (BIMS) assessment score of 15, indicating that R6 is cognitively intact. R6 is responsible for self.Surveyor reviewed R6's electronic medical record and was unable to locate whether R6 was offered, received, or declined the COVID-19 immunizations.On 09/16/2025, at 8:19 AM, Surveyor interviewed Director of Nursing (DON)-B and found out there have been no COVID-19 vaccinations offered since 2023 and no declinations have been found.On 09/16/2025, at 3:20 PM, during the end of day meeting with facility, Surveyor relayed concern to Nursing Home Administrator-A and DON-B that COVID-19 immunizations were not offered to 5 of 5 residents. Surveyor noted no further evidence of documentation of R6 being offered or refusing the COVID-19 vaccination was provided. 2.) R33's Annual Minimum Data Set (MDS) with an assessment reference date of 9/3/25, does not document a Brief Interview for Mental Status (BIMS) assessment, noted to be unable to complete. R33 has an activated Health Care-Power of Attorney. Surveyor reviewed R33's electronic medical record and was unable to locate whether R33 was offered, received, or declined the COVID-19 immunizations.On 09/16/2025, at 8:19 AM, Surveyor interviewed Director of Nursing (DON)-B and found out there have been no COVID-19 vaccinations offered since (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2023 and no declinations have been found.On 09/16/2025, at 3:20 PM, during the end of day meeting with facility, Surveyor relayed concern to Nursing Home Administrator-A and DON-B that COVID-19 immunizations were not offered to 5 of 5 residents.Surveyor noted no further evidence of documentation of R33 being offered or refusing the COVID-19 vaccination was provided.3.) R40's Comprehensive Minimum Data Set (MDS) with an assessment reference date of 6/27/25, documents a Brief Interview for Mental Status (BIMS) assessment score of 10, indicating that R40 has moderate cognitive impairment. Surveyor reviewed R40's electronic medical record and was unable to locate whether R40 was offered, received, or declined the COVID-19 immunizations.On 09/16/2025, at 8:19 AM, Surveyor interviewed Director of Nursing (DON)-B and found out there have been no COVID-19 vaccinations offered since 2023 and no declinations have been found.4.) R65's Quarterly Minimum Data Set (MDS) with an assessment reference date of 7/18/25, documents a Brief Interview for Mental Status (BIMS) assessment score of 15, indicating that R65 is cognitively intact. R65 is responsible for self.Surveyor reviewed R65's electronic medical record and was unable to locate whether R65 was offered, received, or declined the COVID-19 immunizations.On 09/16/2025, at 8:19 AM, Surveyor interviewed Director of Nursing (DON)-B and found out there have been no COVID-19 vaccinations offered since 2023 and no declinations have been found.On 09/16/2025, at 3:20 PM, during the end of day meeting with facility, Surveyor relayed concern to Nursing Home Administrator-A and DON-B that COVID-19 immunizations were not offered to 5 of 5 residents.Surveyor noted no further evidence of documentation of R65 being offered or refusing the COVID-19 vaccination was provided.5.) R75's Quarterly Minimum Data Set (MDS) with an assessment reference date of 8/17/25, documents a Brief Interview for Mental Status (BIMS) assessment score of 14, indicating that R75 is cognitively intact. R75 is responsible for self.Surveyor reviewed R75's electronic medical record and was unable to locate whether R75 was offered, received, or declined the COVID-19 immunizations.On 09/16/2025, at 8:19 AM, Surveyor interviewed Director of Nursing (DON)-B and found out there have been no COVID-19 vaccinations offered since 2023 and no declinations have been found.On 09/16/2025, at 3:20 PM, during the end of day meeting with facility, Surveyor relayed concern to Nursing Home Administrator-A and DON-B that COVID-19 immunizations were not offered to 5 of 5 residents.Surveyor noted no further evidence of documentation of R75 being offered or refusing the COVID-19 vaccination was provided.6.) Surveyor requested CNA-JJ's COVID-19 immunization information and the facility was unable to provide documentation that the vaccine was offered, received, or declined by CNA-JJ.On 09/16/2025, at 11:04 AM, Surveyor interviewed Business Office staff-KK about CNA-JJ being offered the COVID-19 vaccination and was told it is not offered to staff, only the Hepatitis B vaccination is offered.On 06/11/25, at 03:33 PM, during the end of day meeting, Surveyor shared concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that staff are not offered the COVID-19 vaccination.Surveyor noted no further evidence of documentation of staff being offered or refusing the COVID-19 vaccination was provided.

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	525371	A. Building B. Wing	09/30/2025

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not maintain an effective pest control program to address the flying bugs in the facility. *Surveyors observed active pest activity from flies/flying bugs in multiple areas of the Facility's B Unit. *Surveyors observed active pest activity from flies/flying bugs in multiple areas of the Facility's C Unit. Findings include: On 9/15/25 at 10:10 AM Surveyor observed R10's wound treatment. Surveyor noted several swarms of fruit flies hovering by R10's room door on Facility's C Wing. On 9/15/25 at 10:26 AM, Surveyor observed R4's wound treatment. Surveyor noted several swarms of fruit flies hovering by R4's room door and throughout R4's room on Facility's C Wing. On 9/15/25, at 9:52 AM, Surveyor interviewed Maintenance Director-GG regarding pest control for the facility. Maintenance Director-GG states the facility uses [Pest control company] to put bait stations outside the facility or to put a gel down on the floor if there is a concern with ants. Maintenance Director-GG stated Maintenance Director-GG sealed up some cracks where ants were coming in and [Pest control company] provides service once per month. Maintenance Director-GG stated if a resident complains of gnats flying around, Maintenance Director-GG goes into their room to make sure any old food is thrown out and checks the drains and cleans them out per [Pest control company] recommendation. Maintenance Director-GG states since cleaning out the drains, there haven't been as many flies. On 9/15/25 at 1:33 PM, Surveyors shared concerns with Director of Nursing (DON)-B that Surveyor had observations of fruit flies in R4 and R10's resident rooms while wound treatments were being conducted. On 9/17/25 at 8:44 AM, DON-B informed Survey team that there is no facility policy on pest control and if there is a problem identified the facility would call [Pest control company] to come out to take care of it On 9/9/25, at 10:10 AM, during an interview with R32, Surveyor observed a sticky fly strip hanging on a hanger in R32's room on B-unit. On 9/9/25, at 10:13 AM, Surveyor observed a fly flying around in room [ROOM NUMBER] on B-unit. On 9/9/25, at 10:44 AM, Surveyor observed a fly flying around in room [ROOM NUMBER] on B-unit. On 9/9/25, at 11:05 AM, during an interview with R85, Surveyor observed multiple flies flying around R85's room on B-unit. Surveyor asked R85 if there is a problem with flies, R85 replied R85 notices flies in the room. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/9/25, at 1:49 PM, Surveyor interviewed R2, who resides in the same room as R85, if there is a problem with flies. R2 states R2 tries to keep the door closed with the fan on to keep the flies away, but there are a lot around right now. On 9/10/25, at 8:23 AM, during an interview with R32, Surveyor observed multiple flies flying around R32's room on B-unit. Surveyor asked R32 if there is a problem with flies. R32 stated the gnats have been going on for a few months at least, and R32 put up the fly strip in the room to try to help. On 9/15/25, at 9:06 AM, Surveyor observed multiple fruit flies flying around in the hallway of B-unit. On 9/15/25, at 9:52 AM, Surveyor interviewed Maintenance Director-GG regarding pest control for the facility. Maintenance Director-GG states the facility uses [Pest control company] to put bait stations outside the facility or to put a gel down on the floor if there is a concern with ants. Maintenance Director-GG stated Maintenance Director-GG sealed up some cracks where ants were coming in and [Pest control company] provides service once per month. Maintenance Director-GG stated if a resident complains of gnats flying around, Maintenance Director-GG goes into their room to make sure any old food is thrown out and checks the drains and cleans them out per [Pest control company] recommendation. Maintenance Director-GG states since cleaning out the drains, there haven't been as many flies. On 9/15/25, at 1:33 PM, Surveyor shared concern with Director of Nursing (DON)-B that Surveyor had multiple observations of fruit flies and gnats flying around the hallway and resident rooms in B-unit, and Surveyor observed a sticky fly strip hanging in R32's room on B-unit. DON-B stated DON-B would make sure the fly strip was taken down. On 9/15/25, at 3:18 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A that Surveyor had multiple observations of fruit flies and gnats flying around the hallway and resident rooms in B-unit, and Surveyor observed a sticky fly strip hanging in R32's room on B-unit. On 9/16/25, at 1:30 PM, Surveyor observed multiple fruit flies flying around in the hallway of B-unit. On 9/17/25, at 8:44 AM, DON-B informed Surveyor that there is no facility policy on pest control, and if there is a problem identified the facility would call [Pest control company] to come out. On 9/9/2025, at 10:30AM, During an interview with R5, Surveyor observed flies in R5's room and R5 stated, These darn flies, and swatting them away. R5 stated there are always flies flying around R5's bedroom and the facility. On 9/9/2025, at 10:38AM, Surveyor observed fruit flies flying around the hallway. On 9/10/2025, at 12:43PM, Surveyor observed the noontime meal cart in the hallway with 2 flies flying around it. On 9/10/2025, at 12:59PM, Surveyor was standing in hallway around rooms [ROOM NUMBERS], Surveyor observed fruit flies and flies flying around Surveyors computer. On 9/10/2025, at 1:02PM, Surveyor interviewed certified nursing assistant (CNA)-T who stated the flies in the facility are very bad. CNA-T stated residents have fly swatters in their rooms and are always complaining about flies. CNA-T stated there used to be a bug zapper on the patio but has not (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	seen it out there for awhile and the flies seem to get worse on hotter days. CNA-T stated that staff and residents have just grown accustomed to having the flies around because they are always there. CNA-T stated all the units in the facility have issues with flies and fruit flies, but CNA-T primarily works on B-unit. On 9/15/2025, at 9/15/2025AM, Surveyor observed multiple fruit flies flying around in the hallway around rooms 10, 11, 12, and 13. On 9/15/2025, at 9:58AM, Surveyor interviewed maintenance director-GG who stated has been employed with the facility for about 3 (three) months. Maintenance director-GG stated the facility has issues with ants getting into the building, cracks in the building have been sealed to prevent access. Maintenance director-GG stated [Pest control company] comes to the facility every month and walks around the perimeter of the building to inspect for pest activity, [Pest control company] also walks inside to inspect for any concerns. Surveyor asked if maintenance director-GG was aware of fly/ fruit fly concerns in the facility. Maintenance director-GG stated awareness that there have been complaints. Maintenance director-GG stated [Pest control company] said to clean out the sink drain pipes in the room to get rid of any possible causes to the flies. Maintenance director-GG stated if a resident complains of flies/ bugs then maintenance director-GG will clean out the sink pipe and has located straws in the sink pipes. Surveyor requested to review the last 3 months of services provided by [Pest control company]. Surveyor reviewed services provided by [Pest control company] on: 4/9/2025, 5/14/2025, 6/19/2025, 7/22/2025, and 8/19/2025 and noted the following documented observations/ recommendations:- On 4/9/2025 [Pest control company] documented observations of midges (any kind of small fly often referred as no-see-ums) noted in the interior light traps and recommended checking drain lines for standing water in sinks to prevent drain flies from breeding. This concern was documented as still pending from a start date of 9/13/2023 indicating an ongoing concern [Pest control company] has with the facility.- On 5/14/2025 [Pest control company] documented observations of moderate fly activity in every fly light and the fly light in the main lobby was unplugged. 2 holes were noted on the exterior of the facility that was recommended to be plugged/ closed to assist with insect/pest control.- On 6/19/2025 [Pest control company] documented observations of a lot of flying pest activity: moths and flies were inside fly lights caused by doors being left open for a long period of time before closing, and the light trap at the main entrance was unplugged again allowing flying pests to enter facility instead of being attracted to the fly light.- On 7/22/2025 [Pest control company] documented observations of fruit flies flying around drains in the facility. Upon further observation, straws were found wedged in one of the drains and was unable to remove the straws. Fly lights inspected and noted a large number of moths and other insects inside the fly lights indicating doors to the outside are left open for long periods of time allowing flying pests into the facility. Several resident rooms were observed to have ants due to food debris in the rooms. Fruit flies observed in room [ROOM NUMBER] on C-unit, room [ROOM NUMBER] observed to have a break in the wall by the toilet allowing moisture to build up allowing the fruit flies to flourish. Recommendations provided to maintenance director-GG to repair room [ROOM NUMBER] break in the wall, clean out/ inspect all drains in the facility, and ensure door to the exterior are not left open for extended periods of time.- On 8/19/2025 [Pest control company] documented observations of the fly light located in the smoking area, the fly light had a large number of moths and flies in the flight light not allowing flying pests to stick to the glue board. A large number of moths were noted hanging on the wall located by the fly light. Recommendation to inspect and replace fly light glue boards as needed to prevent buildup of flying pests. (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/15/2025, at 3:15PM, Surveyor shared concerns with nursing home administrator (NHA)-A, director of nursing (DON)-B, and regional nurse consultant (RNC)-L regarding pest control in the facility and Surveyors observations of fruit flies and flies on B-unit and resident rooms. Surveyor requested to review the facility 'Pest Control policy. On 9/16/2025, at 1:31PM, Surveyor observed fruit flies along the whole hallway on B-unit. On 9/17/2025, at 8:44AM, DON-B stated the facility does not have a Pest Control policy. [Pest control company] is called whenever there is a concern. Surveyor noted that [Pest control company] has not been contacted regarding addressing the flying pest concerns other than when [Pest control company] is at the facility for their monthly check and each month between 4/2025 – 8/2025 there have been concerns brought forth regarding flying pest in the facility. On 9/17/2025, at 2:15PM, Surveyors observed a large number of ants located underneath the desk in the upstairs conference room. NHA-A and DON-B were made aware.

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	525371	A. Building B. Wing	09/30/2025

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. Based on interview and record review, the facility did not ensure that 7 of 8 sampled staff received training on the facility's compliance and ethics program.This has the potential to affect the 85 residents who reside at the facility and have the potential to receive direct and indirect care from these staff. Findings Include:On 9/30/25, Surveyor requested from Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, evidence that the following staff members received training regarding compliance and ethics:Certified Nursing Assistant (CNA)-WW hire date 8/8/23CNA-TT hire date 9/19/23CNA-XX hire date 9/12/22CNA-YY hire date 10/3/23CNA-ZZ hire date 1/5/06Housekeeping-AAA hire date 1/25/24Speech Language Pathologist (SLP)-BBB hire date 5/16/23Registered Nurse (RN)-CCC hire date 2/1/23Surveyor reviewed completed trainings and noted there was not documentation that CNA-WW, CNA-TT, CNA-XX, CNA-YY, CNA-ZZ, SLP-BBB, or RN-CCC received training of the facility's compliance and ethics program on an annual basis.On 9/30/25, at 11:20 AM, Surveyor shared concerns with NHA-A that seven sampled staff did not have evidence of completing the facility's compliance and ethics program. NHA-A stated NHA-A would try to find any additional information. On 9/30/25, at 3:02 PM, NHA-A stated no additional information was located regarding compliance and ethics training for CNA-WW, CNA-TT, CNA-XX, CNA-YY, CNA-ZZ, SLP-BBB, or RN-CCC.

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	525371	A. Building B. Wing	09/30/2025

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on record review and interview, the facility did not ensure 7 out of 8 staff chosen at random received behavioral health training to care for residents diagnosed with a mental, psychosocial, or other behavioral health conditions. This deficient practice has the potential for staff to lack current knowledge to work with the unique challenges mental health illnesses present and has the potential to affect all 85 residents that have the potential to experience behavioral health issues in the facility.Findings include:Surveyor notes, when asking Nursing Home Administrator (NHA)-A for a policy on required annual in-service training, NHA-A stated, the facility does not have a policy on in-service training. On 9/30/25 at 8:40 AM, Surveyor requested from Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, evidence that the following staff members received training regarding behavioral health:Certified Nursing Assistant (CNA)-WW, date of hire 8/8/23CNA-TT, date of hire date 9/19/23CNA-XX, date of hire 9/12/22CNA-YY, date of hire 10/3/23CNA-ZZ, date of hire 1/5/06Housekeeping-AAA, date of hire1/25/24Speech Language Pathologist (SLP)-BBB, date of hire 5/16/23Registered Nurse (RN)-CCC, date of hire 2/1/23Surveyor reviewed completed trainings in Relias (software for employee education) and noted there was no documentation that CNA- WW, CNA-TT, CNA-XX, CNA-ZZ, Housekeeping- AAA, SLP-BBB and RN-CCC received training of the facility's compliance and ethics program on an annual basis.On 9/30/25 at 11:20 AM, Surveyor interviewed NHA-A who stated, Human Resources is responsible for assuring staff receive the required training. Surveyor notified NHA-A that there was no evidence CNA-WW, CNA-TT, CNA-XX, CNA-ZZ, Housekeeping- AAA, SLP-BBB and RN-CCC received the behavioral health training. NHA-A stated, NHA-A would consult with team and get back to Surveyor if any additional information could be found. On 9/30/25, at 3:02 PM, NHA-A stated no additional information was located regarding behavioral health training for CNA-WW, CNA-TT, CNA-XX, CNA-ZZ, Housekeeping- AAA, SLP-BBB and RN-CCC. Surveyor notified NHA-A and DON-B that no training for behavioral health for the identified staff is a concern. NHA-A and DON-B acknowledged the missing training.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525371	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Nursing & Rehab	1300 West Silver Spring Dr Glendale, WI 53209

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents whose Medicare part A benefits ended were provided with written beneficiary protection notifications for 4 (R15, R100, R101, R102) of 5 residents sampled for beneficiary notifications. The facility did not provide 4 Residents (R15, R100, R101, & R102) of 5 sampled residents a written Advanced Beneficiary Notice (ABN), which includes financial liability information and appeal rights, at the time Medicare Part A coverage ended. Findings include: The facility policy titled, Advance Beneficiary Notice Policy implemented [DATE], documents, in part: Policy: It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage. Policy Explanation and Compliance Guidelines.:c. A Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123, shall be issued to the resident/representative when Medicare covered services(s) are ending, no matter if resident is leaving the facility or remaining in the facility. This informs the resident on how to request an appeal or expedited determination from their Quality Improvement Organization (QIO).i. This notice is used when all covered services end for coverage reasons.ii. An exhaustion of benefits is not considered a termination for coverage reasons.5. To ensure that the resident, or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided at least two days before the end of a Medicare covered Part A stay or when Part B therapies are ending.6. The Business Office Manager, or designee, is responsible for issuing notices.Notice of Medicare Non-Coverage (NOMNC) (Form CMS 10123-NOMNC) is utilized to provide written notification to resident or resident representative that Medicare Part A coverage is ending in two or more days. The notification includes appeal rights and provides the third party reviewer name and phone number to begin an immediate appeal.Advance Beneficiary Notice (ABN) (Form CMS-10055) is utilized to provide written notification to resident or resident representative of services Medicare A will no longer cover, an estimated cost of those services, and three options which include each choice's effect on appeal rights.During the survey, a list of 5 residents whose Medicare A benefits have expired was provided to Surveyor. On [DATE], at the end of day meeting, Surveyor asked for the notices that should have been provided to the resident or families prior to the benefit ending.On [DATE], at 7:45am, Nursing Home Administrator (NHA)-A informed Surveyor they could only find one NOMNC, stating: the lady who used to do them worked at the facility for 30 years and passed away. They are still redistributing her work. NHA-A doesn't believe there are anymore that would have been completed.On [DATE], at 3:19pm, during the end of day meeting with the Facility, the concern that only one of 5 residents received proper notices that Medicare Part A benefits were ending was shared. No additional information was provided as to why the facility did not provide ABN information to residents or their representatives.

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	525371	A. Building B. Wing	09/30/2025

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview and record review the Facility did not address and resolve grievances conveyed during Resident Council meetings on behalf of 12 of 12 residents who attended the meeting.Per July Resident Council meeting minutes residents expressed concern that staff were not wearing name tags. Surveyor noted no documentation this was thoroughly investigated, along with an appropriate resolution.Findings include:The Facility Policy titled Resident Council last revised April 2017 documents, in part: Policy Interpretation and Implementation.5. A Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern.The Facility Policy titled Grievances/Complaints, Filing last revised April 2017 documents, in part: Policy Interpretation and Implementation.3. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response.On 9/10/2025, at 10:18am, Surveyor was reviewing previous Resident Council meeting minutes and noted that in July a concern was brought up that staff need name tags.On 9/10/2025, at 1:46pm, Surveyor interviewed Resident Council members asking Does the facility consider the views of the resident or family groups and act promptly upon grievances and recommendations? The issue that half of the staff do not wear name tags was again brought up.On 9/15/2025, at 8:32am, Surveyor observed Licensed Practical Nurse (LPN)-Y on unit B not wearing a name tag.On 9/15/2025, at 8:42am, Surveyor interviewed Director of Social Services (SS)-F regarding who is responsible for grievances from residents. It was shared that for resident council concerns if SS-F is allowed to attend the meeting they will take notes, otherwise the Activity Director (EE) who runs the meetings takes notes and brings to SS-F. SS-F was aware of the concern that staff are not wearing name tags however did not write it up or address as a grievance. The other Social Worker in the shared office wrote out the grievance as we talked. SS-F took out a bag of blank name tags and said she has been working on handing them out. On 9/15/2025, at 9:23am, Surveyor observed LPN-P on unit A not wearing a name tag.On 9/15/2025, at 9:25am, Surveyor observed Director of Activities-EE pushing a wheelchair in hall with no name tag on.On 9/15/2025, at 9:30am, Surveyor observed Certified Nursing Assistant (CNA)-T and CNA-S both with no name tag on.On 9/15/2025, at 9:32am, Surveyor observed housekeeping staff-FF with no name tag on.On 9/15/2025, at 9:34am, Surveyor observed LPN-Z without a name tag on.On 09/15/2025, at 10:25am, Surveyor interviewed Nursing Home Administrator (NHA)-A and asked during Resident Council if issues are brought up what is the process to address concerns. NHA-A replied that activity's staff are to write a grievance for every issue brought up, then take to the Director of Social Services. These grievances are then discussed quarterly at QAPI (Quality Assurance Performance Improvement). Surveyor let NHA-A know of concern that name tags not being worn by staff was an issue on the agenda for July, no grievance was written, Residents expressed the concern continued to be an issue during the survey and Surveyor has observations that name tags still are not being worn by staff.No additional information was provided regarding the July Resident Council meeting minutes indicating residents expressed concern that staff were not wearing name tags, and the issue was not written as a grievance or an appropriate resolution put in place.

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	525371	A. Building B. Wing	09/30/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility did not ensure that the Minimum Data Set (MDS) assessment accurately reflected the resident's status at the time of the assessment for 12 (R5, R50, R66, R75, R34, R3, R4, R60, R2, R6, R65, and R9) of 20 residents reviewed. * R3, R4, R5, R34, R50, R60, R65, R66, and R75's MDS were inaccurately coded indicating a Preadmission Screening and Resident Review (PASARR) 2 was not required when the resident's PASARR 1 indicated residents having a severe mental illness. * R2's MDS assessment coded R2 having an indwelling foley catheter. R2 does not have an indwelling foley catheter. * R6's MDS did not accurately reflect that R6 had dental issues. * R9's MDS assessment coded anticoagulant use. R9 was not taking an anticoagulant medication. Findings include: 1.) R5 was admitted to the facility on [DATE] with diagnoses of bipolar disorder, major depressive disorder, anxiety disorder, mild cognitive impairment, and post traumatic stress disorder. R5 did not have an activated power of attorney and was R5's own person. R5's quarterly minimum data set (MDS) dated [DATE] documented in Section A: Identification Information, R5 was documented as a NO for Preadmission Screening and Resident Review (PASARR) level 2, as not having a serious mental illness or intellectual disability or a related condition. This was coded inaccurately as R5 has a PASARR documenting YES for question: Does this person have a major mental disorder? On 9/16/2025, at 8:50 AM, Surveyor interviewed MDS Coordinator-E, who stated MDS Coordinator-E is continuing to train and working with the clinical team and a regional MDS employee to get the workload done. MDS Coordinator-E was not aware a PASARR 2 was even completed for R5 as it was never scanned in to Point Click Care (PCC) the electronic health record program the facility utilizes. MDS Coordinator-E indicated if the PASARR was scanned in, then the MDS assessment would be accurately coded. On 9/17/2025, at 9:51 AM, Surveyor interviewed Director of Nursing (DON)-B, who stated MDS Coordinator-E is accountable for completing MDS accurately. On 9/17/2025, at 10:05 AM, Surveyor informed Nursing Home Administrator (NHA)-A of concern with R5's MDS assessment not being accurately coded for R5's PASARR status. 2.) R34 was admitted to the facility on [DATE] with a diagnosis of schizophrenia. The annual Minimum Data Set (MDS) dated [DATE] documents in section A1500, Is the resident currently considered by the state level II PASARR (preadmission screening and resident review) process to have serious mental illness and/or intellectual disability or a related condition? The answer to this assessment was No. (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R34 had a PASARR level II completed on 4/20/22 due to his diagnosis of schizophrenia. 3.) R3 was admitted to the facility on [DATE] with diagnoses of bipolar and anxiety disorder. The annual Minimum Data Set (MDS) dated [DATE] documents in section section A1500, Is the resident currently considered by the state level II PASARR (preadmission screening and resident review) process to have serious mental illness and/or intellectual disability or a related condition? The answer to this assessment was No. R3 had a PASARR level II completed on 9/6/24 due to her diagnoses of bipolar and anxiety disorder. 4.) R6 was admitted to the facility on [DATE] with diagnoses of dysphagia, chronic respiratory failure and chronic obstructive pulmonary disease. On 9/9/25 at 10:23 a.m. Surveyor interviewed R6. R6 stated he has missing teeth and needs to see the dentist. R6 showed Surveyor his mouth. R6 had missing and broken teeth. The annual Minimum Data Set (MDS) dated [DATE] documents under section L Oral/Dental Status, that R6 had no dental issues. On 9/16/2025, at 8:50 AM, Surveyor interviewed MDS Coordinator-E, who stated MDS Coordinator-E is continuing to train and working with the clinical team and a regional MDS employee to get the workload done. MDS Coordinator-E was not aware a PASARR 2 was even completed for R3 and R34 as it was never scanned in to Point Click Care (PCC) the electronic health record program the facility utilizes. MDS Coordinator-E indicated if the PASARR was scanned in, then the MDS assessment would be accurately coded. MDS Coordinator-E was not aware R6 had dental issues. On 9/17/2025, at 10:05 AM, Surveyor informed Nursing Home Administrator (NHA)-A of concern with R3 and R34's MDS assessments not being accurately coded for PASARR and R6's MDS assessment being coded incorrectly for R6's dental status. 5.) R50 was admitted to the facility on [DATE] with diagnoses of post-traumatic stress disorder, depression and generalized anxiety disorder. R50's Preadmission Screening and Resident Review (PASARR) level 1 documents, yes to R50 is suspected of having a serious mental illness and requires a PASARR level 2 screening. R50's Minimum Data Set (MDS) comprehensive assessment dated [DATE], documents in section A, no for the Preadmission Screening and Resident Review: Is the resident currently considered by the State level 2 PASARR process to have serious mental illness and/or intellectual disability or a related condition. This is a MDS discrepancy compared to the results of the PASARR level 1 screening. On 09/16/2025 at 8:32 AM, Surveyor interviewed Minimum Data Set (MDS) Coordinator- E and asked how MDS Coordinator-E determines how to answer the question in the MDS, section A regarding the Preadmission Screening and Resident Review: Is the resident currently considered by the State level 2 PASARR process to have serious mental illness and/or intellectual disability or a related condition. MDS Coordinator-E stated MDS-Coordinator-E accesses each resident's medical record and reviews what is stated on the PASARR level 1 and then answers the MDS question above, yes or no. Surveyor asked why the need for a PASARR level 2 would be marked NO under R50's MDS comprehensive assessment dated [DATE] when it was identified on the PASARR level 1 that a Level (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2 PASARR was needed. MDS Coordinator-E stated that MDS- Coordinator-E must have read the question incorrectly. 09/16/2025 9:45 AM notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of concerns relating to the PASARR MDS discrepancy for R50. 6.) R65 was admitted to the facility on [DATE] with diagnoses of depression, hoarding disorder and bipolar disorder. R65's Preadmission Screening and Resident Review (PASARR) level 1 dated 4/15/23, documents, yes to R65 is suspected of having a serious mental illness that requires a PASARR level 2 screening. R65's Minimum Data Set (MDS) comprehensive assessment dated [DATE], documents in section A, no for the Preadmission Screening and Resident Review: Is the resident currently considered by the State level 2 PASARR process to have serious mental illness and/or intellectual disability or a related condition. This is a MDS discrepancy compared to the results of the PASARR level 1 screening. On 09/16/2025 at 8:32 AM, Surveyor interviewed Minimum Data Set (MDS) Coordinator- E and asked how MDS Coordinator-E determines how to answer the question in the MDS, section A regarding the Preadmission Screening and Resident Review: Is the resident currently considered by the State level 2 PASARR process to have serious mental illness and/or intellectual disability or a related condition. MDS Coordinator-E stated MDS-Coordinator-E accesses each resident's medical record and reviews what is stated on the PASARR level 1 and then answers the MDS question above, yes or no. Surveyor asked why the need for a PASARR level 2 would be marked NO under R65's MDS comprehensive assessment dated [DATE] when it was identified on the PASARR level 1 that a PASARR level 2 was needed. MDS Coordinator-E stated that MDS- Coordinator-E must have read the question incorrectly. 09/16/2025 9:45 AM notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of concerns relating to the PASARR MDS discrepancy for R65. 7.) R2 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (weakness) following cerebral infarction (stroke) affecting right dominant side, and type 2 diabetes mellitus with diabetic polyneuropathy (nerve damage). R2's Quarterly Minimum Data Set (MDS) assessment dated [DATE] in section H: bowel and bladder documents R2 has an indwelling catheter. The MDS documents R2 has a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. On 9/9/25, at 1:55 PM, Surveyor interviewed R2, who stated R2 does not currently use a catheter and has not had a catheter for a few years. On 9/16/25, at 8:32 AM, Surveyor asked MDS Coordinator-E how many MDS Coordinators were employed at the facility. MDS Coordinator-E stated MDS Coordinator-E is the only MDS Coordinator in the facility, but there is also an MDS Coordinator that works remotely. Surveyor shared the concern with MDS Coordinator-E that R2's Quarterly MDS assessment dated [DATE] indicated R2 uses an indwelling catheter, however R2 stated R2 does not currently have an indwelling and has not had a catheter for a few years. MDS Coordinator-E stated sometimes the MDS pulls old information over (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525371	A. Building B. Wing	09/30/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from a previous assessment, so it was likely missed that the information had to be updated. On 9/16/25, at 3:29 PM, Surveyor shared concern of the above MDS discrepancy with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. 8.) R9 was admitted to the facility on [DATE]. R9's order for heparin, an anticoagulant, was discontinued on 4/14/2025. On R9's Quarterly Minimum Data Set (MDS) assessment in Section N: Medications, an MDS nurse documented R9 was taking an anticoagulant. This was coded inaccurately as R9 did not receive any anticoagulation medication during the seven day lookback period. In an interview on 9/16/2025 at 8:32 AM, Surveyor asked MDS Coordinator-E how many MDS Coordinators were employed at the facility. MDS Coordinator-E stated MDS Coordinator-E is the only MDS Coordinator in the facility but there is also an MDS Coordinator that works remotely. Surveyor shared with MDS Coordinator-E the concern R9's Quarterly MDS assessment coded R9 was receiving an anticoagulation medication and R9's heparin had been discontinued on 4/14/2025. MDS Coordinator-E stated each MDS assessment pulls information from the previous MDS assessment and MDS Coordinator-E and the remote MDS Coordinator has to manually go in and change the information that is no longer applicable to the resident. On 9/16/2025 at 3:20 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern R9's Quarterly MDS assessment dated [DATE] was coded inaccurately for the use of an anticoagulant. 9.) R66 was admitted to the facility on [DATE] with diagnoses of depression, transient ischemic attack and cerebral infarction. R66's admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview Mental Status (BIMS) score of 15, indicating cognition was intact, and is understood and understands others. On R66's Comprehensive Minimum Data Set (MDS) assessment in Section A: Identification Information, an MDS nurse documented R66 as a NO for Preadmission Screening and Resident Review (PASARR) level 2, as not having a serious mental illness or intellectual disability or a related condition. This was coded inaccurately as R66 has a PASARR level 1 documenting YES for question: Does this person have a major mental disorder? The PASARR level 2 also documents YES for above question. On 9/16/2025, at 8:50 AM, Surveyor interviewed MDS Coordinator-E, who indicated being in training still and working with the clinical team and a regional MDS employee to get the workload done. MDS-E stated that MDS-E didn't know a PASARR 2 was even completed for this R66 as it was never scanned in to Point Click Care (PCC) the electronic health record program the facility utilizes. MDS-E indicated that if the PASARR was scanned in, then MDS-E would have answered the MDS assessment correctly. On 9/17/2025, at 9:51 AM, Surveyor interviewed Director of Nursing (DON)-B, who indicated that MDS-E is accountable for completing MDS accurately. DON-B stated that DON-B completed a verbal education with the MDS-E nurse, on MDS-E's responsibilities in the building, and what MDS-E needs (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to be completing and how. On 9/17/2025, at 10:05 AM, Surveyor informed Nursing Home Administrator (NHA)-A of concern with MDS assessments for R66 being completed accurately. NHA-A stated an understanding and indicated that the facility just brought on 2 new people for MDS, to help as the current workload is not flowing. 10.) R75 was admitted to the facility on [DATE] with diagnoses of no affective disorder, bipolar type, generalized exciting disorder, Paraneoplastic neuromyopathy and neuropathy. R75's Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview Mental Status (BIMS) score of 14, indicating cognition was intact, and is understood and understands others. On R75's Comprehensive Minimum Data Set (MDS) assessment in Section A: Identification Information, an MDS nurse documented R75 as a NO for PASARR level 2, as not having a serious mental illness or intellectual disability or a related condition. This was coded inaccurately as R75 has a PASARR documenting YES for question: Does this person have a major mental disorder? PASARR 2 also documents YES for above question. On 9/16/2025, at 8:50 AM, Surveyor interviewed MDS Coordinator-E, who indicated being in training still and working with the clinical team and a regional MDS employee to get the workload done. MDS-E stated that MDS-E didn't know a PASARR 2 was even completed for this R75 as it was never scanned in to Point Click Care (PCC) the electronic health record program the facility utilizes. MDS-E indicated that if the PASARR was scanned in, then MDS-E would have answered the MDS assessment correctly. On 9/17/2025, at 9:51 AM, Surveyor interviewed Director of Nursing (DON)-B, who indicated that MDS-E is accountable for completing MDS accurately. DON-B stated that DON-B completed a verbal education with the MDS-E nurse, on MDS-E's responsibilities in the building, and what MDS-E needs to be completing and how. On 9/17/2025, at 10:05 AM, Surveyor informed Nursing Home Administrator (NHA)-A, of concern with MDS assessments for R75 being completed accurately. NHA-A stated an understanding and indicated that the facility just brought on 2 new people for MDS, to help as the current workload is not flowing. 11.) R34 was admitted to the facility on [DATE]. R34's admission Minimum Data Set (MDS) dated [DATE] documents in section A1500, Is the resident currently considered by the state level II PASARR (preadmission screening and resident review) process to have serious mental illness and/or intellectual disability or a related condition? The answer to this assessment was No. R34 had a PASARR level II completed on 6/16/25. On 9/16/2025 at 8:50 AM, the Survey team interviewed MDS Coordinator-E who stated that they are continuing to train on MDS assessments. MDS Coordinator-E is currently working with the clinical team and a regional MDS employee to get the workload done to the facility. MDS Coordinator-E was not aware a PASARR 2 was even completed for R34 as the document was never scanned into the facility's electronic medical record program. MDS Coordinator-E indicated if the PASARR was scanned in, then the MDS assessment would be accurately coded. On 9/17/2025 at 10:05 AM, the Survey team informed Nursing Home Administrator (NHA)-A of concern (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525371	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with R34's MDS assessment not being accurately coded for PASARR. The facility did not provide any additional information at this time. 12.) R4 was admitted to the facility on [DATE] with a diagnosis of Bipolar Disorder. R4's Annual Minimum Data Set (MDS) dated [DATE] documents in section A1500, Is the resident currently considered by the state level II PASARR (preadmission screening and resident review) process to have serious mental illness and/or intellectual disability or a related condition? The answer to this assessment was No. R4 had a PASARR level II completed on 5/4/23. On 9/16/2025 at 8:50 AM, the Survey team interviewed MDS Coordinator-E who stated that they are continuing to train on MDS assessments. MDS Coordinator-E is currently working with the clinical team and a regional MDS employee to get the workload done to the facility. MDS Coordinator-E was not aware a PASARR 2 was completed for R4 as the document was never scanned into the facility's electronic medical record program. MDS Coordinator-E indicated if the PASARR was scanned in, then the MDS assessment would be accurately coded. On 9/17/2025 at 10:05 AM, the Survey team informed Nursing Home Administrator (NHA)-A of concern with R4's MDS assessment not being accurately coded for PASARR. The facility did not provide any additional information at this time.

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	525371	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Nursing & Rehab	1300 West Silver Spring Dr Glendale, WI 53209

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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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 4 (R13, R75, R66, R65) of 20 residents reviewed had a comprehensive care plan developed and implemented so that residents can attain their highest practicable physical, mental and psychosocial well-being. *R13, R75, R66, and R65 have diagnoses and or identification of behaviors that the facility has not established individualized care plan's to include interventions for staff to implement based upon assessments of individual residents needs. Findings include: 1.) R13 was admitted on [DATE] with diagnoses of moyamoya disease (a cerebrovascular disorder that affects the brain's blood vessels), sequelae of other cerebrovascular disease, cerebral infarction, unspecified vascular dementia, mild, with agitation. R13's Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. Surveyor reviewed R13's care plan and did not observe a care plan that addressed mood or behaviors for R13. There were no focus areas or interventions that addressed R13's dementia or agitation. On 9/15/2025, at 10:22 AM, Surveyor interviewed Director of Social Services (DSS)-F, who stated that care plans for any behaviors or mood disorders would be started by the MDS nurse after admission. Surveyor observed monitoring of behaviors in the tasks tab for Certified Nursing Assistants to document if observed from R13. There were no interventions for behaviors or agitation in this tab. On 9/15/2025, at 12:36 AM, Surveyor observed R13 having agitation with another peer and using profanity, staff separated residents right away. On 9/15/2025, at 12:38 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-HH, who stated that R13 does have some behaviors, most of the time its wandering, but R13 is redirected easily. CNA-HH stated that staff would look at care plans for interventions to use for behaviors for R13. On 9/15/2025, at 12:44 PM, Surveyor interviewed R13's nurse, Licensed Practical Nurse (LPN)-P, who stated R13 is redirected easily with behaviors. LPN-P stated that any interventions should be care planned. LPN-P attempted to pull up the care plan in the electronic health record (EHR) but could not pull up the care plan when attempted to show Surveyor. On 9/15/2025, at 1:03 PM, Surveyor interviewed Assistant Director of Nursing-Licensed Practical Nurse (ADON-LPN)-C, who pulled up R13's care plan and both surveyor and ADON-LPN-C could not locate any care areas that addressed behaviors or had interventions for Behaviors. ADON-LPN-C stated that the MDS nurse completes these and it should be in R13's care plan, ADON-LPN-C stated that ADON-LPN-C will be updating this in the care plan for R13. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/15/2025, at 1:05 PM, Surveyor interviewed DSS-F, who stated that R13 should absolutely have a care plan for behaviors. DSS-F stated the MDS nurse would have started this care plan. DSS-F indicated that DSS-F will tailor the care plan if a behavior occurs like the behaviors R13 had earlier. DSS-F stated that DSS-F will alter the care plan after the MDS nurse starts but with R13's diagnoses the MDS nurse should have started a focus area for behaviors right after admission. On 9/16/2025, at 8:50 AM, Surveyor interviewed MDS Coordinator-E, who stated to still be in training. MDS Coordinator-E stated that MDS Coordinator-E starts the care plans but works with the clinical team as MDS Coordinator-E is still learning the process. MDS-Coordinator-E indicated that MDS-Coordinator-E is working on care plan now for R13's mood and behaviors. On 9/17/2025, at 9:55 AM, Surveyor interviewed Director of Nursing (DON)-B, who stated that it is DON-B's expectations that R13 would have mood and behavior care plan started and individualized. DON-B indicated that DON-B will be revamping and re- educating staff on care planning. On 9/17/2025, at 10:07 AM, Surveyor informed Nursing Home Administrator (NHA)-A, of the concern that R13 didn't have a care plan for dementia with agitation. Surveyor informed NHA-A of no interventions for mood or behaviors in R13's medical record, for staff to utilize when behaviors or mood occurs. NHA-A stated the facility just hired 2 new MDS nurses, as the MDS nurse we currently have is still in training. No additional information was provided as to why R13 did not have a comprehensive care plan developed for behaviors or mood as R13 has diagnosis of dementia with agitation. 2.) R75 was admitted to the facility on [DATE] with diagnoses of schizoaffective disorder, bipolar type, generalized anxiety disorder, Paraneoplastic neuromyopathy and neuropathy. R75's Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 14, indicating cognition was intact, and is understood and understands others. Surveyor reviewed R75's care plan and did not observe a care plan that addressed mood or behaviors. There were no focus areas or interventions that addressed R75's schizoaffective disorder, bipolar type and anxiety disorder. Surveyor observed monitoring of behaviors in the tasks tab for Certified Nursing Assistants to document if observed from R75. There were no interventions for behaviors or mood for staff to monitor. On 9/15/2025, at 12:38 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-HH, who stated that staff would look at care plans for interventions to use for behaviors for residents. On 9/15/2025, at 12:44 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-P, who stated that any interventions for behaviors should be care planned. LPN-P attempted to pull up the care plan in point click care (computer health program) but could not pull up the care plan when attempted to show Surveyor. On 9/17/2025, at 10:07 AM, Surveyor informed Nursing Home Administrator (NHA)-A, of the concern that R75 didn't have a care plan for schizoaffective disorder, bipolar type and anxiety disorder. Surveyor informed NHA-A of no interventions for mood or behaviors in R75's medical record, for staff (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to utilize when behaviors or mood occurs. NHA-A stated the facility just hired 2 new MDS nurses, as the MDS nurse we currently have is still in training. No additional information was provided as to why R75 did not have a comprehensive care plan developed for behaviors or mood as R75 has diagnosis of schizoaffective disorder, bipolar type and anxiety disorder. 3.) R66 was admitted to the facility on [DATE] with diagnoses of depression, transient ischemic attack and cerebral infarction. R66's admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating cognition was intact, and is understood and understands others. Surveyor reviewed R66's care plan and did not observe a care plan that addressed mood or behaviors. There were no focus areas or interventions that addressed R66's depression diagnosis. Surveyor observed monitoring of behaviors in the tasks tab for Certified Nursing Assistants to document if observed from R66. There were no interventions for behaviors or mood identified. On 9/15/2025, at 12:38 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-HH, who stated that staff would look at care plans for interventions to use for behaviors for residents. On 9/15/2025, at 12:44 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-P, who stated that any interventions for behaviors should be care planned. LPN-P attempted to pull up the care plan in point click care (computer health program) but could not pull up the care plan when attempted to show Surveyor. On 9/17/2025, at 10:07 AM, Surveyor informed Nursing Home Administrator (NHA)-A, of the concern that R66 didn't have a care plan for depression diagnosis. Surveyor informed NHA-A of no interventions for mood or behaviors in R66's medical record, for staff to utilize when behaviors or mood occurs. NHA-A stated the facility just hired 2 new MDS nurses, as the MDS nurse we currently have is still in training. No additional information was provided as to why R66 did not have a comprehensive care plan developed for behaviors or mood as R66 has diagnosis of depression. 4.) R65 was admitted to the facility on [DATE] with diagnoses of depression, hoarding disorder and bipolar disorder. R65's Minimum Data Set (MDS) comprehensive assessment dated [DATE], documents a BIMS (Brief Interview for Mental Status) score of 14 on a scale of 0 to 15, indicating R65 is cognitively intact. R65's MDS, section I documents both depression and bipolar disorder for Psychiatric/Mood Disorders. R65's Preadmission Screening and Resident Review (PASARR) level 1 dated 4/15/23, documents, yes to R65 is suspected of having a serious mental illness. Surveyor reviewed R65's medical record for physician orders and no orders were found for psychiatric care, nor behavior monitoring or tracking related to depression, bipolar, and/or hoarding disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed R65's medical record for Treatment Administration Record (TAR) and no TAR was found where the clinical staff should be able to monitor and track behavior related to depression, bipolar, hoarding disorder. Surveyor reviewed R65's care plan and there was minimal or no evidence of a care plan with interventions that addressed mood, behaviors, hoarding or bipolar disorder. Surveyor reviewed R65's Certified Nursing Assistant (CNA) instruction sheet, referred to as a Kardex, and could not find any evidence for how to care for R65 regarding behaviors related to depression, bipolar, and hoarding disorder. R65's Care Plan, date initiated 8/3/23, documents a Focus area, I sometimes have behaviors which including refusing to provide information from hospital visits. I have a hx (history) of making accusations against other people as well as my belongings. I also refuse cares, labs, blood sugar checks, ancillary services, medications, treatments, etc. I often don't let staff in my room including house keepers, psych provider etc. I refuse interventions for infections such as flu swabs even when symptomatic (R65) prefers not to have any labs drawn at the facility nor outpatient. The Goal for R65 is, I will allow the facility to obtain information that will help with continuation of my care. Interventions include, Encourage res. (sic) to be accepting of cares and lab work. If res. (sic) refuses ensure that she is safe and re approach later, Give me my medications as my doctor has ordered date initiated, 08/28/2023. Inform resident of any new lab orders; update NP and cancel order if resident refuses, date initiated: 06/17/2025. Let my physician know if I my behaviors are interfering with my care, date initiated: 08/03/2023.Offer me something I like as a diversion such as books, TV shows, etc. date initiated: 8/28/2023.Please refer me to my psychologist/psychiatrist as needed, date Initiated: 08/28/2023. Please tell me what you are going to do before you begin, date initiated: 08/21/2023. Risk and benefits reviewed with resident, date Initiated: 03/17/2025. Risk vs Benefit of refusal for infection interventions: sickness, infection, death, date initiated: 02/05/2025. Speak to me unhurriedly and in a calm voice, date Initiated: 08/03/2023. R65's Care Plan, date initiated 8/3/23, documents a Focus area, I get nervous and anxious In the dark at times, when half awake due to past traumatic event, sexual assault when I was [AGE] year, date initiated: 07/23/2024. The Goal for R65 is, I will remain comfortable and feel safe, date initiated: 07/23/2024, revision on: 01/23/2025. Interventions include, Approach me from the front and address me by name, date initiated: 07/23/2024. Please avoid things that make me more anxious when you come in at night to see if I need incontinence care- make sure if I appear anxious at night, make sure you let me know your name and what you are doing. You may need to leave me, let me know you will be back and reapproach, date initiated: 07/23/2024 and revision on: 08/14/2024. On 09/09/2025 at 11:44 AM, Surveyor interviewed R65 who stated R65 is anxious and not sure if she is treated for it. R65 stated depression is present and R65 still has her moments. R65 stated, R65 has not been treated well in life. On 09/17/2025 at 8:12 AM Surveyor interviewed Director of Social Services (Director of SS)- F and Director of Nursing (DON)-B. Director of SS-F stated that care plans for any behaviors or mood disorders would be started by the MDS (Minimum Data Set) nurse after admission. Surveyor asked if R65 had any mood or diagnosed behaviors monitored or tracked in the TAR or care planned and DON-B accessed R65's medical record and verified that R65 did not. Surveyor asked if R65 had anything in the Kardex for the CNA's to help care for R65 with mood or other behaviors and DON-B stated, no. Surveyor asked how would the facility know to identify and then monitor mood and behavior that (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would need interventions. Director of SS-F, stated it would be driven from the physician orders and R65 did not have the necessary orders for monitoring mood and behavior. DON-B also acknowledged there are no physician orders for psychiatric care. 09/17/2025 8:30 AM surveyor notified NHA-A and DON-B of concern with R65's lack of assessment, care plan and monitoring/tracking for mood and behaviors. No other information has been provided at this time.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observation, interview and record review, the facility did not provide an ongoing program to support residents in their choice of activities, designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident. This deficient practice has the potential to affect all residents residing on the facility's C wing at the time of survey.*Surveyor had observations of residents on facility's C wing not being provided with appropriate activity choices.*Review of the facility's activity calendar indicates that a variety of meaningful activities are not consistently provided at the facility on weekendsFindings Include:Surveyor conducted observation on facility's C wing throughout the survey. On 9/10/25 at 9:00 AM, Surveyor observed R4, R11, R48, R49 and R83 in the C wing dining area around a table. A television in the dining room corner had a morning talk show displayed with muted volume. No activity engagement was observed during this observation.On 9/10/25 at 9:55 AM, Surveyor observed residents on the facility's C wing with 4 multi-colored desk top bells distributed among the top of the table. Surveyor observed multiple pieces of plastic, play kitchen food sets including a plastic, play corn cob, a plastic, play carrot and a plastic, play tomato on the top of the table. No activity engagement was observed during this observation. On 9/10/25 at 10:01 AM, Surveyor conducted an interview with Certified Nursing Assistant (CNA)-OO. Surveyor asked CNA-OO what type of recreational activities are offered to residents residing on the facility's C wing. CNA-OO responded that there had previously been an activity staff member who was great with residents on the C wing who had an activity calendar that staff and residents could follow but that they haven't seen any calendar as of late. Staff added that they had found bells and play food in the closet and placed it out on the table to have something for residents to at least look at while there was no current activity staff available to C wing residents. CNA-OO told Surveyor that they were very sad that the previous activity director was no longer working at the facility. CNA-OO added that staff are not able to sit with residents very much to provide entertainment or stimulation as they are busy providing cares. Surveyor asked CNA-OO if it would be appropriate for residents residing on C wing to have children's play food on a tabletop as a meaningful appropriate activity. CNA-OO responded that that is all they had to provide to residents this morning. Surveyor asked if any scheduled activities are being provided to C wing residents at any point during the day. CNA-OO shrugged their shoulders and responded that nothing is scheduled for activities that they are aware of. On 9/10/25, Surveyor requested Activity Calendars for July, August and September 2025. On 9/10/25 at 3:33 PM, Surveyor conducted an interview with Activity Director-EEE. Activity Director-EEE was unable to provide activity calendars from July or August 2025 as they are new to the Activity Director role and the previous Activity Director had taken the older calendars with them. Surveyor reviewed the September 2025 activity calendar. Surveyor noted that there is limited to no activity programming offered on Sundays in September besides televised football games.On 9/11/2025 at 3:30 PM at the daily exit meeting, Surveyor shared concerns with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B about concerns related to observations of age inappropriate activities on the facility's C wing, missing activity calendars and lack of meaningful activity programming on the weekends for residents at the facility. The facility did not provide any additional information at this time.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility did not complete a performance review at least once every 12 months for 3 of 4 Certified Nursing Assistants (CNA) reviewed. This had the potential to affect all 85 residents who reside in the facility. *The facility was unable to provide a performance review completed within the last year for CNA-JJ.*The facility was unable to provide a performance review completed within the last year for CNA-OO.*The facility was unable to provide a performance review completed within the last year for CNA-PP. Findings include:The facility's Employee Handbook section related to Evaluations documents: All employees will be subject to periodic job performance evaluations by their supervisor. This usually happens at least annually. The evaluation will be reviewed with the employee by the supervisor at the time of presentation.On 09/16/2025, at 8:57 AM, Surveyor interviewed Business Office staff-KK regarding performance reviews for CNA and was told they are done annually on their anniversary date. Surveyor requested to see the last one completed for four CNA staff.On 09/16/2025, at 1:42 PM, Surveyor was provided one of the four performance reviews requested. Surveyor asked what the process is for performance reviews and was told monthly an email is sent from the Regional Human Resources Director with staff due for review, each department with staff due are included in the email. The performance review document is located on the shared drive for supervisors to use. Surveyor asked who makes sure the performance reviews are completed, and the response was it is the responsibility of the department head. On 09/16/2025, at 2:50 PM, during the end of day meeting, with Nursing Home Administrator-A and Director of Nursing-B, Surveyor told of concern regarding 3 of 4 requested CNA performance evaluations were not available. No additional information was provided as to why the CNA performance evaluations were not done on at least a yearly basis.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the physician acted upon recommendations by the pharmacist for 5 (R3, R6, R33, R58, R66) of 5 residents reviewed with pharmacy recommendations. * R3, R6, R33, R58, and R66 had no documented physician response to pharmacist recommendations after the medication regimen was reviewed during the last six months and no indication pharmacist recommendations were followed up on. Findings include: The facility policy titled Use of Psychotropic Medication(s), with implemented date 1/1/2025 and no revised date, documents: . Policy: It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint.-A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics.-The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents, their families and/or representatives, other professionals, and the interdisciplinary team.-The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis such as: . during the pharmacist's monthly medication regimen review . 1.) R58 admitted to the facility on [DATE] with diagnoses including major depressive disorder, other epilepsy (a neurological condition characterized by recurrent seizures), extrapyramidal and movement disorder (involuntary body movements), schizophrenia, [NAME] (an eating disorder where a person eats non-food items), and unspecified dementia, moderate, with other behavioral disturbance. R58 had a legal guardian. R58 has a Care Area Assessment (CAA) for psychotropic drug use dated 4/15/25, which documents R58 receives antidepressant and antipsychotic medications for diagnoses of depression and schizophrenia, is monitored for medication effectiveness and side effects, and is seen by psychiatrist as needed. R58's Quarterly Minimum Data Set (MDS) dated [DATE] documents R58 uses antipsychotic and antidepressant medications, and R58 has a BIMS score of 12, indicating moderately impaired cognition. Surveyor reviewed pharmacy notes in R58's electronic health record dated 3/6/25, 5/7/2025, 7/3/2025, and 9/9/2025 with the following documented: medication regimen review completed. One or more recommendations were made for this resident. To see these and other recommendations please refer to the Director of Nursing monthly consultation report. Surveyor reviewed copies of four pharmacist medication regimen reviews for the last six months (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided by Director of Nursing (DON)-B. Surveyor noted the date is not documented on each of the four medication regimen reviews. Surveyor reviewed the first pharmacist recommendation, which recommends attending physician/prescriber reviews R58's Lorazepam dose of 0.5 milligram (mg) every 24 hours as needed (PRN). There is no documented physician response to indicate if the prescribing physician reviewed this recommendation, and there is no evidence that this recommendation was acted upon. Surveyor reviewed the second pharmacist recommendation, which recommends attending physician/prescriber reviews R58's Lorazepam dose of 0.5 mg every 24 hours PRN. There is no documented physician response to indicate if the prescribing physician reviewed this recommendation, and there is no evidence that this recommendation was acted upon. Surveyor reviewed the third pharmacist recommendation, which documents R58 is due for gradual dose reduction (GDR) for the following medications: Haloperidol 150 mg intramuscular every 28 days, Olanzapine 10 mg daily, and Trazodone 25 mg nightly. There is no documented physician response to indicate if the prescribing physician reviewed this recommendation, and there is no evidence that this recommendation was acted upon. Surveyor reviewed the fourth pharmacist recommendation, which documents R58 is due for gradual dose reduction (GDR) for the following medications: Haloperidol 150 mg intramuscular every 28 days, Olanzapine 10 mg daily, and Trazodone 25 mg nightly. There is no documented physician response to indicate if the prescribing physician reviewed this recommendation, and there is no evidence that this recommendation was acted upon. On 9/11/25, at 12:04 PM, Surveyor interviewed DON-B regarding medication regimen reviews not having a date or documented physician response. DON-B stated DON-B reached out to the pharmacist to obtain copies of the medication regimen reviews and provided Surveyor with those copies. DON-B stated there are no other copies at the facility at this time. On 9/16/25, at 3:29 PM, Surveyor informed Nursing Home Administrator (NHA)-A and DON-B of the concern regarding missing physician responses to pharmacist recommendations over the last 6 months. No further information was provided to Surveyor regarding why there is no documented physician response on medication regimen reviews. 2.) R33 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, Psychosis and Dementia. R33's Quarterly Minimum Data Set (MDS) dated [DATE] documents that R33 receives the following types of psychoactive medications: Antipsychotic, Anti-Depressant, Anti-Convulsant (an anti-seizure medication that has the ability to control mood stability). On 9/15/25, Surveyor requested R33's Pharmacist Medication Regimen Reviews (MRR) for the previous six months. Surveyor noted that R33's MRR dated 6/3/25 8/8/25 and 9/9/25 had Pharmacy recommendations that were not addressed by the facility. Surveyor noted: On 9/15/25 at 3:27 PM, Surveyors interviewed Director of Nursing (DON)-B. Surveyor asked DON-B (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	why R33's MRR Pharmacy Recommendations in June 2025, August 2025 and September 2025 were not addressed. DON-B responded that they had no additional information to offer regarding why R33's Pharmacy Recommendations were not addressed by the facility. No additional information was provided to the Survey team at this time. No additional information was provided by the facility regarding R33's representative providing consent to receive the psychotropic medications that R33 was prescribed. 3.) R6 was admitted the facility on 12/29/21 with diagnoses of dysphagia, chronic respiratory failure, chronic obstructive pulmonary disease, dementia and major depressive disorder. The pharmacy recommendations dated 7/3/25 and 8/8/25 recommended five medications to be reviewed for either discontinuing the medication or changing the orders. The pharmacist recommended to discontinue or change the following medications, Certizine 10 mg, Guaifenesin ER (extended release) 600 mg, Lidocaine 5% ointment, Mylanta and Simethicone 125 mg. There is no evidence these recommendations were followed up on by the physician. 4.) R3 was admitted to the facility on [DATE] with diagnoses of bipolar and anxiety disorder. The pharmacist made recommendations on 6/3/25, 7/3/25 and 8/8/25 regarding medication discontinuing and recommending lab monitoring. The 6/3/25 the pharmacist recommended discontinuing or changing the following orders, artificial tears, ibuprofen, ondansetron and oxycodone. The 7/3/25 and 8/8/25 pharmacist recommended a TSH (thyroid stimulating hormone) to be drawn due to R3 being prescribed levothyroxine 200 mcg (micrograms) daily There is no evidence these recommendations were followed up on by the physician On 9/16/25 at 3:15 p.m. Surveyor interviewed DON-B. Surveyor asked DON-B who is responsible for ensuring the physician is made aware of pharmacy recommendations. DON-B stated the previous DON was responsible for the pharmacy recommendations being brought to the provider's attention and following through with any changes to orders. DON-B stated she has no further information. 5.) R66 was admitted to the facility on [DATE] with diagnoses of depression, transient ischemic attack and cerebral infarction. R66's admission Minimum Data Set (MDS), dated [DATE], documented a brief interview mental status (BIMS) score of 15, indicating cognition was intact, and is understood and understands others. Surveyor reviewed R66's Electronic Medical Record (EMR) which did not document any pharmacy recommendations for R66 since admission. Surveyor requested documents of any pharmacy recommendations since admission in July. Surveyor received one pharmacy recommendation completed by a Registered Pharmacist (RPh) who performed the following medication review: Prior to admission this resident appears to take the following (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525371	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Nursing & Rehab	1300 West Silver Spring Dr Glendale, WI 53209

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hydrochlorothiazide 25 milligrams. This medication is not part of current patient medication order. The document asked if R66 should continue? There are 3 boxes that could be checked and then asks for date and signature, this part of the form was blank, no answer or signature. Surveyor notes R66's EMR did not include monthly medication reviews from July 2025 (admission month) through September 2025. Surveyor noted no progress notes addressing the pharmacy recommendation for R66. On 9/15/2025, at 10:11 AM, Surveyor interviewed Director of Nursing (DON)-B, who stated the completed pharmacy recommendations is a problem currently at the facility. DON-B has no way to show surveyor a completed pharmacy recommendation, DON-B stated not having any documentation that shows it was addressed or how it was addressed. DON-B indicated that DON-B can't do anything about it except take the hit and try to fix it now. DON-B stated that DON-B can't control what happened when DON-B wasn't at the facility and unfortunately, this is the current situation. DON-B stated to Surveyor, DON-B is just waiting for this to be done so i can fix the problem moving forward. On 9/16/2025, at 3:34 PM, Surveyor informed Nursing Home Administrator (NHA)-A, of concern that there was no evidence of R66's pharmacy recommendations being addressed by R66's health provider. No additional information received as to why there was no evidence that R66's pharmacy recommendations were addressed by R66's health provider.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, drugs used in the facility were not labeled in accordance with currently accepted professional principles, to include the opened on or expiration date when applicable for 1 of 2 medication carts reviewed. Medication cart B contained insulin that was not dated when opened and open stock medications that were not dated when opened. Findings include: The Facility policy titled Vials and Ampules of Injectable Medications with effective date of 10/25/2014, documents, in part: Policy: Vials and Ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal.Procedures.B. The date opened and the initials of the first person to use the vial are recorded on multidose vials [on the vial label or an accessory label affixed for that purpose] . F. Medication in multidose vials may be used [until the manufacturer's expiration date/for the length of time allowed by state law/according to facility policy/for thirty days] if inspection reveals no problems during that time. USP <797> guidelines recommend discarding multidose vials (other than some insulins) at 28 days after opened. The Facility policy titled Storage of Medications with revision date of 5/1/2018, documents, in part: Expiration Dating.C. Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmics, nitroglycerin tablets, blood sugar testing solutions and strips, once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency.E. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated.1. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a date opened and expiration notation line). The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating.On 9/9/2025, at 12:52pm, Surveyor reviewed Licensed Practical Nurse (LPN)-RR's medication cart on the B hallway. Surveyor observed multiple insulin pens in a drawer without dates: Surveyor also observed: R12's bottle of Lispro, no dateR25's 1 of 2 pens no dateR37's 1 of 2 pens no dateR54's 1 of 2 pens no dateR81's 2 of 3 pens no dateR85's 1 of 2 pens no dateR99 both pens no dateSurveyor opened a drawer where stock medications are stored and none of the opened containers were dated when opened.On 9/9/2025, at 12:58pm, Surveyor interviewed LPN-RR regarding the medications not being dated and was told LPN-RR would throw the medications out and put new stock in the cart.On 09/10/2025, at 3:19 PM, during the end of day meeting with Nursing Home Administrator-A and Director of Nursing (DON)-B Surveyor shared concern of observation that insulin pens were not dated and opened stock medications were not dated on unit B cart. DON-B assured Surveyor this had been taken care of.No additional information was provided as to why the facility did not ensure that opened insulin pens and stock medications were dated according to professional principles.

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	525371	A. Building B. Wing	09/30/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents Pneumococcal immunizations were offered, or refused, as eligible. This was observed with 4 (R6, R33, R65, and R75) of 5 residents whose immunization records were reviewed. *R6, [AGE] years old, has no documentation of Pneumococcal vaccine being offered *R33, [AGE] years old, has no documentation of Pneumococcal vaccine being offered *R65, [AGE] years old, has no documentation of Pneumococcal vaccine being offered*R75, [AGE] years old, has no documentation of Pneumococcal vaccine being offered Findings include: The facility's policy titled, Infection Prevention and Control Program, implemented 10/1/22 documents, in part: 7. Influenza and Pneumococcal Immunization.:b. Residents will be offered the pneumococcal vaccines recommended by the CDC upon admission, unless contraindicated or received the vaccines elsewhere. c. Education will be provided to the residents and/or representatives regarding the benefits and potential side effects of the immunizations prior to offering the vaccines. d. Residents will have the opportunity to refuse the immunizations. e. Documentation will reflect the education provided and details regarding whether or not the resident received the immunizations.The facility's policy titled, Vaccine Information Statements, implemented 3/1/19 documents, in part: Prior to the administration of any vaccine, a copy of the most current, relevant CDC Vaccine Information Statement (VIS) will be provided to any child or adult receiving the vaccine or such information will be provided to the legal representative who has the authority to consent to the immunization of a minor child or incompetent adult. Intent of Policy: It is the intent of this policy to provide instructions for the use of CDC's Vaccine Information Statements (VIS) as required under the National Childhood Vaccine Injury Act (42 U.S.C. S3o0aa-26) as well as our current State law(s) governing immunization requirements. (Refer to CDC's VIS statement entitled Instructions for Using Vaccine Information Statements.) Policy Explanation and Compliance Guidelines: 1. Prior to the administration of each vaccine, the person receiving the immunization, or his/her legal representative, will be provided with a copy of CDC's current vaccine information statement relative to that vaccine. 2. Vaccine Information Statements (VIS) will, as appropriate, be supplemented with visual presentations or oral explanations to assist vaccine recipients in understanding the benefits and potential side effects of such vaccinations. 3. A notation will be made in each resident's medical record at the time vaccine information materials are provided indicating: a. The edition date of the Vaccine Information Statement provided, and b. The date the VIS was provided.4. Individuals receiving vaccines, or their legal representative, will be required to sign a consent form prior to the administration of such vaccine(s). The completed, signed, and dated record will be placed in the individual's permanent medical record.The facility's policy titled, Pneumococcal Vaccine (Series), implemented 3/1/19 documents, in part: It is our policy to offer our residents, staff, and volunteer workers immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations. Policy Explanation and Compliance Guidelines: 1. Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. 2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders. 3-Prior to offering the pneumococcal immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization. a. The individual receiving the immunization, or the resident representative, will be provided with a copy of CDC's current vaccine information statement relative to that vaccine. b. If necessary, the vaccine information statement will be supplemented with visual presentations or oral explanations to assist vaccine recipients in understanding. 4.The resident/representative retains the (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	right to refuse the immunization. A consent form shall be signed prior to the administration of the vaccine and filed in the individual's medical record. 5. The type of pneumococcal vaccine (PCV23, PPSV23/PPSV) offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations. 6. Usually only one (1) pneumococcal polysaccharide vaccination (PPSV) is needed in a lifetime. However, based on an assessment and practitioner recommendation, additional vaccines may be provided. 7. A series of vaccinations will be offered to immunocompetent* adults ˆ 65, depending on current vaccination status and practitioner recommendation: a. No previous vaccination (or vaccination status is unknown): PCV13 first, then PPSV23 one year later. b. Previously received PPSV23 at age ˆ 65: PCV13 at least 1 year after receipt of PPSV23. c. Previously received PPSV23 before age [AGE] years who are now aged ˆ 65: PCV13 at least 1 Y after receipt of PPSV23, then PPSV23 after 5 years of previous vaccination (no earlier than on year of PCV13). (* Residents who are immunocompromised may receive the series of vaccinations within a shortened interval in accordance with current CDC guidelines and practitioner recommendation, but no sooner than 8 weeks. These residents may receive up to 3 doses of PPSV23.) 8. The resident's medical record shall include documentation that indicates at a minimum, the following: a. The resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization. b. The resident received the pneumococcal immunization or did not receive due to medical contraindication or refusal.1.) R6's Annual Minimum Data Set (MDS) with an assessment reference date of 7/11/25, documents a Brief Interview for Mental Status (BIMS) assessment score of 15, indicating that R6 is cognitively intact. R6 is responsible for self.R6 is over [AGE] year. There isn't documentation of any pneumococcal vaccinations being offered or refused while admitted at facility. R6 would be eligible for the PCV15, PCV20 or PCV21 per PneumoRecs VaxAdvisor.On 09/16/2025, at 9:00 AM, Surveyor interviewed Director of Nursing (DON)-B who stated was working on immunization information that was requested, would also look in Wisconsin Immunization Record (WIR).On 9/16/2025, at 11:00 AM, Surveyor followed up with DON-B and no Pneumococcal vaccination information was located, still wants to look one more place.On 09/16/2025, at 3:20 PM, during the end of day meeting with facility, Surveyor relayed concern to Nursing Home Administrator-A and DON-B that Pneumococcal immunizations were not offered to 4 of 5 residents that were eligible.Surveyor noted no further evidence of documentation of R6 being offered or refusing the pneumococcal vaccine upon admission to the facility was provided.2.) R33's Annual Minimum Data Set (MDS) with an assessment reference date of 9/3/25, does not document a Brief Interview for Mental Status (BIMS) assessment, noted to be unable to complete. R33 has an activated Health Care-Power of Attorney. R33 is over [AGE] year. There isn't documentation of any pneumococcal vaccinations being offered or refused while admitted at facility. R33 would be eligible for the PCV15, PCV20 or PCV21 per PneumoRecs VaxAdvisor.On 09/16/2025, at 9:00 AM, Surveyor interviewed Director of Nursing (DON)-B who stated was working on immunization information that was requested, would also look in Wisconsin Immunization Record (WIR).On 9/16/2025, at 11:00 AM, Surveyor followed up with DON-B and no Pneumococcal vaccination information was located, still wants to look one more place. On 09/16/2025, at 3:20 PM, during the end of day meeting with facility, Surveyor relayed concern to Nursing Home Administrator-A and DON-B that Pneumococcal immunizations were not offered to 4 of 5 residents that were eligible. Surveyor noted no further evidence of documentation of R33 being offered or refusing the pneumococcal vaccine upon admission to the facility was provided. 3.) R65's Quarterly Minimum Data Set (MDS) with an assessment reference date of 7/18/25, documents a Brief Interview for Mental Status (BIMS) assessment score of 15, indicating that R65 is cognitively intact. R65 is responsible for self.R65 is over [AGE] year. There isn't documentation of any pneumococcal vaccinations being offered or refused while admitted at facility. R65 would be eligible for the PCV15, PCV20 or PCV21 per PneumoRecs VaxAdvisor.On 09/16/2025, at 9:00 AM, Surveyor interviewed Director of Nursing (DON)-B who stated was working on immunization information that was requested, would also look in (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wisconsin Immunization Record (WIR).On 9/16/2025, at 11:00 AM, Surveyor followed up with DON-B and no Pneumococcal vaccination information was located, still wants to look one more place.On 09/16/2025, at 3:20 PM, during the end of day meeting with facility, Surveyor relayed concern to Nursing Home Administrator-A and DON-B that Pneumococcal immunizations were not offered to 4 of 5 residents that were eligible. Surveyor noted no further evidence of documentation of R65 being offered or refusing the pneumococcal vaccine upon admission to the facility was provided.4.) R75's Quarterly Minimum Data Set (MDS) with an assessment reference date of 8/17/25, documents a Brief Interview for Mental Status (BIMS) assessment score of 14, indicating that R75 is cognitively intact. R75 is responsible for self.R75 is over [AGE] year. There isn't documentation of any pneumococcal vaccinations being offered or refused while admitted at facility. R75 would be eligible for the PCV15, PCV20 or PCV21 per PneumoRecs VaxAdvisor.On 09/16/2025, at 9:00 AM, Surveyor interviewed Director of Nursing (DON)-B who stated was working on immunization information that was requested, would also look in Wisconsin Immunization Record (WIR).On 9/16/2025, at 11:00 AM, Surveyor followed up with DON-B and no Pneumococcal vaccination information was located, still wants to look one more place.On 09/16/2025, at 3:20 PM, during the end of day meeting with facility, Surveyor relayed concern to Nursing Home Administrator-A and DON-B that Pneumococcal immunizations were not offered to 4 of 5 residents that were eligible.Surveyor noted no further evidence of documentation of R75 being offered or refusing the pneumococcal vaccine upon admission to the facility was provided.

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	525371	A. Building B. Wing	09/30/2025

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that 2 (R33 & R58) of 5 residents and/or their representative that were reviewed, were provided the risks and benefits for prescribed psychotropic medication. 1. R33 received psychotropic medication with no evidence the risks and benefits were explained, reviewed, or provided. 2. R58 received antipsychotic and antianxiety medications with no evidence of risks and benefits were explained, reviewed, or provided. Findings include: The facility's policy titled Use of Psychotropic Medication(s), with implemented date 1/1/2025 and no revised date, documents: .Policy: It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint.-A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics.-The indications for initiating, maintaining, or discontinuing medications . will be determined by evaluating the resident's physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment.-The resident's medical record shall include documentation of this evaluation and the rationale for chosen treatment options. This includes any indicated documentation of rationale for prescribing multiple psychotropic medications or switching from one type of psychotropic medication, specifically an antipsychotic medication, to another category of psychotropic medication. -Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase.-The resident has the right to accept or decline the initiation or increase of a psychotropic medication.-The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deems to use (e.g., written consent form .) . 1.) R58 admitted to the facility on [DATE] with diagnoses including major depressive disorder, other epilepsy (a neurological condition characterized by recurrent seizures), extrapyramidal and movement disorder (involuntary body movements), schizophrenia, [NAME] (an eating disorder where a person eats non-food items), and unspecified dementia, moderate, with other behavioral disturbance. R58 had a legal guardian. R58 has a Care Area Assessment (CAA) for psychotropic drug use dated 4/15/25, which documents R58 receives antidepressant and antipsychotic medications for diagnoses of depression and schizophrenia, is monitored for medication effectiveness and side effects, and is seen by psychiatrist as needed. R58's Quarterly Minimum Data Set (MDS) dated [DATE] documents R58 uses antipsychotic and antidepressant medications, and R58 has a BIMS score of 12, indicating moderately impaired (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognition. A psychiatric progress note dated 3/20/25 documents increase Olanzapine 7.5 milligrams (mg) to 10 mg at nighttime for agitation related to dementia and Pica. A psychiatric progress note dated 4/10/25 documents decrease Lorazepam 0.5 mg twice a day to every day as needed (PRN) for increased agitation or anxiety. A psychiatric progress note dated 5/15/25 documents discontinue Lorazepam 0.5 mg. Surveyor was unable to locate any documentation that the consent for risk and benefits for anti-anxiety or antipsychotic medications were explained, reviewed, or provided to the resident representative. On 9/15/25, at 3:27 PM, Surveyor interviewed Director of Nursing (DON)-B, who stated no medication consents were located in the building, and if the consent was not scanned into a resident's electronic health record, then the facility does not have record of it at this time. No additional information was provided regarding resident representative consent to changes in the antipsychotic and antianxiety medications that R58 was prescribed. 2.) R33 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, Psychosis and Dementia. R33's Quarterly Minimum Data Set (MDS) dated [DATE] documents that R33 receives the following types of psychoactive medications: Antipsychotic, Anti-Depressant, Anti-Convulsant (an anti-seizure medication that has the ability to control mood stability). Surveyor reviewed R33's physician orders and noted that R33 receives the following medications: Seroquel (an antipsychotic medication) 75 mg BID (twice daily), Depakote Sprinkles (an anticonvulsant medication) 125 mg BID and Mirtazapine (an antidepressant medication that aids in sleep and appetite) 7.5 mg Q HS (administered at Hour of sleep daily). Surveyor was unable to locate any documentation that the consent for risk and benefits for psychotropic medications were reviewed or provided to the resident representative. On 9/15/25 at 3:27 PM, Surveyors interviewed Director of Nursing (DON)-B, who stated no medication consents were able to be located at the facility. DON-B added that if the consent was not scanned into a resident's electronic health record that the facility does did not retain any record of it at this time. No additional information was provided by the facility regarding R33's representative providing consent to receive the psychotropic medications that R33 was prescribed.

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	525371	A. Building B. Wing	09/30/2025

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on observation and interview, the facility did not ensure that residents have reasonable access to use the telephone, in a place where calls can be made without being overheard. This concern was expressed by 1 (R35) of 12 residents attending the resident council meeting.Residents with a desire to use a facility phone have the options of the receptionist desk, Social Services office, nurse's station or by the vending and ice machines.Findings include:On 9/10/25, at 1:46pm, during the Resident Council meeting, R35 expressed the concern that if you don't have a cell phone there are no phones in resident rooms. R35 has to go to nurse's station where there is no privacy.On 9/15/25, at 8:32am, Surveyor interviewed Licensed Practical Nurse (LPN) -Y regarding where a resident can use a facility phone and was told they can use the one in the nurses station or by the vending machines off unit B. On 9/15/25, at 8:42am, Surveyor interviewed Director of Social Services (SS)-F and asked about a phone for residents to use and was told when residents have personal calls to make they often use the phone in the Social Services office when SS-F is there.On 9/15/25, at 9:30am, Surveyor interviewed Certified Nursing Assistant (CNA)-T regarding if a resident asked to use the phone where would they go, CNA-T replied they would take them to the telephone by vending machines. Surveyor asked about traffic in area and was told it is a high traffic area, it is on the way to the smoking area, vending machines and ice machine which staff use, so not much privacy in area.On 9/15/25, at 9:30am, Surveyor interviewed CNA-S about a phone for residents to use and was told they would ask someone on the wing as they are new but believes there is one in front by receptionist desk they have seen residents using.On 9/15/25, at 9:34am, Surveyor interviewed LPN-Z about a phone for resident use and was told residents can use the phone at the nurse's station or receptionist desk and believes there is one in the back area by B (unit). Surveyor asked if there is anywhere a resident could use the phone privately and was told in the back area.Surveyor observed the back area by unit B and noted it is by the vending machines, ice machine and in the route to the smoking area.Surveyor noted the LPN and CNA that were interviewed all would have the resident use a phone in a public area with no privacy.On 09/15/2025, at 10:25am Surveyor informed Nursing Home Administrator (NHA)-A of concern that there is not a telephone available for residents to use privately. NHA-A responded that they cannot just build a room. No additional information was provided as to why the facility did not ensure that residents have reasonable access to the use of telephone, in a place where calls can be made without being overheard.

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	525371	A. Building B. Wing	09/30/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not ensure a resident's right to a clean, comfortable, and homelike environment for 1 (R32) of 85 resident rooms observed.R32's floor was observed to be very sticky over multiple days. Findings include:The facility policy titled Routine Cleaning and Disinfection with implemented date 1/1/2025 and no revised date documents: . Policy: it is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment .-Cleaning refers to the removal of visible soil from objects and surfaces and is normally accomplished manually or mechanically using water and detergents or enzymatic products.R32 admitted to the facility on [DATE] with diagnoses including early-onset cerebellar ataxia (unsteady movements due to damage to the part of the brain that controls balance and coordination), depression, anxiety, and hoarding disorder. R32's Quarterly Minimum Data Set (MDS) dated [DATE] documents R32 has a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition, R32 uses a walker, R32 requires set up assistance for bed mobility and transfers, and R32 requires supervision for walking 10 ft and partial assistance for walking 50 ft. On 9/9/25, at 10:10 AM, during an interview with R32, Surveyor observed the floor in R32's room was very sticky with each step Surveyor took throughout the room. On 9/10/25, at 8:23 AM, during an interview with R32, Surveyor observed the floor in R32's room was very sticky with each step Surveyor took throughout the room. Surveyor asked R32 if the floor has been cleaned recently. R32 stated the staff takes out garbage, sweeps the floor, and cleans the sink and toilet but was not sure if the floor was mopped recently. On 9/15/25, at 10:01 AM, Surveyor interviewed Supervisor of Housekeeping-VV regarding daily housekeeping tasks for resident rooms. Supervisor of Housekeeping-VV stated daily cleaning includes disinfecting sinks, mirrors, toilets, doorknobs and bedside tables, and resident floors get swept and mopped daily. Supervisor of Housekeeping-VV stated one room in each wing gets a deep clean, which is rotated until all rooms have been completed. Supervisor of Housekeeping-VV stated a deep clean would include dusting curtains, moving the bed to wipe down the whole bed frame, and all corners of the room is swept and mopped, including behind dressers. Supervisor of Housekeeping-VV stated if housekeeping were made aware a resident's floor is sticky, housekeeping would mop the floor, but Supervisor of Housekeeping-VV had not been made aware of any resident rooms with sticky floors. Surveyor shared concern with Supervisor of Housekeeping-VV that Surveyor had multiple observations of the floor being very sticky in R32's room. Supervisor of Housekeeping-VV stated someone would clean R32's floor. On 9/15/25, at 3:18 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that Surveyor had multiple observations of R32's floor being sticky.

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	525371	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Nursing & Rehab	1300 West Silver Spring Dr Glendale, WI 53209

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure each resident's drug regimen was free from unnecessary drugs for 1 (R58) of 5 residents reviewed.R58 did not have adequate monitoring while receiving antipsychotic medication. Findings include:The facility policy titled Use of Psychotropic Medication(s), with implemented date 1/1/2025 and no revised date, documents: . Policy: It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint.-A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics.-Residents who received an antipsychotic medication will have an Abnormal Involuntary Movement Scale (AIMS) test performed on admission, quarterly, with a significant change in condition, change in antipsychotic medication .R58 admitted to the facility on [DATE] with diagnoses including major depressive disorder, other epilepsy (a neurological condition characterized by recurrent seizures), extrapyramidal and movement disorder (involuntary body movements), schizophrenia, [NAME] (an eating disorder where a person eats non-food items), and unspecified dementia, moderate, with other behavioral disturbance. R58 had a legal guardian. R58's Significant Change MDS dated [DATE] documents R58 uses antipsychotic medications. R58 has a Care Area Assessment (CAA) for psychotropic drug use dated 4/15/25, which documents R58 receives antidepressant and antipsychotic medications for diagnoses of depression and schizophrenia, is monitored for medication effectiveness and side effects, and is seen by psychiatrist as needed. R58's care plan for focus area psychotropic medications with initiation date 10/14/2013 documents interventions: .-AIMS assessment per facility policy (date initiated 10/14/2013, revision on 12/02/2016) .The psychiatric progress note dated 8/7/25 documents R58's current medications include Haldol Decanoate 150 milligrams (mg) intramuscular every 28 days for schizophrenia and Olanzapine 10 mg nightly for schizophrenia. Olanzapine was increased from 5 mg to 7.5 mg on 2/22/24, then increased to 10 mg on 3/20/25. Surveyor reviewed R58's electronic health record (EHR) and noted AIMS evaluations completed: 4/20/2023, 9/14/2023, 4/20/2025, and 8/29/2025. Surveyor noted an AIMS assessment was not documented as being completed from 9/14/2023 until 4/20/2025.On 9/15/25, at 1:25 PM, Surveyor interviewed Director of Nursing (DON)-B regarding AIMS assessments not being completed between 9/14/2023 and 4/20/2025. DON-B stated DON-B realized AIMS assessments were not being completed during a recent internal audit, and the facility has since started doing them again. No further information was provided as to why R58 did not receive adequate monitoring while taking antipsychotic medications.

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	525371	A. Building B. Wing	09/30/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not report 3 of 3 allegations to the state agency within the required time frame. R58 sustained a fall with fracture that was not reported to the state agency. R66 had an allegation of physical and verbal abuse by a staff member that was not reported to the state agency. R94 had an allegation of verbal abuse by a staff member that was not reported to the state agency within the required 2 hour time frame. Findings include: 1.) R94 was admitted to the facility on [DATE] with Major Depressive Disorder and Alcoholic Cirrhosis (a liver condition exacerbated by chronic alcohol abuse). Surveyor reviewed R94's electronic medical record. Surveyor reviewed a facility self report related to an allegation of verbal abuse between R94 and a staff member that occurred on 7/9/25. Surveyor noted R94's abuse allegation was reported to Director Social Services (SS)-F on 7/10/25. Surveyor noted a facility self report was reported to the state agency on 7/17/25. On 9/11/25 at 3:29 PM, Surveyor conducted an interview with Director SS-F. Surveyor asked Director SS-F why the facility did not report R94's allegation on verbal abuse by a staff member to the state agency within the required 2 hour time frame. Director SS-F was unable to explain why the facility self report was not reported to the state agency within the required 2 hour time frame. On 9/16/25, at 3:29 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor shared concern that R94's allegation of verbal abuse by a staff member was not reported to the state agency within the required 2 hour time frame. The facility did not share any additional information with Surveyor at this time. 2.). R58 admitted to the facility on [DATE] with diagnoses including major depressive disorder, other epilepsy (a neurological condition characterized by recurrent seizures), extrapyramidal and movement disorder (involuntary body movements), schizophrenia, and unspecified dementia, moderate, with other behavioral disturbance. R58 had a legal guardian. Nursing progress note dated 2/14/25, at 4:19 AM documents, . resident found laying on left side and wheelchair flipped upside down. Resident stated . was going to the bathroom. Resident transported to the hospital per on-call nurse practitioner recommendation. Surveyor reviewed the hospital history and physical (H&P) document in R58's electronic health record (EHR) from hospital stay 2/14/25-2/18/25. The hospital course documents R58 presented to the emergency department (ED) from nursing home on 2/14/25 after [R58] tripped over foot and fell and had complaints of pain to lower back, head, and neck. Imaging studies in ED showed nondisplaced fracture of the left sacral ala (fracture in the bone at the base of the spine) and nondisplaced fracture (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the lateral cortex of the right inferior pubic ramus (fracture in the bone in the lower part of the pelvis). Orthopedic surgery was consulted and recommended pain control and therapy, no surgical intervention was indicated, weight bearing as tolerated (WBAT). Cross-reference F689. Surveyor did not locate a facility reported incident regarding R58's fall on 2/14/25. On 9/16/25, at 3:29 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A, who stated R58's fall on 2/14/25, which resulted in serious bodily injury, was not reported to proper authorities, and was not sure why it was not reported at the time of injury. 3.) R66 was admitted to the facility on [DATE] with diagnoses of depression, transient ischemic attack and cerebral infarction. R66's discharge Minimum Data Set (MDS), dated [DATE], documented a Brief Interview Mental Status (BIMS) score of 15, indicating cognition was intact, and is understood and understands others. On 9/9/2025, at 12:44 PM, Surveyor interviewed R66, who stated Certified Nursing Assistant (CNA)-X, pushed R66 hard in the chest. R66 stated this occurred about 4 weeks ago. R66 indicated standing in the bathroom naked, and CNA-X came in and started working with R66's roommate but left the door to the bathroom open. R66 stated to CNA-X, that there is a sign to close the door and why is the door open. R66 stated going back to bed after and CNA-X then pushed her in the chest hard. R66 stated CNA-X was fired and R66 feels safe because the facility took care of it, as CNA-X was fired right away. On 9/09/2025, at 2:29 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor requested information regarding reports or grievances from R66. NHA-A indicated R66's allegations were already reported to the facility. NHA-A stated that NHA-A would have to look at Director of Social Services (DSS)-F's investigations to see if this was reported to local and state agencies, as DSS-F is out of the facility. On 9/10/2025, at 7:31 AM, Surveyor was informed by NHA-A, that the state agency was updated related to new allegations from 9/9/2025. NHA-A indicated that R66 never said anyone touched R66 with the first allegations, from 8/5/2025. NHA-A indicated that these new allegations are now being investigated. NHA-A stated that these new allegations need to be reported to the state. On 9/10/2025, at 8:36 AM, Surveyor Interviewed Admissions Director (AD)-U, who stated AD-U filled out a grievance about a month ago for R66. On 9/10/2025, Surveyor reviewed R66's grievance investigation from 8/5/2025: This included a grievance/concern form, this document was filled out by AD-U with verbal remarks from CNA-X. This investigation also had a teachable moment form that documented, CNA-X entered a room without knocking. A grievance documentation that documented R66's complaint as: Resident stated that aide [CNA-X] entered her room without knocking. [R66] was naked and felt disrespected. (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Statements from other residents on the unit asking if they ever felt their privacy was violated by staff entering without knocking, which all documented No. There was also an education included in the packet which included bedside manner, completed by all staff. Surveyor reviewed the Documented grievance, dated 8/5/2025, from AD-U, which documented: [R66] said the CNA told [R66] that [CNA-X] will not be doing shit for [R66]. [R66] response was I OK with that. On 9/11/2025, at 3:32 PM, Surveyor interviewed Director of Social Services (DSS)-F, who indicated that DSS-F and NHA-A, will both review facility investigations to decide if it is reportable. DSS-F stated after interview with R66, that there were no statements from R66 about physical or verbal abuse, per DSS-F interview with R66. On 9/11/2025, at 3:48 PM, Surveyor interviewed DSS-F, and Surveyor asked about state or local agencies being informed of allegations from 8/5/2025. DSS-F stated, No and indicated that DSS-F didn't know of the full allegations, on 8/5/2025. DSS-F and surveyor reviewed AD-U's grievance document dated 8/5/2025. DSS-F stated that what was documented on this grievance would need to be reported. DSS-F stated this is not the full investigation and DSS-F will give additional information after locating. On 9/15/2025 11:47 AM, Surveyor interviewed AD-U who stated that this grievance would be considered abuse, and this is why AD-U made sure DSS-F received the documented grievance right away. On 9/15/2025, Surveyor reviewed the statement from R66 that documented: no one pushed me! dated 9/9/2025. Surveyor did not observe a report from state or local agencies being informed of the allegations that were reported on 9/9/2025, at 2:29 PM, by Surveyor. Surveyor was informed on 9/10/2025 by NHA-A, that the facility reported allegations from 9/9/2025 to the state, this was in error. On 9/16/2025, at 8:40 AM, Surveyor interviewed DSS-F about police notification from 9/9/2025 and DSS-F stated the DSS-F is not sure if NHA-A updated the police. DSS-F indicated that the state agency was also not updated and indicated that DSS-F thought NHA-A reported to the state and [NAME]-versa, so neither of them reported it yet. DSS-F stated the report received from this Surveyor on 9/9/2025, will now be considered reported late. On 9/16/2025, at 1:05 PM, Surveyor was informed by DSS-F that the local agencies were not informed of allegations from 8/5/2025 or 9/9/2025, and that DSS-F will be calling the police right now. On 9/16/2025, at 1:30 PM, Surveyor observed the local police arrived at the facility to get a statement from R66, but R66 was out of the building and could not give a statement. On 9/17/2025, at 9:44 AM, Surveyor informed Director of Nursing (DON)-B, of the late reporting to state and local agencies after R66's allegations of abuse on 8/5/2025. Surveyor also informed DON-B of reported abuse allegations from Surveyor to NHA-A on 9/9/2025, not being reported. DON-B (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated that the facility was recently cited for this and this is not new, regardless of how we feel about it, we need to report. We have gone over reporting abuse, and we will be educating staff on this. On 9/17/2025, at 10:01 AM, Surveyor informed NHA-A of the concern with reporting. Surveyor informed NHA-A that R66's allegations on the documented grievance form from 8/5/2025 were not reported timely. Surveyor informed NHA-A that allegations from R66 to surveyor on 9/9/2025, were also not reported timely. As of the time of this write up, no additional information was received as to why R66's allegations were not reported timely to local or state agencies.

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	525371	A. Building B. Wing	09/30/2025

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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 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 interview and record review, the facility did not ensure 3 of 3 allegations of abuse were thoroughly investigated by the facility. R58 sustained a fall with fracture that was not thoroughly investigated by the facility. R66 had an allegation of physical and verbal abuse by a staff member that was not thoroughly investigated by the facility. R94 had an allegation of verbal abuse by a staff member that was not thoroughly investigated by the facility. Findings include: 1.) R94 was admitted to the facility on [DATE] with Major Depressive Disorder and Alcoholic Cirrhosis (a liver condition exacerbated by chronic alcohol abuse). Surveyor reviewed R94's electronic medical record. Surveyor reviewed a facility self report related to an allegation of verbal abuse between R94 and a staff member that occurred on 7/9/25. Surveyor noted R94's abuse allegation was reported to Director Social Services (SS)-F on 7/10/25. Surveyor noted that the facility's investigation did not include interviews with additional residents regarding their safety at the facility and possible knowledge of R94's abuse allegation. On 9/11/25 at 3:29 PM, Surveyor conducted an interview with Director SS-F. Surveyor asked Director SS-F why the facility did not conduct interviews with other residents that may have had knowledge of R94's abuse allegation. Director SS-F was unable to explain why there were missing interviews from residents who may have had knowledge of R94's abuse allegation and to ensure that residents feel safe. On 9/16/25 at 3:29 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor shared concern that the facility's investigation of R94's abuse allegation was not thoroughly completed. The facility provided no additional information to Surveyor at this time. 2.) R58 admitted to the facility on [DATE] with diagnoses including major depressive disorder, other epilepsy (a neurological condition characterized by recurrent seizures), extrapyramidal and movement disorder (involuntary body movements), schizophrenia, and unspecified dementia, moderate, with other behavioral disturbance. R58 had a legal guardian. Nursing progress note dated 2/14/25, at 4:19 AM documented, . resident found laying on left side and wheelchair flipped upside down. Resident stated . was going to the bathroom. Resident transported to the hospital per on-call nurse practitioner recommendation. Surveyor did not note any documentation on the last time the resident was checked on or offered toileting assistance in the fall investigation provided. Surveyor reviewed hospital history and physical (H&P) document in R58's electronic health record (EHR) from hospital stay 2/14/25-2/18/25. The hospital course documents R58 presented to the (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emergency department (ED) from nursing home on 2/14/25 after [R58] tripped over foot and fell and had complaints of pain to lower back, head, and neck. Imaging studies in ED showed nondisplaced fracture of the left sacral ala (fracture in the bone at the base of the spine) and nondisplaced fracture of the lateral cortex of the right inferior pubic ramus (fracture in the bone in the lower part of the pelvis). Orthopedic surgery was consulted and recommended pain control and therapy, no surgical intervention was indicated, weight bearing as tolerated (WBAT). Cross-reference F689. On 9/11/25, at 8:55 AM, Surveyor interviewed Director of Nursing (DON)-B who stated only risk assessments, progress notes, and care plans were located for R58's fall on 2/14/25. DON-B stated there is no other information available to include staff statements or when R58 was last toileted or checked on. DON-B stated while DON-B was not working at the facility between 12/31/2024 and early August 2025, the normal fall protocol that was in place prior to DON-B leaving was not being completed, which previously included staff statements and a more thorough investigation. DON-B stated once DON-B returned to the facility in August 2025, the fall investigation process has been improved, but was unable to provide any information regarding why a thorough investigation was not completed for R58's fall on 2/14/25. On 9/16/25, at 1:45 pm, Surveyor interviewed Med Tech (MT)-AA who stated after a resident has a fall, whoever found the resident would write a statement and give it to a nurse to follow up on. MT-AA stated the statement would include information on what could have been done to prevent the fall. On 9/16/25, at 2:16 PM, Surveyor spoke with Licensed Practical Nurse (LPN)-BB via phone call, who was the nurse on duty at the time of R58's fall on 2/14/25. LPN-BB stated typically after a resident has a fall, the nurse would perform an assessment on the resident, contact the doctor on call to decide if the resident needs to get sent out to the hospital, and then paperwork would be filled out including risk management, a progress note, and information on what could have been done to avoid the fall. On 9/16/25, at 3:29 PM, Surveyor informed Nursing Home Administrator (NHA)-A and DON-B of the concern that R58's fall on 2/14/25, which resulted in serious bodily injury, was not thoroughly investigated. No further information was provided as to why a thorough investigation did not occur at the time of R58's fall. 3.) R66 was admitted to the facility on [DATE] with diagnoses of depression, transient ischemic attack and cerebral infarction. R66's discharge Minimum Data Set (MDS), dated [DATE], documented a Brief Interview Mental Status (BIMS) score of 15, indicating cognition was intact, and is understood and understands others. On 9/9/2025, at 12:44 PM, Surveyor interviewed R66, who stated Certified Nursing Assistant (CNA)-X, pushed R66 hard in the chest. R66 stated this occurred about 4 weeks ago. R66 indicated standing in the bathroom naked, and CNA-X came in and started working with R66's roommate but left the door to the bathroom open. R66 stated to CNA-X, that there is a sign to close the door and why is the door open. R66 stated going back to R66's bed after and CNA-X then pushed R66 in the chest hard. R66 stated CNA-X was fired and R66 feels safe because the facility took care of it, as CNA-X was fired right away. On 9/09/2025, at 2:29 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor requested information regarding reports or grievances from R66. NHA-A indicated R66's allegations (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525371	A. Building B. Wing	09/30/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were already reported to the facility. NHA-A stated that NHA-A would have to look at Director of Social Services (DSS)-F's investigations to see if this was reported to local and state agencies, as DSS-F is out of the facility. On 9/09/2025, at 3:29 PM, Surveyor interviewed Social Services (SS)-V and Surveyor asked if SS-V had any additional information about the grievance from R66. SS-V stated that DSS-F was aware of these allegations and these allegations were investigated by DSS-F. On 9/10/2025, at 7:31 AM, Surveyor interviewed NHA-A, who stated that after looking at these allegations further, that R66 was in the bathroom naked, Certified Nursing Assistant (CNA)-X opened R66's door, that employee doesn't work here anymore. NHA-A indicated there was no pushing reported on 8/5/2025. NHA-A stated that R66 defends R66 well, these allegations are not accurate because R66 wouldn't put up with that treatment. This was a grievance, that we addressed for R66 and the first allegations, were of poor bedside manners, and we did complete an education with that. The education was for bedside manner, I'll bring that to you. On 9/10/2025, at 8:36 AM, Surveyor Interviewed Admissions Director (AD)-U, who stated AD-U filled out a grievance about a month ago for R66. AD-U stated that R66 didn't say anything about CNA-X pushing R66. AD-U stated that AD-U filled out a grievance for this allegation. On 9/11/2025, at 3:32 PM, Surveyor interviewed DSS-F, who indicated that after DSS-F virtually interviewed with R66 on 9/9/2025 that allegations were reported to state agency. DSS-F indicated that there were no statements from R66 about physical or verbal abuse found from back on 8/5/2025 and allegations from 9/9/2025 are new. Verbal abuse allegations: On 9/10/2025, Surveyor reviewed R66's grievance investigation from 8/5/2025: This included a grievance/concern form, this document was filled out by AD-U with verbal remarks from CNA-X. This investigation also had a teachable moment form that documented, CNA-X entered a room without knocking. A grievance documentation that documented R66's complaint as: Resident stated that aide[CNA-X] entered her room without knocking. [R66] was naked and felt disrespected. Statements from other residents on the unit asking if they ever felt their privacy was violated by staff entering without knocking, which all documented No. There was also an education included in the packet which included bedside manner, completed by all staff. Surveyor reviewed the Documented grievance, dated 8/5/2025, from AD-U, which documented: [R66] said the CNA told [R66] that [CNA-X] will not be doing shit for [R66]. [R66] response was I OK with that. On 9/11/2025, at 3:48 PM, Surveyor interviewed DSS-F, who indicated that Surveyor is missing a lot (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of information from the investigation. DSS-F stated that DSS-F didn't see that grievance form from AD-U until now. DSS-F stated that DSS-F didn't know about those allegations and would have addressed this right away if DSS-F knew about that allegation. DSS-F stated that Surveyor is still missing some information. DSS-F stated DSS-F will give surveyor more information on this on Monday. DSS-F stated state or local agencies were not informed as DSS-F wasn't aware of these allegations until now. On 9/15/2025, at 10:21 AM, Surveyor received additional documentation from DSS-F. Surveyor did not observe a statement from R66 from 8/5/2025 in the documents received. The only documentation found that addressed R66's allegation was the grievance description document, completed by DSS-F. This grievance documented: [R66] was naked and felt disrespected. On 9/15/2025, at 10:57 AM, Surveyor interviewed DSS-F, regarding R66's grievance investigation, dated 8/5/2025. Surveyor informed DSS-F that there were no statements from R66 regarding an interview that occurred with R66 on 8/5/2025. DSS-F stated there is some and that those will be given to Surveyor. On 9/15/2025 11:47 AM, Surveyor interviewed AD-U, who stated that the grievance from 8/5/2025, from R66 would be considered abuse. AD-U stated this is why AD-U made sure DSS-F received the documented grievance right away. AD-U stated that R66 never stated that R66 was pushed by CNA-X to AD-U. AD-U indicated that the verbal altercation was documented on the grievance from 8/5/2025. On 9/15/2025, Surveyor received a document from DSS-F. Surveyor reviewed the statement from R66, dated 9/9/2025, that documented: no one pushed me!. There was concern with a thorough investigation as the new packet that was handed to surveyor from DSS-F documented the description of incident as: On 9/9/25, the social worker was alerted by state surveyors regarding a possible incident involving the resident and a staff member. Due to the seriousness of the matter and the need to address it promptly, the social worker met with the resident virtually to obtain further information. The resident alleged that during the previous month, certified nursing assistants [CNA-X] pushed her on the shoulder. When asked if she had reported this incident to staff, the resident stated that she informed the nurse at the time but did not notify any other staff members. The description of R66's allegations of abuse did not match previous allegations given to Surveyor on 9/15/2025. This allegation documented R66 stated no one touched R66, and this allegation was missing from the packet received on 9/16/2025 from DSS-F. On 9/16/2025, at 8:38 AM, Surveyor informed DSS-F, that after review of the allegation investigation, dated 8/5/2025, that allegations from R66 were missing from DSS-F's investigation report. Surveyor explained that R66's statements from the 9/9/2025 investigation has two completely different statements from R66. One saying it occurred and one saying it did not. DSS-F stated that DSS-F addressed the 9/9/2025 allegations virtually with R66. DSS-F stated that R66 denied that these allegations happened. DSS-F stated that these allegations are going through a lot of different hands and were trying to get it structured. Surveyor informed DSS-F, the expectations would be that with allegations of abuse that all statements from R66 be included in the investigation packet. (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/2025, at 9:49 AM, Surveyor informed Director of Nursing (DON)-B, of the concern of allegations of verbal abuse on 8/5/2025 and physical abuse on 9/9/2025 being thoroughly investigated. Surveyor informed DON-B that there were statements from R66 missing from 8/5/2025 investigation and missing information from the 9/9/2025 investigation. DON-B indicated that it is DON-B's expectation that staff thoroughly investigate allegations of abuse. DON-B stated any abuse allegation would need to be thoroughly investigated. On 9/17/2025, at 10:01 AM, Surveyor informed NHA-A, of the concern with thorough investigations of abuse allegations. Surveyor informed NHA-A that R66's allegations on the documented grievance form from 8/5/2025 were not investigated thoroughly. Surveyor informed NHA-A that allegations from R66 to surveyor on 9/9/2025, were not thoroughly investigated. NHA-A indicated that the facility did not complete a thorough investigation for R66's allegations. NHA-A stated, We missed that, abuse allegations should be investigated thoroughly. As of the time of this write up, no additional information was received as to why R66's, allegations of abuse were not thoroughly investigated.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 2 (R2 & R91) of 3 residents reviewed for hospitalizations received the proper notice of transfer or written notice of bed hold policy to include the rate to reserve the resident's bed. *R2 was transferred to the hospital on 5/9/25 and 6/13/25. A bed hold reserve bed payment rate/policy and procedure detail was not provided in writing to R2 upon transfer on 5/9/25, and a transfer notice and bed hold rate was not provided in writing to R2 upon transfer on 6/13/25. *R91 was transferred to the hospital on 7/26/25. A transfer notice and bed hold rate was not provided in writing to R91 upon transfer. Findings include: The facility policy titled Bedhold Notice Upon Transfer with implemented date 3/1/2019 documents: .Policy- at the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. -before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or the resident representative written information that specifies: 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; the reserved bed payment policy in the state plan policy, if any; the facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed.-in the event of an emergency transfer of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies.-the facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or representative in the resident's file. 1.) R2 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (weakness) following cerebral infarction (stroke) affecting right dominant side, and type 2 diabetes mellitus with diabetic polyneuropathy (nerve damage). R2 is their own person. R2 was hospitalized on [DATE] for nausea and vomiting. Surveyor reviewed R2's electronic health record (EHR) and located a bed hold policy and notice of transfer dated 5/9/25 with R2's signature, however, no reserve bed payment rate/policy and procedure detail was specified on the notice. R2 was hospitalized on [DATE] for nausea and vomiting. Surveyor reviewed R2's EHR and did not locate a bed hold notice nor notice of transfer from this date. On 9/11/25, at 12:00 PM, Director of Nursing (DON)-B informed Surveyor that no bed hold notice was located for R2's hospitalization on 6/13/25. On 9/15/25, at 9:26 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-P regarding the process when a resident gets transferred to the hospital. LPN-P stated if a resident goes to the hospital, paperwork would get completed including a medication list, facesheet, and a bed hold notice would get filled out by the nurse taking care of the resident. LPN-P stated the bed hold then goes to medical records. LPN-P stated a resident will sign the notice if they are their own person and then the (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse will sign the notice. LPN-P stated the nurse would document a progress note once the resident gets sent to the hospital. LPN-P stated the transfer notice is included on the bed hold form. On 9/15/25, at 2:10 PM, Surveyor interviewed Medical Records-II who stated Medical Records-II obtains the bed hold forms from a basket then uploads the form into the resident's medical chart. Medical Records-II stated a copy of the bed hold form is not provided to the resident after uploading it to the chart. On 9/15/2025, at 3:25PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A, DON-B, and regional nurse consultant (RNC)-L that R2 did not have evidence that a bed hold or transfer notice was provided to R2 on 6/13/25 when transferred to the hospital, the bed hold and transfer notice that was provided to R2 on 5/9/25 did not indicate a bed hold reserve bed payment rate/policy and procedure detail for the resident, and that a copy of the bed hold and transfer notice was not provided to the resident for either hospitalization. NHA-A replied to confusion on what rate to document on the bed hold policy. Surveyor informed NHA-A that the resident needs to be notified of the rate they would be held accountable for if the resident agrees to hold their bed. 2.) R91 admitted to the facility on [DATE] and has diagnoses that include left above the knee amputation with phantom limb syndrome, type 2 diabetes mellitus, absence of the right toes, opioid dependence with unspecified opioid induced disorder, major depressive disorder, and history of tuberculosis. R91's quarterly Minimum Data Set (MDS) dated [DATE] indicated R91 had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15. R9 did not have an activated power of attorney and was their own person. R91 was transferred and admitted to the hospital on [DATE] with episodes of having brown, coffee ground like emesis. Surveyor reviewed R91's medical record and did not locate a bed hold or transfer notice for R91's admission to the hospital on 7/26/2025. On 9/11/2025, at 9:08AM, Surveyor requested to review R91's bed hold and transfer notice for 7/26/2025. Nursing home administrator (NHA)-A and director of nursing (DON)-B stated R91 often refused to sign the bed hold transfer notice. Surveyor asked how are refusals documented. DON-B replied that a refusal to sign the bed hold transfer notice should be documented in progress notes and on the bed hold transfer notice form with the refusal date and time. Surveyor informed NHA-A and DON-B that there was no documentation in the progress notes that R91 refused to sign the bed hold/ transfer notice form on 7/26/2025. Surveyor requested to review a bed hold transfer notice form. Surveyor reviewed the bed hold/ transfer notice form and noted that the bed hold reserve bed payment rate/policy and procedure detail is not included on the bed hold policy for the resident and/or resident representative. On 9/15/2025, at 2:10PM, Surveyor interviewed medical records-II who stated medical records-II picks up any bed hold/transfer notice forms from the units and scans right into the computer into the resident's medical record. Surveyor asked if a copy is given or sent to the resident and/or resident representative. Medical records-II stated that a copy of the bed hold/transfer notice is not given to the resident and/or resident representative that medical records-II is aware of. On 9/15/2025, at 3:25PM, Surveyor shared concerns with NHA-A, DON-B, and regional nurse (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consultant (RNC)-L that R91 did not have evidence that a bed hold/ transfer notice was provided to R91 on 7/26/2025 when transferred to the hospital, the bed hold/ transfer notice does not indicate a reserve bed payment rate/policy and procedure detail for the resident and/or resident representative, and a copy of the bed hold/ transfer notice is not provided to the resident and/ or resident representative.

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	525371	A. Building B. Wing	09/30/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R50) of 11 residents reviewed with a completed level 1 Preadmission Screening and Resident Review (PASARR) indicating a need for the completion of a level 2 PASARR had one completed. *R50's PASARR level 1 indicated R50 is suspected of having a serious mental illness and requires a PASARR level 2 screening. R50 did not have a PASARR level 2 screen completed within 30 days of admission to determine need for specialized services. R50's level 2 PASARR was completed almost 2 years post admission.Findings include:Surveyor notes the facility did not have a PASARR policy and procedure.R50 was admitted to the facility on [DATE] with admitting diagnoses of post-traumatic stress disorder and depression. A diagnosis of generalized anxiety disorder was added on 2/5/24.R50's Physician Orders documents, Buspirone oral tablet 5 mg (milligrams), give 1 tablet by mouth two times a day related to generalized anxiety disorder with an order date of 8/9/24. Fluoxetine oral capsule 40 mg (milligrams), give 1 capsule by mouth one time a day for OCD (obsessive compulsive disorder), anxiety related to generalized anxiety disorder with an order date of 3/21/25. Monitor Anti-Psychotic [MED] side effects QSHIFT (each shift): every shift for monitoring with an order date of 9/10/2025. MONITOR - Behavior Symptoms; every shift with an order date of 10/6/2023. Non-Pharmacological interventions every shift for Behavior Monitoring with an order date of 7/12/2023. Resident is prescribed medication for depression. Document number of times per shift that any of these behaviors occur: states feels sad or depressed, crying, tearfulness, social isolation, every shift for Behavior Monitoring with an order date of 7/12/2023. R50's PASARR level 1 indicated R50 is suspected of having a serious mental illness and requires a PASARR level 2 screening. R50's PASARR level 2 was submitted on 5/1/25, 1 year and 10 months following admission.On 9/11/25 at 1:20 PM, Surveyor interviewed Director of Nursing (DON)-B and asked why the PASSAR 2 was dated 5/1/25 when resident was originally admitted on [DATE]. DON-B stated that if a resident has a new diagnosis, medication, or behavior following admission, the PASARR 2 could be added with new changes. Surveyor stated the investigation into R50 did not indicate R50 had a new diagnosis or changes based on the medical record triggering a level 2 at that time. Surveyor also noted there is no indication of a level 2 being completed prior to 5/1/25 to coincide with the timing of admission and completion of the level 1. 09/15/2025 at 10:17 AM Surveyor interviewed DON -B and Director of Social Services (Director of SS)-F. Director of SS-F stated the reason why the PASARR level 2 was submitted late for R50 is because Director of SS-F conducted an audit on 5/1/25 and discovered a new diagnosis of generalized anxiety was added on 2/5/24 that would have required a PASARR level 2. Director of SS-F stated a PASARR level 2 was then completed on 5/1/25. Surveyor stated to Director of SS-F that a PASARR level 2 should have been submitted no later than 30 days post admission date of 7/11/23 as the PASARR 2 was required with the admission diagnosis of Post-Traumatic Stress Disorder and Depression as documented in PASARR level 1. DON-B acknowledged the error.No additional information was provided at this time.

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	525371	A. Building B. Wing	09/30/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure 1 (R2) of 1 resident who is dependent with their activities of daily living received the necessary services to maintain their grooming and hygiene. R2's fingernails were observed to be extremely long, and R2's urinal was observed not to be emptied timely. Findings include:The facility policy titled Providing Nail Care with implemented date 3/1/19 and no revised date, documents: . Policy . the purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health . -identify conditions that increase risk for foot or nail problems, such as diabetes, peripheral vascular disease, heart failure, renal disease, or stroke .-routine cleaning and inspection of nails will be provided during activities of daily living (ADL) care on an ongoing basis . -routine nail care, to include trimming and filing, will be provided on a regular schedule. Nail care will be provided between scheduled occasions as the need arises . -the resident's plan of care will identify: the frequency of nail care to be provided, the type of nail care to be provided, the person(s) responsible for providing nail care .-principles of nail care . only licensed nurses shall trim or file fingernails of residents with diabetes . The facility policy titled Helping a Resident with Toileting with implemented date 3/1/19 and no revised date, documents: . Policy . it is the practice of this facility to assist residents with toileting needs in order to maintain the resident's dignity as well as proper hygiene .R2 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (weakness) following cerebral infarction (stroke) affecting right dominant side, and type 2 diabetes mellitus with diabetic polyneuropathy (nerve damage). R2's Care Area Assessment (CAA) for functional abilities dated 1/22/25 documents R2 requires extensive help with ADLs due to severely limited mobility . proceed with ADL care plan.R2's Quarterly Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. MDS documents R2 has impaired range of motion (ROM) in the upper extremities on one side and impaired ROM in the lower extremities on one side. MDS documents R2 requires minimal to moderate assistance for toileting hygiene, upper and lower body dressing, personal hygiene, bed mobility, and is dependent for sit to stand and bed to chair transfers. MDS documents R2 is occasionally incontinent of urine. R2's physical function deficit related to mobility impairment and self care impairment care plan initiated 8/8/2021 documents the following interventions: -nail care as needed (PRN) (date initiated 8/26/21)-toileting assistance of limited assist (date initiated 8/8/21, revision on 7/31/24)R2's alteration in elimination of bowel and bladder care plan initiated 10/10/2022 documents the following interventions:-check and change every 2-3 hours and as needed (PRN). Offer toileting on request and PRN (date initiated 10/10/22, revised 10/10/22)-use of briefs/pads for incontinence protection (date initiated 10/10/22)Surveyor noted there are no interventions documented in the care plan regarding R2's use of a urinal for bladder elimination. On 9/9/25, at 1:48 PM, Surveyor observed R2 lying in bed, and a urinal was observed half-full hanging on the side of R2's bed. Surveyor observed R2 to have extremely long fingernails on both hands, with the nails longer on the right hand, which is contracted. During interview with R2, R2 stated I need my fingernails cut and stated R2's stroke in 2021 resulted in weakness in dominant right side. On 9/9/25, at 3:01 PM, Surveyor observed the urinal still half-full hanging on the side of R2's bed. On 9/10/25, at 12:54 PM, Surveyor observed R2's fingernails continue to be extremely long. Surveyor observed R2's urinal half-full hanging on R2's bed. On 9/15/25, at 9:06 AM, during interview with R2, Surveyor observed R2's fingernails continue to be extremely long. R2 stated R2 thinks the nurse has to come in to cut R2's fingernails, but states I haven't had them cut in so long, I'm not sure what the process is. Surveyor observed R2's urinal half-full hanging on R2's bed. On 9/15/25, at 9:43 AM, Surveyor interviewed licensed practical nurse (LPN)-P regarding typical care for a resident who uses a urinal. LPN-P stated staff would make sure the resident is able to hold the urinal or would provide assistance if the resident is not able to hold the (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urinal independently. LPN-P stated following use of the urinal, staff would provide peri care, note the urine output, then dump out the urinal into the toilet and rinse the urinal. LPN-P stated staff would empty a urinal when the resident puts on the call light after using or during rounds every two hours if it was noted to have urine in it. Surveyor asked LPN-P how fingernails are typically managed for residents who require assistance with ADLs. LPN-P stated when a resident needs their fingernails cut, the fingernails are soaked in water prior to cutting. LPN-P stated if the resident is diabetic, the aides would let the LPN on duty know the resident's nails need to be cut. On 9/15/25, at 1:33 PM, Surveyor shared the concern with Director of Nursing (DON)-B that Surveyor had several observations of R2's fingernails being extremely long and R2's urinal being full, and R2's care plan did not specify that R2 uses a urinal or the intervals that urinal care should be provided by staff.

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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 interview and record review the facility did not ensure 1 (R5) of 1 resident reviewed for post traumatic stress disorder (PTSD) received culturally competent, trauma informed care in accordance with professional standards of practice and accounting of resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of R5.* R5 does not have a person centered care plan for triggers and interventions for R5's PTSD diagnosis. R5 has no quarterly trauma assessments completed.Findings include:The facility policy titled Trauma Informed Care dated 10/1/2022 documents: It is the policy if this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/ or re-traumatization.Policy Explanation and Compliance Guidelines: .2. The facility will use a multi-pronged approach to identifying a resident's history of trauma, as we as his or her cultural preferences, this will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), admission assessment, the history and physical, the social history/assessment, and others.4. The facility will collaborate with resident trauma survivors, . and any other healthcare professionals (such as psychologist .) to develop and implement individualized care plan interventions.6. The facility will identify triggers which may re-traumatize residents with a history of trauma. The trigger specific interventions will identify ways to decrease the resident's exposure to triggers with re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan.7. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma . These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery.R5 was admitted to the facility on [DATE] and has diagnoses that include major depressive disorder, bipolar disorder, anxiety disorder, mild cognitive impairment, PTSD, hoarding disorder, alcohol abuse, and insomnia. R5's annual Minimum Data Set (MDS) dated [DATE] indicated R5 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15 and the facility assessed R5 requiring supervision with activities of daily living (ADL's) and indicated R5 had verbal behaviors towards others. R5 did not have an activated power of attorney and was their own person.On 10/1/2024 nursing completed a trauma informed care assessment on R5. Nursing documented the following:A. PTSD Screen: Read: Sometimes things happen that are unusually or especially frightening, horrible, or traumatic. For example: a serious accident or fire, a physical or sexual assault or abuse, earthquake, flood, or war .1.Have you ever experienced this kind of event, YES or NO?Nursing checked the answer, NO, which indicated R5 had not experienced any of the above traumatic events. Surveyor notes the nurse that completed R5's trauma assessment on 10/1/2024 was no longer employed with the facility and not available for interview. Surveyor reviewed R5's behavior care plans and noted that there was no specific person centered focus or interventions for R5 regarding what are R5's triggers for R5's PTSD or interventions to help R5 with preventing or assisting with circumstances that may result if R5's PTSD is triggered.On 9/15/2025, at 9:10AM, Surveyor spoke with certified nursing assistant (CNA)-S who stated they started employment at the facility about 2 weeks ago. Surveyor asked what kind of PTSD triggers would R5 experience and what interventions would assist R5 in dealing with those possible triggers. CNA-S stated she was not aware R5 had a history of PTSD and was not sure what R5's triggers or interventions would be. Surveyor asked CNA-S how that information would be communicated to the staff so staff is aware of potential triggers that could interfere with R5 and cause a concern or where to find interventions to assist R5 through an episode if R5 was to experience an episode with R5's PTSD. CNA-S stated nursing would report it or it might be in the (continued on next page)

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	525371	A. Building B. Wing	09/30/2025

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's care plan or on the CNA Kardex. CNA-S was not sure if PTSD triggers and interventions were listed anywhere for R5.On 9/16/2025, at 9:26AM, Surveyor interviewed licensed practical nurse (LPN)-P and director of nursing (DON)-B. LPN-P did not know what R5's PTSD triggers were or what caused R5 to have PTSD. LPN-P stated R5 has a hard time remembering things and will get upset about that, but redirection helps with that. LPN-P stated PTSD triggers and interventions should be in the care plan for the resident and documented so staff are aware and can assist R5 by preventing any PTSD triggers and implementing any interventions in the event R5 may experience a PTSD event. DON-B was not aware of what PTSD events R5 experienced in the past. DON-B stated R5 at times will have behaviors when R5 feels people being judgmental . but is not sure if that could be a trigger for R5's PTSD. DON-B stated would have to look into it further for R5. Surveyor asked how often trauma assessments are completed when there is a diagnosis of PTSD. DON-B stated resident should have an admission trauma assessment and then quarterly after that or as needed. DON-B stated that would initiate a care plan with the PTSD triggers and interventions for a resident. DON-B was not sure why R5 would have been documented as no on R5's traumatic assessment on 10/1/2024 and should have been followed up on and other trauma assessments completed quarterly. Surveyor requested to review R5's psychiatric progress notes and CNA Kardex.Surveyor reviewed R5's CNA Kardex and noted no documentation for possible triggers for R5's PTSD and no interventions to prevent possible PTSD triggers for R5.Surveyor reviewed R5's psychiatric progress notes from February 2025 - August 2025. R5 was visited monthly from the psychiatric nurse practitioner (NP). R5's progress notes documented: .Social History- .- Childhood: (R5) reports a rough childhood. Reports abuse from father and uncle.- Trauma/ Abuse: Mental/ Verbal, Physical, and Sexual abuse were identified. (R5) reports as a child from (R5's) father and uncle.Surveyor noted that the above documentation is not included on R5's care plan or CNA Kardex as possible triggers or situations to look for R5's care or possible interventions to prevent triggering circumstances for R5.On 9/16/2025, at 1:50PM, Surveyor interviewed director of social services (DSS)-F who stated DSS-F was not sure what factors contributed to R5's PTSD concerns. DDS-F stated R5 has a history of alcoholism and would drink to cope and that would bring on some behaviors R5 experiences. Surveyor asked DDS-F what situations drew R5 to drinking to cope with. DDS-F was not sure what situations would prompt R5 to drink. Surveyor asked how often trauma assessments should be completed. DDS-F stated an admission trauma assessment should be completed on admission to the facility and if the resident is marked yes for PTSD history than quarterly trauma assessments get triggered to be completed. Surveyor asked why R5 was not triggered yes on the trauma assessment. DDS-F was not sure why R5 was not marked for PTSD, however it should have been followed up on and readdressed because R5 had the diagnoses of PTSD. DDS-F stated R5's psychiatric progress notes are sent via email to SSD-F and then discussed amongst the interdisciplinary team (IDT). DDS-F was not sure why the documentation of R5's past verbal/ physical, sexual, and physical abuse from family was never captured and documented on R5's care plan or why specific interventions for R5 were never developed to help cope with R5's PTSD triggers. On 9/16/2025, at 3:19PM, Surveyor shared concerns with nursing home administrator (NHA)-A, DON-B, and regional nurse consultant (RNC)-L regarding R5 not having a person centered care plan for R5's triggers and interventions for R5's PTSD diagnosis. Surveyor shared concern that R5 has not received any trauma assessments since 10/1/2024.

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	525371	A. Building B. Wing	09/30/2025

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Bayshore Nursing & Rehab	1300 West Silver Spring Dr Glendale, WI 53209

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 comprehensively assess a resident before and after applying bed mobility devices. This was observed with 1 (R40) of 1 residents observed with bed mobility devices.*R40 was observed with bilateral bed mobility devices without any attempted alternatives, indication for use, or scheduled maintenance of mobility devices. R40's Bed Rail Assessment was incomplete and documented right bedrail only. R40 does not have a consent signed for mobility devices nor have a mobility device evaluation for installment. R40 does not have a physician order for mobility devices nor a physician order for monitoring of potential residual side effects with a mobility device. Findings include:The facility policy entitled, Use of Restraints Policy, date revised, July 2022, documents in part. Policy Statement: Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline for staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented.Policy Interpretation and Implementation: 1. Physical Restraints are defined as any manual or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the systems. 9. Restraints shall only be used upon the written order of a physician an after obtaining consent from the resident and/or representative (sponsor). The order should include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom); b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint. 14. Residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraints use.16. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination.17. Care plans for residents will reflect interventions that address not only the immediate medical symptoms (s), but the underlying problems that may be causing the symptom(s).R40 was admitted on [DATE] with a diagnoses that include hemiplegia and hemiparesis following a cerebral infarction (stroke) affected right dominant side, congestive heart failure, vascular disease, depression and anxiety.On 09/09/2025 at 12:07 PM, Surveyor observed R40 in bed with partial bilateral bed rails.R40's medical record does not have any evidence of attempted alternatives, indication for use, or scheduled maintenance of mobility devices documented.R40's Bed Rail Assessment completed on 6/3/25, documents R40 is non-Ambulatory, level of consciousness does not fluctuate, does not have alteration in safety awareness due to cognitive decline, has a history of falls, has displayed poor bed mobility or difficulty moving to a sitting position on the side of the bed, does not have difficulty with balance or poor trunk control, does not have difficulty with postural hypertension, has expressed a desire to have Side Rails/Assist Bar for safety and/or comfort and is not visually challenged. No options were chosen for interventions to include the following options, a. Lower the bed to the floor b. Provide restorative care to enhance abilities to safely stand and walk c. Provide frequent staff monitoring at night d. Provide assisted toileting for the resident at night e. Visual and verbal (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reminders to use the call bell. The side rail placement recommendations document, right side. There is no signature or date of the resident or responsible party and no signature and date for the registered nurse completing the Bed Rail Assessment.R40's medical record does not have any evidence of a signed consent for mobility devices to include risks and benefits to assure R40 could make an informed decision.R40's medical record does not have any evidence of documentation and/or evaluation for installment of a mobility device, to include but not limited to, space between mattress and side rails to reduce risk of entrapment, measurement for size and weight, bed dimensions, and manufacturers recommendations for installing and maintaining mobility devices, medical diagnosis, symptoms, movement and positioning, ability to toilet self safely, and cognition.R40's medical record does not have any evidence of a physician order for mobility devices.R40's medical record does not a have any evidence of a physician order for monitoring of potential residual side effects with a mobility device. R40's Care Plan documents, in part, . Focus: I have a physical functioning deficit related to: Mobility impairment, Self care impairment, Rt. (right) hemi, etc. Side rails for bed mobility - refuses meds and treatments at times. Date Initiated: 06/28/2024 Goals: Bed mobility with side Rails. Date Initiated: 06/11/2025 Interventions: Reviewed with resident risk and benefits of using side rails. Date Initiated: 06/11/2025.09/11/2025 at 11:19 AM Surveyor interviewed Director of Nursing (DON)-B. Surveyor stated there was no evidence of a physician order for bed rails, device evaluation, nor consent in the medical record. DON-B confirmed there is no physician order, device evaluation or consent. Surveyor asked what kind of monitoring is being done for checking safety of R40 with bed rails and DON-B stated, there currently is no monitoring taking place. DON-B acknowledged that a consent is needed for acknowledgment of risks and benefits. Surveyor notified DON-B the Bed Rail assessment was for a right rail only and observed bilateral in R40's room and informed DON-B there was no signature of RN or resident/rep on Bed Rail Assessment. DON-B reviewed and acknowledged the errors.09/11/2025 at 11:45 AM Surveyor interviewed Maintenance Director- GG who stated the process for installing mobility devices on beds is as follows, the nurses call maintenance and provide a verbal request. Maintenance checks to see if bed is rented or not and then proceeds with either calling rental company to install or facility installs. Rental company will ask if the bed is standard or bariatric and maintenance approximates resident weight. Maintenance Director- GG stated there is no process in place to complete a device evaluation nor standard maintenance checks on bedrails nor process to reference manufacturer guidelines. 9/11/2025 at 1:45 PM Surveyor interviewed Nursing Home Administrator (NHA)-A, who stated R40's bed is facility owned and NHA-A spoke to the previous maintenance personnel who installed the bed rails for R40. NHA- A stated the previous maintenance personnel told NHA-A the nurses were the responsible party for completing the gap assessment. Surveyor asked what a gap assessment was and NHA-A stated it was the measurement of the distance between mattress and bed frame for railings and size of mattress. Surveyor asked if there is an assessment form for the gap assessment and NHA-A stated, no.9/11/2025 at 2:00pm surveyor notified NHA-A and DON-B of concerns regarding R40's mobility devices and lack of assessment, monitoring, orders and consent. Surveyor also notified NHA-A and DON-B the Bed rail assessment only indicated need for right side bed rail and bilateral was installed. No further information was provided at this time.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on observation, interview and record review the facility did not ensure 1 (R6) of 1 residents reviewed for dental concerns had the necessary services for dental care. On 9/9/25 at 10:23 a.m. Surveyor interviewed R6. R6 explained he had broken teeth and was told he could see the dentist and no one from the facility has helped him with this concern. Surveyor observed broken and missing teeth in R6's mouth. Findings include:R6 was admitted the facility on 12/29/21 with diagnoses of dysphagia, chronic respiratory failure and chronic obstructive pulmonary disease. On 9/9/25 at 10:23 a.m. Surveyor interviewed R6. R6 stated he has missing teeth and needs to see the dentist. R6 showed Surveyor his mouth. R6 had missing and broken teeth. The medical record reveals on 7/23/25 R6 had a dental exam and the dental note documents, patient has 13 teeth/roots present. Patient had several teeth extracted last year and was supposed to have another oral surgery appointment for more extractions. Facility staff needs to set up oral surgery appointment. Will follow up after extractions are done for healing eval/treatment plan.There is no evidence, in the medical record R6 has an oral surgery appointment.On 9/15/25 at 7:58 a.m. Surveyor interviewed Director of Nursing (DON)-B. Surveyor explained to DON-B the concern regarding R6 teeth and need for oral surgery. DON-B stated R6 has not been to the oral surgeon and an appointment has not been made. DON-B stated she thinks the barrier could be because R6 would have to be transported via a stretcher. DON-B stated she would look into finding a possible oral surgeon for R6.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interview and record review, the facility did not ensure the medical records for 1 (R95) of 1 residents was accurate and complete based upon standards of practice.R95 was transferred to a hospital for care. The medical record does not include documentation for the reason for the transfer and where R95 was transferred to.Findings include:R95 was admitted to the facility on [DATE] with diagnoses of morbid obesity, chronic obstructive pulmonary disease and type 2 diabetes. The discharge MDS (minimum data set) dated 7/18/25 documents R95 was discharged to the hospital. The nurses notes does not document any assessment related to the need to send R95 to the hospital. On 9/16/25 at 3:15 p.m. Surveyor interviewed DON-B. Surveyor explained the concern R95 was discharged to the hospital and there isn't documentation of an assessment related to the need to send R95 out to the hospital. DON-B stated she understood and had no information. DON-B stated she expects nurses to document an SBAR (situation, background, assessment and recommendation) when a resident is discharged to the hospital.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility did not ensure that 1 of 4 Certified Nursing Assistants (CNA-JJ) reviewed completed the required annual 12 hours of educational training. Findings include: The Facility Assessment Tool last updated 5/2025, documents required in-service training for nurse aides. In-service training must:-Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year.On 9/16/25, at 11:04am, Surveyor interviewed business office-KK regarding the four CNA employed over one year that Surveyor requested annual training hours for. One of the CNA only had 2.1 hours in the last year and was hired on 8/8/23. Business office-KK will look into why CNA-JJ is short.On 9/16/25, at 1:20pm, Surveyor interviewed business office-KK again and was told when the report was run again it shows 5.6 hours of training which is still short of the 12 required. Surveyor asked how the facility monitors that training is being completed. Business office-KK responded that they do monthly audits. Surveyor asked how CNA-JJ fell through the cracks and was told they must have been overlooked.On 09/16/2025, at 2:50pm, during the end of day meeting, Surveyor let Nursing Home Administrator-A and Director of Nursing-B know concern that one (CNA-JJ) of four CNA sampled that were here over 1 year did not complete 12 hours of annual training.No additional information was provided as to why the facility did not ensure that CNA-JJ received the required 12 hours of continuing competence training.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and record review, the facility did not ensure the most recent State Survey results were readily accessible to residents, family members and legal representatives. This had the potential to affect all 85 residents who resided in the facility at the time of the survey.The facility State Survey results were not readily accessible for review.Findings include:The facility policy titled, Availability of Survey Results implemented 1/1/2025, documents, in part: Policy: The purpose of this policy is to uphold a resident's right to examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility.Policy Explanation and Compliance Guidelines:1. A readable copy of our company's most recent federal and/or state survey report and plan of correction for any identified deficiencies is maintained in a 3-ring loose leaf binder titled Results of Most Recent Survey.2. The survey binder is located (in the main lobby) and is available for review by interested persons who wish to review information relative to our company's compliance with federal or state rules, regulations, and guidelines governing our company's operation.3. A representative of management is assigned the responsibility of making weekly inspections of the survey binder to ensure that the binder contains current information, is located in its designated area(s), and is readily accessible without one having to ask staff members for the information.4. The facility will maintain reports of any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility. This information will be available for any individual to review upon request.6. Signs identifying the availability and location of our survey binder and availability of previous survey results are posted throughout the building and public bulletin boards.On 9/10/2025, at 1:46pm, during the Resident Council meeting, residents in attendance stated they did not know where to view the state survey binder. At the conclusion of the Resident Council meeting Surveyor observed the wall where the State Survey binder was indicated to be located. It was not there.On 09/10/2025, at 2:15pm, Surveyor interviewed Nursing Home Administrator (NHA)-A and was told they put the binder up here (indicating the wall where Surveyor previously looked) and it keeps disappearing. Need to figure out how to keep it here without chaining it to the desk.On 09/15/2025, at 10:25am, Surveyor let NHA-A know of concern that the State Survey binder is not readily available for review. NHA stated in June or July they made one and it was carried out of the building, then again in August it was taken. Will have to chain it down because it keeps getting stolen.No additional information was provided as to why the facility did not have the State Survey binder readily accessible to residents, family members and legal representatives.