STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525380	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun Prairie Senior Living	228 W. Main St. Sun Prairie, WI 53590

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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 maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 34 residents who reside in the facility.Surveyor observed cereal spilled on the floor and an open container for storing dry pasta in the kitchen pantry.Surveyor observed milk temperatures to be out of range on room trays being delivered to residents for lunch.Surveyor observed sanitizing solution to test outside of the recommended range for parts per million (ppm) concentration.Surveyor observed male staff to have facial hair and to be working with resident food without hair restraints in place.Surveyor observed a refrigerator for resident snacks to be broken with melted, warm food inside of the refrigerator and freezer. This is evidenced by: Example - Pantry foodSurveyor requested a food safety policy, but the facility was unable to provide one.The Food and Drug Administration (FDA) Food Code 2022, includes in part: Food Storage . Food shall be protected from contamination by storing the Food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .On 03/29/26 at 8:29 AM, Surveyor did an initial tour of the kitchen and observed cereal spilled all over the floor in the panty. Surveyor also observed a clear bin of dry pasta with the lid uncovered. On 3/29/26 at 10:03 AM, Surveyor went through the kitchen again with DFS S (Director of Food Services). Surveyor informed DFS S about the cereal on the floor in the pantry and the uncovered lid on the dry pasta. Surveyor and DFS S walked into the pantry. Most of the cereal had been cleaned up, but there were still some on the floor. DFS S acknowledged this. DFS S also closed the lid on the storage bin of pasta. On 3/31/26 at 4:33 PM, Surveyor shared concerns with NHA A (Nursing Home Administrator), DON B (Director of Nursing), and CSRN O (Clinical Support Registered Nurse). Example - Milk temperaturesSurveyor requested a food safety policy, but the facility was unable to provide one.The Food and Drug Administration (FDA) Food Code 2022, includes in part: 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. Time/Temperature control for safety - food shall be maintained:.(2) At 5 C (41 F) or less.On 3/29/26 at 11:47 AM, Surveyor observed room trays stacked in two carts for residents who want to eat lunch in their rooms. Drinks were on the trays covered with plastic wrap.On 3/29/26 at 12:25 PM, staff members placed food on room trays on one cart and were preparing to take them to resident rooms. [NAME] T took the temperature of food on one of the trays but did not take the temperature of any beverages. Surveyor asked [NAME] T if she could take the temperature of a glass of milk that had been sitting on one of the room trays in the cart. [NAME] T took the temperature of the milk. It was 69 degrees F. [NAME] T indicated that was high and had new milk poured for the tray.On 3/29/26 at 12:27 PM, Surveyor told DFS S (Director of Food Services) about the temperature of the milk being 69 degrees. DFS S said the temperature should be lower. Surveyor asked DFS S to take the temperature of a glass of milk sitting on a tray on the second cart. DFS S took the temperature of the milk. It was 71 degrees. DFS S indicated the temperature was warmer than usual because it didn't come straight from the refrigerator. DFS S discarded the milk and replaced it on two trays on the cart.On 3/30/26 at 1:17 PM, Surveyor interviewed DFS S about the process for preparing room trays for meals. DFS S indicated staff had poured the drinks for the room trays too far in advance and he will revisit the policy with (continued on next page)

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

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

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(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	staff. Staff should be cold holding drinks until they go out. DFS S indicated they often take the temperature of the milk before it goes out. DFS S indicated staff should be taking the temperature of beverages along with trays before they are sent out.On 3/31/26 at 4:33 PM, Surveyor shared concerns with NHA A (Nursing Home Administrator), DON B (Director of Nursing), and CSRN O (Clinical Support Registered Nurse). Example - Sanitizing solutionFacility policy, titled Manual Sanitation, revised 01/2023, states in part: .*First sanitizer bucket will be made at am (morning) shift and then checked every four hours thereafter to ensure it meets the appropriate disinfectant level. Test strips should be used to test that the final concentration of the solution is 150-400 PPM (parts per million). A sanitizer is recommended for sanitizing utensils of surfaces which have direct contact with food, and which cannot be sanitized by immersion in 180 degree F. *75 degrees F 200-300p ppm room temperature (Ultimate Sanitizer). On 3/30/26 at 1:15 PM, Surveyor asked DFS S (Director of Food Services) to demonstrate how to test the sanitizing solution used by the facility. DFS S poured sanitizing solution into a bucket and used a test strip to determine the ppm (parts per million) concentration of the testing solution. DFS S indicated it tested at 500 ppm. Surveyor asked how DFS S knew this was the proper range for the sanitizing solution to be at and he said it is what he was told by the company that oversees the food service staff. Surveyor and DFS S looked at the sanitizing solution bottle (Ultimate Sanitizer) and could not identify if this was the correct ppm concentration. Surveyor asked for the facility's policy.On 3/30/26 at 4:40 PM, Surveyor reviewed the facility policy with DFS S and asked if 500 ppm is in the correct range for the sanitizing solution. DFS S indicated 500 ppm is a little high and said he would be contacting food service management to follow up on this and make adjustments. Surveyor also reviewed a printed electronic log kept by kitchen staff members with DFS S. The log recorded the sanitizing solution ppm as 175 ppm each day. Surveyor asked DFS S who is testing the solution and recording it each day. DFS S indicated the solution is being tested each day, but they do not keep a log of the test results each day. DFS S indicated that number recorded on the log is actually the water temperature. On 4/1/26 at 3:00 PM, Surveyor shared concern with NHA A (Nursing Home Administrator), DON B (Director of Nursing), and CSRN O (Clinical Support Registered Nurse).Example - [NAME] restraintsThe Food and Drug Administration (FDA) Food Code 2022, includes in part: Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed or worn to effectively keep their hair from contacting exposed food .Facility policy, titled [NAME] and Hairnet, revised 7/9/25, states in part: Purpose: The purpose of this policy is to: Beards and mustache hair must be covered while in kitchen food product area. Facial hair restraints are required in any food production area. Facial hair is not exempt from the hair restraining standard. It is up to each campus to define which type of facial hair requires a beard net. Procedure: Some common approaches include: -Cover all beard or mustache hair that is more than 1/8 of an inch growth. -Like hair restraints, facial hair restraints must be worn. -A clean or new guard must be used at the start of each shift.On 3/29/26 at 11:47 AM, Surveyor observed DFS S (Director of Food Services) to be working on the lunch meal preparation without donning a beard restraint to cover his facial hair. On 3/30/26 at 1:11 PM, Surveyor observed [NAME] U preparing food in the kitchen with a beard and no beard restraint in place. [NAME] U applied a beard restraint a few minutes later.On 3/30/26 at 1:17 PM, Surveyor interviewed DFS S and asked what the policy is for covering facial hair with a beard restraint. DFS S indicated the policy is anything over 1/8 of an inch should be covered. Surveyor asked for the facility policy on this. On 3/30/26 at 4:40 PM, Surveyor asked DFS S how 1/8 of an inch is measured for facial hair on employees when determining if they should wear a beard restraint. DFS S said 1/8 of an inch is the first level on a trimming device and said typically staff members are good at being clean shaven and not having facial hair. Surveyor informed DFS S that the general guideline is that all facial hair requires a beard restraint. On 4/1/26 at 1:00 PM, NHA A (Nursing Home Administrator) indicated the facility's policy on beard restraints is what was provided. The facility does not have a more specific policy that it provides to kitchen staff regarding facial hair needing to be covered if it is over (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1/8 of an inch.On 4/1/26 at 3:00 PM, Surveyor shared concern with NHA A, DON B (Director of Nursing), and CSRN O (Clinical Support Registered Nurse). Example - RefrigeratorSurveyor requested a food safety policy, but the facility was unable to provide one.The Food and Drug Administration (FDA) Food Code 2022, includes in part: 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. Time/temperature control for safety - food shall be maintained:.(2) At 5 C (41 F) or less. The freezer equipment should be designed and maintained to keep foods in the frozen state.On 4/1/26 at 1:00 PM, Surveyor inspected a refrigerator in the conference room with a sign indicating it is for resident snacks. Surveyor opened the refrigerator door and observed several packs of melted Jell-O. The refrigerator was running and the temperature inside was warm. The refrigerator emitted a foul odor into the conference room. Surveyor also opened the freezer door and observed individual ice cream cups that appeared unfrozen because the temperature in the freezer was so warm. On 4/1/26 at 1:35 PM, Surveyor interviewed DFS S (Director of Food Services) and ADFS Z (Assistant Director of Food Services) and asked who is responsible for monitoring that refrigerator temperature. DSF S and ADFS Z indicated the resident snack refrigerator had been broken for weeks and they were surprised to hear it was still running with food inside. DFS S and ADFS Z indicated maintenance had been told about this issue and they were supposed to take care of it a long time ago.On 4/1/26 at 2:18 PM, Surveyor spoke with PSA R (Plant Services Assistant). PSA R indicated that kitchen staff had never submitted a work order for the broken refrigerator and that they had just notified him about this issue a few minutes ago.On 4/1/26 at 3:00 PM, Surveyor shared concern with NHA A (Nursing Home Administrator), DON B (Director of Nursing), and CSRN O (Clinical Support Registered Nurse).

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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, interview, and record review, the facility did not ensure each resident had a safe, clean, comfortable, and homelike environment or ensure housekeeping provided necessary services to maintain a sanitary, orderly, and comfortable area for 2 of 16 sampled residents (R4 & R44). R4 reported to Surveyor that their divider curtain was soiled and that their carpet had not been vacuumed. R44 reported that their toilet overflows and no one will fix it. Evidenced by: Facility did not provide a policy on housekeeping. Example 1: R4 was admitted to the facility on [DATE] with diagnoses that include end stage renal disease, congestive heart failure, and type 2 diabetes mellitus. R4's most recent Minimum Data Set (MDS) dated [DATE] states that R4 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating that R4 is cognitively intact. On 3/29/26 at 9:29 AM, Surveyor interviewed R4. R4 reported to Surveyor that their room divider curtain was soiled, and it grosses out their visitors. Surveyor observed the curtain to have several brownish-black spots on it. Surveyor also noted that R4's carpet had debris and smashed popcorn on it. R4 stated that the popcorn was from a couple of days ago. Surveyor asked R4 if their carpet gets vacuumed daily, R4 stated that it didn't get vacuumed yesterday and that they didn't vacuum it yesterday. On 3/30/26 at 12:10 PM, Surveyor observed R4's room. Surveyor noted that the debris and smashed popcorn remained on the floor, and the divider curtain remains stained. On 3/31/26 at 8:41 AM, Surveyor observed R4's room and noted that the area appears to have been vacuumed. On 3/31/26 at 8:48 AM, Surveyor interviewed Hskpr J (Housekeeper). Surveyor asked Hskpr J how often the resident rooms are vacuumed, Hskpr J stated that they are vacuumed everyday and that they had to unclog the vacuum this morning. Surveyor asked Hskpr J what steps they take if a room divider curtain is soiled, Hskpr J stated that maintenance would have to take it down so that it can get washed. Surveyor asked Hskpr J to observe R4's curtain. Surveyor asked Hskpr J if the curtain appeared soiled, Hskpr J stated that it has something on it, but it might be stained. Surveyor asked Hskpr J if the curtain should be replaced, Hskpr J stated yes. On 3/31/26 at 9:28 AM, Surveyor interviewed NHA A (Nursing Home Administrator) in R4's room. Surveyor asked NHA A how often the resident rooms should be vacuumed, NHA A stated daily. Surveyor reported to NHA A that observations were made for 2 days that R4's carpet had not been (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vacuumed. R4 reported to Surveyor and NHA A that they were trying to pick up the debris with their grabber. Surveyor asked NHA A if the room divider curtain appears soiled, NHA A stated yes and that it should be replaced. Surveyor asked if these concerns were promoting a homelike environment, NHA A stated no. Example 2: R44 voiced concerns about the toilet in her bathroom leaking. R44 was admitted to the facility on [DATE] with diagnoses that include spondylosis with myelopathy (compression of the spinal cord that can result in walking instability and weakness), dizziness and giddiness, and rheumatoid arthritis (pain, swelling, and inflammation in the joints). R44's admission Minimum Data Set (MDS) dated [DATE] states that R44 has a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R44 is cognitively intact. On 3/29/26 at 9:10 AM, Surveyor interviewed R44. R44 indicated the toilet in her bathroom had been leaking since 3/19/26 and said there is a puddle on the floor near the front of her toilet every night. R44 indicated she had complained about it eight times to the aides and they have written notes for maintenance and told them about it. R44 indicated maintenance came in to look at her toilet on 3/25/26 but did not fix the issue. On 3/30/26 at 7:25 AM, Surveyor interviewed DPO Q (Director of Plant Operations) and asked him about R44's leaking toilet. DPO Q indicated the hose in the back of the toilet had been pulled out, so it sprayed water when the toilet was flushed. This was adjusted. DPO Q indicated residents can mess with the toilet sometimes and this happens. DPO Q indicated PSA R (Plant Services Associate) went into R44's room last week but didn't find anything else wrong. Surveyor told DPO Q that R44 indicated that nobody had followed up with her on this and it was still an issue. DPO Q indicated PSA R can be quiet around residents, so he would go and talk to her about the issue. On 3/30/26 at 3:14 PM, Surveyor interviewed R44. R44 indicated DPO Q had stopped in her room earlier that day, but the toilet was not leaking at that time and he didn't say anything to her. Surveyor looked at R44's toilet. There was a large puddle of water on the floor surrounding the front of the toilet. On 3/30/26 at 3:30 PM, Surveyor went to get DPO Q so he could look at R44's toilet. DPO Q observed the puddle on the floor, examined the toilet, and told R44 that he would get it fixed as soon as possible. R44 thanked DPO Q for letting her know and told him this has been an issue for nine days. On 3/31/26 at 9:41 AM, Surveyor interviewed CNA V (Certified Nursing Assistant) about R44's toilet. CNA V indicated she has worked with R44 twice and was aware that her toilet was leaking. The first time she worked with her, R44 asked CNA V to check if there was water on her bathroom floor because she was afraid of slipping. CNA V said this happened approximately a week ago and knew maintenance had been notified about the issue. On 3/31/26 at 2:47 PM, Surveyor interviewed LPN M (Licensed Practical Nurse) about R44's toilet. LPN M indicated she submitted a work order on 3/26/26 when she first found out about R44's toilet leaking. LPN M indicated she was unsure if it had been leaking prior to 3/26. On 3/31/26 at 9:49 AM, DPO Q let Surveyor know that he changed the ring on R44's toilet last night (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and checked it again this morning and it wasn't leaking. Surveyor asked when he had been notified that the toilet was leaking. DPO Q indicated staff submitted a maintenance request last week and staff notified the maintenance staff about it when they passed them in the hallway. DPO Q said he would check to see when the maintenance request was submitted, as PSA R had initially done a hose adjustment and tightened the base of R44's toilet. On 3/31/26 at 12:25 PM, DPO Q brought Surveyor a work order for R44's toilet with a due date of 3/26/26. The work order was created that day (on 3/31/26). The work order indicated PSA R had fixed a loose hose tank and tightened R44's toilet base. Surveyor asked if 3/26 was when they were notified about the toilet leaking and DPO Q said yes. On 4/1/26 at 11:50 AM, Surveyor interviewed R44. R44 indicated her toilet was fixed and no longer leaking.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not make prompt efforts to document, investigate, and resolve grievances a resident may have for 1 of 2 residents reviewed for grievances (R26). R26's Activated Power of Attorney (APOA) expressed concerns regarding R26 not getting out of bed for activities and that R26 had a broken wheelchair. The facility failed to provide a written resolution to R26's APOA. Evidenced by:The facility policy titled Resident Concern Process last reviewed 12/16/24 states in part .4. The facility staff will follow these basic steps in response to a complaint: *Listen to the concern without interruption *Thank the person who brought the concern to staff * Apologize to the person bringing the concern and acknowledge that what happened is not our standard * Not make excuses for why or how this has happened * Take steps to correct the problem *Make the problem their own by following up to make sure it is resolved and stays resolved *Any concern that is suspected to be abuse, neglect or misappropriation of funds must be reported immediately to the Executive Director and the Director of Health Services. 5. Enter the concern using the desktop icon labeled Resident Concern Form. All concerns should be entered electronically.7. Follow-up from the department leader will occur within 24-48 with resolution entered in [Facility Program] .9. The department leader will investigate and discuss the concerns with the team and will implement or educate to prevent further concerns. 10. The department leader will document the resolution on the concern form using an addendum when needed and will follow up with the person reporting the concern to explain the solution.14. Resident rights for filing a grievance.* At the conclusion of the investigation for a concern or grievance, the resolution will be documented and shared with the resident or his/her representative. This may be verbal or in writing. R26 was admitted to the facility on [DATE] with diagnoses that include dementia, progressive supranuclear ophthalmoplegia (a rare neurodegenerative disorder characterized by progressive loss of eye movement control, balance issues, and cognitive decline), type 2 diabetes mellitus, and dysphasia, oropharyngeal phase (the inability to swallow food or drink. The condition can also cause breathing difficulties, choking, and drooling). R26's most recent Minimum Data Set (MDS) dated [DATE] states that R26 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating that R26 is cognitively intact. On 3/31/26 at 8:12 AM, Surveyor interviewed APOA K. APOA K reported to Surveyor that they had brought concerns regarding R26 to NHA A (Nursing Home Administrator) and that NHA A does not always return their calls or follow up on concerns. APOA K reported that they expressed concerns about R26 not getting out of bed on 2 Sundays in December (the 21st and the 28th) to attend activities and they left messages for NHA A that weren't returned. On 3/31/26 at 9:21 AM, Surveyor requested any grievances related to R26 and APOA K's concerns. NHA A reported that they believe the concerns were written up as grievances and would provide the investigations to Surveyor. NHA A provided Surveyor with a spreadsheet of grievances for the month of December. The document contained: R26 name, Concern date: 12/28/25, Nature of concern: Daughter upset that resident was not up for activities. Wheelchair was noted by staff that a part was broken. [Hospice Agency] was called to come out and evaluate chair. Dissatisfaction level: Concerned, Date entered: 12/28/25, Resolution: Satisfactorily- Hospice came in and replaced wheelchair that was broken. Resolution date: 12/28/25, resolution date entered: 12/29/25, Social Services Review: yes, Comments: working on establishing date for care conference with daughter, Date resolution entered: 12/29/25. It is important to note, there was no grievance filed regarding APOA K's concerns on 12/21/25. On 4/1/26 at 10:01 AM, Surveyor interviewed NHA A. Surveyor asked NHA A what the facility's process was for grievances, NHA A stated that the facility has an online forum and a paper forum for submitting concerns and that if staff receives a concern, they will enter it there right away. Surveyor asked NHA A if there was an investigation into why R26 was not gotten up for activities, could staff have provided R26 with an (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alternate wheelchair, was R26 interviewed, was staff interviewed, and did they contact the daughter regarding their concerns, NHA A stated that they were usure about the investigation. Surveyor asked NHA A if they provided R26's APOA with a written resolution, NHA A stated no.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately to the administrator of the facility and to other officials, including the State Survey Agency, in accordance with State law through established procedures for 1 of 16 Residents (R43) reviewed for abuse.R43 and FM G (Family Member) reported an allegation of abuse and the facility did not submit a report to the State Agency (SA).Evidenced by:The facility's Abuse and Neglect Procedural Guidelines policy, dated 8/29/19, states, in part: Facility has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. 1. The facility has implemented processes in an effort to provide a comfortable and safe environment. 2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures. 3.a. Verbal Abuse-verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. i. Staff to resident-any episode;.c. Mental/Emotional Abuse-mental abuse if the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. d. Identification.ii. Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal.iv. IMMEDIATELY notify the Executive Director.ii. The Executive Director is responsible for: 1. Notification to the State Department of Health (per State guidelines) and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies, as indicated.g. Reporting/response i. Any staff member, resident, visitor or resident representative may report known or suspected abuse, exploitation, neglect, or misappropriation to local or state agencies. ii. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.R43 admitted to the facility 2/20/26. R43's Minimum Data Set (MDS) dated [DATE] indicates a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident is cognitively intact.On 3/31/26 at 2:10 PM, Surveyor interviewed R43 and FM G (Family Member). R43 stated that two nights ago, around 3:00 AM, a CNA (Certified Nursing Assistant) was in the room and stated, You're trouble. When I speak, you don't speak. FM G stated the CNA's comments were reported to DSS E (Director of Social Services) earlier today.On 4/1/26 at 9:50 AM, Surveyor interviewed R43 who stated, it didn't feel too good. I didn't understand why I would be called trouble and her saying ?you don't speak when I'm speaking'; I just shut up, but I didn't know how I'd explain what I needed. I am at their mercy.On 4/1/26 at 8:25 AM, Surveyor interviewed DSS E who stated she was aware of the concern yesterday (3/31/26) and investigation had been started by LPN D (Licensed Practical Nurse), as LPN D knew who was working.On 4/1/26 at 8:45 AM, Surveyor interviewed LPN D and NHA A (Nursing Home Administrator). LPN D stated I heard 3rd hand that the son had made a comment about a staff member concern. LPN D stated she did not recall the exact comment but had reached out to the two staff members who were scheduled to see if they had conversation with the resident. NHA A stated I was told that R43 didn't like the staff member's approach. NHA A indicated being unaware of the comment that was reported by R43 / FM G. Surveyor asked NHA A if this comment could be considered abuse. NHA A (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated it depends on the context. Surveyor asked how that would be determined. NHA A stated through interview of the resident. Surveyor asked if the resident was interviewed. NHA A stated no, I was unaware that this comment was made. I wasn't fully aware of the concern. Surveyor asked if NHA A would expect to be made aware. NHA A stated yes, I heard from AC F (Admissions Coordinator) that there was a concern with approach. Surveyor asked if the concern was reported to State Agency. NHA A stated no.On 4/1/26 at 9:04 AM, Surveyor interviewed AC F who stated I was with DSS E when FM G reported. I felt like it should be escalated. I went to LPN D. Anytime there is a concern with a resident it should be taken to management for resident comfort and safety. Surveyor asked if the comment was potentially abuse. AC F stated, I would say that is not any way that I would want someone speaking to my mother. I gave the statement information to LPN D. I believe that NHA A was aware.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure it had evidence that an alleged violation was thoroughly investigated for 2 of 16 Residents (R27 and R34) reviewed for abuse. Facility did not thoroughly investigate an allegation of abuse (resident-to-resident) for R27 and R34. Evidenced by: Facility Policy entitled 'Abuse, Neglect and Exploitation Procedural Guidelines, states in part: .The facility has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Procedures: The facility has implemented processes in an effort to provide a comfortable and safe environment. The Executive Director (also known as NHA A, Nursing Home Administrator) and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures. Physical Abuse - includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Resident to resident abuse with or without cause. Investigation: The Executive Director is accountable for investigating and reporting; iii. Investigating different types of alleged violations; iv. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation. V. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause. No documentation was provided to show that other residents or responsible parties were interviewed to see if others may have been affected. R27 was admitted to the facility on [DATE] with diagnoses including stroke (blood flow to the brain is blocked or a vessel bursts), hemiparesis (one sided body weakness). R34 was admitted to the facility 4/9/25 with diagnoses including stroke, chronic encephalopathy (brain damage that causes confusion, altered mental status and personality changes, seizures), cerebral ischemia (reduced blood flow reduces oxygen to the brain), unspecified convulsions (symptom of seizure), and major depressive disorder (persistent sadness) Self-Report Date Occurred: 12/31/25Date Discovered: 12/31/25Describe the Incident: R34 made contact with the top of R27's head. Residents (R34 and R27) were immediately separated. R27's skin assessment completed with no new findings noted. R27 denies any pain or injury from incident. Investigation initiated and interventions put in place to keep residents apart. Describe the Effect: R27 denied any pain or injury - immediately separated Explain what steps the entity took upon learning of the incident: Residents separated immediately Summary of Investigation: On the above date and approximate time, an incident occurred in the dining room prior to the evening meal involving Resident 34 (R34) and Resident 27 (R27). The residents were observed engaging in their usual bantering and playful teasing, which staff report has historically been harmless and reciprocal. During this interaction, R34 tapped R27 on the back of his head. Staff were present in the dining room at the time of the incident and immediately intervened, separating both residents and redirecting them to ensure physical and psychosocial safety. No further physical contact occurred. Due to the nature of event an investigation was immediately initiated, and initial report was made to DQA (Division of Quality Assurance) per CMS (The Centers for Medicare and Medicaid Services) guidelines Head-to-toe assessment was completed on R27 with no injuries, bruising, swelling or neurological changes noted. R27 denied any physical or emotional pain or discomfort following the incident. NHA A (Nursing Home Administrator), attending medical providers, and emergency contacts were notified promptly. New orders obtained for neurological monitoring every shift for three days for R27 with no abnormal findings noted. Psychosocial monitoring was initiated and remains ongoing. R27 indicates he feels safe in the facility and expresses no concerns or fear regarding R34. He denied pain or distress related to the incident. R34 did not express intent to harm and was redirected appropriately at the time of the incident. A review of R34's medical and psychiatric history was completed as part of the investigation. R34 has a documented history of chronic encephalopathy (brain damage that causes confusion, altered mental state and personality changes, seizures), cerebral ischemia (reduced blood (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	flow reduces oxygen to the brain), unspecified convulsions (symptom of seizure), and major depressive disorder (persistent sadness). Psychiatric provider documentation indicates poor judgement, poor limited insight, poor impulse control, flight of ideas, and tangential thought process. R34 remains under the care of Behavioral Care Solutions (psychiatric provider). Psychiatric provider updated on the incident and request was made for further psychiatric assessment with further recommendations if indicated. The incident was isolated and brief, with immediate staff intervention. Upon investigation it is noted that R34 and R27 reported feeling safe. Staff supervision was present and appropriate at the time of the incident. R34's cognitive and psychiatric impairments may have contributed to impaired impulse control. Care plans for both residents were reviewed and updated to reflect the incident along with individualized interventions. Increased monitoring and redirection strategies were reinforced for Resident A, particularly during social interactions. Education initiated regarding de-escalation techniques, early identification of escalating, and redirection strategies. Based on thorough investigation, this incident was promptly identified and addressed, with appropriate interventions implemented to ensure resident safety. No injuries occurred, and the affected resident reports feeling safe in the facility. The facility took immediate and appropriate action consistent with CMS (The Centers for Medicare and Medicaid Services) regulations to prevent recurrence, address contributing factors, and protect the physical and psychosocial well-being of all residents. Two staff members, RN H (Registered Nurse) and LEA I (Life Enrichment Associate) witnessed the resident-to-resident incident.RN H signed the following typed statement: On Wednesday 12/31/25 R27 was sitting in his electric wheelchair at the dinner table. R34 stood up from her wheelchair and popped him on his head. As I (RN H) looked up while watching another resident taking her pills-R34 was standing up over R27. I (RN H) stated, (R34's name), don't do that. R27 told her, What the hell, do not touch me. I (RN H) immediately checked R27 head to toe-there were no related bruises or scratches noticed. I (RN H) notified the NP (Nurse Practitioner) right away as well as his family member. On 3/29/26 at 9:50 AM, Surveyor spoke with R27. R27 stated he does not recall this incident and feels safe at the facility. On 3/29/26 at approximately 10:00 AM, Surveyor spoke with R34. R34 does not recall this incident and feels safe at the facility. On 3/31/26 at 3:05 PM, Surveyor called RN H. Surveyor requested RN H return the phone call. RN H did not return Surveyor's phone call. LEA I (Life Enrichment Associate) signed the following typed statement: On Wednesday 12/31/25 at dinner, R34 went up behind R27 and tapped him on the back of his head multiple times. RN H and LEA I told R34 to stop what she was doing and redirected her back to her table. LEA I later provided education to R34 regarding her actions and told her that is was [sic] not appropriate and she cannot continue to do those things. On 3/31/2026 3:10 PM, Surveyor spoke with LEA I. Surveyor asked LEA I to describe the resident-to-resident incident she witnessed in the dining room. LEA I stated, R34 came up behind R27 and started hitting him on top of the head with her open hand. LEA I stated she and RN H witnessed it and right away separated R34 from R27. LEA I stated we (LEA I and RN H) advised R34 that this was not the right thing to do. Surveyor asked LEA I to demonstrate how R34 hit 27. LEA I stated it wasn't a tap it was a smack. LEA I demonstrated that R34 hit R27 hard on the head with her open palm. LEA I stated, R27 was wearing a baseball hat at the time. LEA I stated, R34 and R27 do not attend activities together and staff keep them separated. LEA I stated, she has not seen R34 become escalated or make physical contact with any other residents. It is important to note, the facility interviewed R34 and R27 however, the facility did not interview other residents to determine to scope of the issue. On 4/01/26 at 7:55 AM, Surveyor spoke with NHA A (Nursing Home Administrator). NHA A has worked at the facility for three (3) months. NHA A stated, this incident occurred right after she started working at the facility. NHA A stated, she was notified that R34 approached R27 from behind and tapped R27 on the back of the head. LEA I intervened immediately and RN H assessed. NHA A stated, no concerns were noted with R27 and he feels safe at the facility. Surveyor asked NHA A, if the facility interviewed other residents to determine the scope of the concern. NHA A stated, no. Surveyor asked NHA A if she should have interviewed other residents to (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determine the scope of the concern with R34. NHA A stated, no, because the incident was a resident-to-resident incident, so she only interviewed R27. NHA A stated, she was not aware she should have interviewed other residents to determine the scope of this concern. This is not a thorough investigation.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the assessments must accurately reflect the resident's status for 1 of 16 residents' (R5) Minimum Data Sets (MDS) reviewed for accuracy. R5's MDS dated [DATE] does not have her pressure injury (PI; localized damage to skin and underlying tissue caused by prolonged pressure) coded correctly. This is evidenced by: The Facility does not have a Policy and Procedure for MDS accuracy. The Facility follows the Resident Assessment Instrument (RAI) manual. Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/23, documents the following, in part: .The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR (Code of Federal Regulations) 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status . On 7/16/25 Hospice identified, assessed and measured R5's PI's as follows: Pt (patient) now has a 9.0 x 17.3 cm (centimeter) open area that at the coccyx has undermining at 7-9 o'clock with a depth of 2.1 cm with the left buttock having 2 (two) necrotic areas, and the right buttock as 2 necrotic , slough present to coccyx area. On 7/16/25 R5's Nurse Practitioner assessed and documented the following PIs (pressure injuries):Decubitus ulcer of coccyx, unstageableDecubitus ulcer of left buttock, unstageableDecubitus ulcer of right buttock, stage 3 R5's current Physician Orders includes, in part, as follows: 2/11/26 Bilateral buttocks/coccyx: Cleanse with wound cleanser, pat dry, loosely pack .25% Dakins moistened gauze into wound leave a tail exposed, cover tail with one sheet of collagen. Apply Optilock. Apply sure prep (skin prep) to surrounding peri wound. Secure with zinc oxide tape. Change daily and PRN (as needed). Special Instructions: May overlap dressings to cover coccyx area. R5's MDS dated [DATE] documents the following, in part: .Section M . M0210 Unhealed Pressure Ulcer/Injury marked .NO . On 4/1/26 at 3:05 PM, Surveyor spoke with Clinical Support RN O (Registered Nurse). Surveyor asked Clinical Support RN O, would you expect MDS's to be completed accurately, Clinical Support RN O stated, yes. Surveyor asked Clinical Support RN O, should R5's MDS document her PI's. Clinical Support RN O stated, yes.

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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 follow through with the appropriate steps of the Preadmission Screening and Resident Review (PASRR) process for 1 of 5 residents (R43) reviewed for PASRR screening. R43 did not have a PASRR Level I (1) completed. This is evidenced by: The facility provided the Wisconsin Department of Health Services Forward Health Update, volume 2023-37, dated 11/2023, for their PASRR policy. The Forward Health Update states, in part: Federal regulations.require that all individuals seeking admission to a Medicaid-enrolled nursing facility be screened to determine the presence of a major mental illness and/or developmental disability. Nursing facilities fulfill this requirement by conducting a preadmission Level I screen for anyone who meets the definition of a ?new admission.'. R43 was admitted to the facility on [DATE], was on hospital leave from 2/21/26-3/20/26, and readmitted to the facility on [DATE], with diagnoses that include Parkinson's disease (neurological disorder affecting movement), depression, and insomnia due to other mental disorder. Surveyor requested PASRR documentation for R43. On 4/1/26 at 1:00 PM, NHA A (Nursing Home Administrator) indicated they were unable to locate a PASRR on file for R43. On 4/1/26 at 1:30 PM, Surveyor asked DON B (Director of Nursing) if a PASRR should have been completed for R43. DON B indicated if it is in the facility's policy, it should have been completed.

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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 that a resident who is unable to carry out activities of daily living (ADLs) receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene for 2 of 5 sampled Residents (R4 & R41).R4 reported that they have only had 1 shower since their admission to the facility.R41 reported that they have only had 1 shower since their admission to the facility. R41 has facial hair that is approximately 1/4- 1/2 long and facility staff has not shaved R41.Evidenced by:The facility does not have a policy for ADLs (Activities of Daily Living).Example 1R4 was admitted to the facility on [DATE] with diagnoses that include end stage renal disease, congestive heart failure, and type 2 diabetes mellitus.R4's most recent MDS (Minimum Data Set) dated 2/25/26 states that R4 has a BIMS (Brief Interview of Mental Status) of 15 out of 15, indicating that R4 is cognitively intact. R4's MDS also states that R4 requires substantial/maximal assistance for showering/bathing.R4's care plan dated 2/17/26 states in part .Problem: Profile Care Guide Goal: To communicate resident care needs Approach: .Showers: TWICE WEEKLY PER SCHEDULE AND PRN (as needed) .Transfers: One Assist.The facility's Shower Schedule states that R4 is scheduled to have a shower on Friday AM shift.R4's Point of Care History states that R4 only received a shower on 2/28/26.On 3/29/26 at 9:26 AM, Surveyor interviewed R4. Surveyor asked R4 if they were getting their showers as scheduled, R4 stated no, and that they have only had 1 shower since admission.Example 2R41 was admitted to the facility on [DATE] with diagnoses that include malignant neoplasm of prostate (prostate cancer), dementia, and anxiety.It is also important to note that R41 is missing 3 fingers on their left hand, only has partial thumb and partial 5th digit.R41's care plan dated 3/20/26 states in part .Problem: Profile Care Guide Goal: To communicate resident care needs. Approach: .Showers: TWICE WEEKLY PER SCHEDULE AND PRN (as needed) Transfers: One Assist.The facility's Shower Schedule states that R41 is scheduled to have a shower on Saturday PM shift.R41's Point of Care History states that R41 has not had a shower since their admission to the facility.On 3/29/26 at 9:14 AM, Surveyor interviewed R41. Surveyor observed that R41 had 1/4-1/2 facial hair. Surveyor asked R41 if they were getting their showers as scheduled, R41 stated that they believe that they have had one shower but was not sure. Surveyor asked R41 if they liked the whiskers on their face, R41 stated no but no one is shaving them, and they can't do it themselves.On 3/30/26 at 1:51 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B how many showers R4 and R41 have had, DON B stated that from reviewing the documentation, R4 has had 1 shower since admission, and there is no documentation of R41 receiving a shower. Surveyor asked DON B if residents should have showers as scheduled, DON B stated yes. Surveyor asked DON B how often residents should be shaved, DON B stated that they were unsure.On 3/30/26 at 2:00 PM, Surveyor interviewed CNA P. Surveyor asked CNA P how often residents get shaved, CNA P stated anytime they ask or everyday as part of their ADLs. Surveyor asked CNA P if they knew the last time R41 was shaved, CNA P stated that they did not know. Surveyor asked CNA P who got R41 up this morning, CNA P stated that they did. Surveyor asked if R41 was shaved today, CNA P stated no. Surveyor and CNA P went to observe R41, who still had long whiskers. Surveyor asked CNA P if they noticed R41's whiskers when they got them up, CNA P stated no.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that the resident environment remains as free of accident and hazards as possible for 2 of 4 sampled residents (R27 & R26). Surveyor observed R27's motorized wheelchair (Motorized Assistive Devices) being charged in the conference room. NHA A (Nursing Home Administrator) states the wheelchair should be charged in the Conference Room. Surveyor observed the Conference Room to not have a fire safe door. R26 has an order to be supervised at meals. The facility was not providing supervision with breakfast. Evidenced by The facility did not have a policy for charging electric wheelchair batteries. The facility also did not have a policy for Motorized Assistive Devices. On 3/31/26 at 8:30 AM, Surveyor observed R27's wheelchair battery charging in the conference room while Surveyors were in the conference room. On 3/31/26 at 8:37 AM, Surveyor asked NHA A (Nursing Home Administrator) to walk to conference room with Surveyor. Surveyor showed NHA A the battery charging. NHA A stated, this is R27's battery for his wheelchair. Surveyor asked NHA A if the battery should be charged behind a fire-proof door. NHA A stated that batteries should not be charged in resident areas but she is unsure if they need to be charged behind a fire-proof door. NHA A stated, residents do not utilize the conference room. NHA A stated, she will check the facility policy and get back to Surveyor. Surveyor reviewed the facility's March Activity Calendar. The facility's Activity Calendar further demonstrates the conference room is utilized by residents for the following: (3/1, 3/8, 3/15, 3/22, 3/29/26) Book Club each Sunday 3/16/26 Absentee Voting: Spring Election (3/3, 3/10, 3/17, 3/24, 3/31/26) Bible Sharing each Tuesday On 3/31/26 at 8:55 AM, R27 entered the conference room and stated his family member is bringing him dinner tonight and will have her dog. R27 stated they are going to use the conference room. R27 inquired what time Surveyors would be done today. Of note: This further demonstrates that residents utilize the conference room. On 3/31/26 at 9:25 AM, NHA A (Nursing Home Administrator) stated the facility does not have a policy regarding charging batteries. Surveyor asked NHA A, why it is important to charge batteries behind a fire proof door. NHA A stated, in case it was to explode it is isolated and fumes can be harmful to residents and personnel. Surveyor asked NHA A what the room is called where the battery is located. NHA A stated the conference room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 2 R26 was admitted to the facility on [DATE] with diagnoses that include dementia, progressive supranuclear ophthalmoplegia (a rare neurodegenerative disorder characterized by progressive loss of eye movement control, balance issues, and cognitive decline), type 2 diabetes mellitus, and dysphasia, oropharyngeal phase (the inability to swallow food or drink. The condition can also cause breathing difficulties, choking, and drooling). R26's most recent MDS (Minimum Data Set) dated 2/6/26 states that R26 has a BIMS (Brief Interview of Mental Status) of 15 out of 15, indicating that R26 is cognitively intact. R26's physician's order dated 7/28/25 states OT (Occupational Therapy) evaluated: use built up handle utensils (spoon and fork) during mealtimes supervision required for spilling. Three times a day. R26's care plan dated 3/27/23 states in part .Problem: Profile Care Guide Goal: To communicate resident care needs. Approach: .Approach start date: 6/6/25 Eating: Use built up handle utensils (spoon and fork) during mealtimes. Supervision with all meals for safety. On a regular mechanical soft diet with no straws. R26's Dining/Eating Assistance Needed assessment dated [DATE] states in part: .Eating assistance – Indicate resident's current ability to eat meals: Needs frequent cueing with meal. Current fluid consistency: Nectar. Complicated eating problems- Check all that apply: Difficulty swallowing, Recent episode of coughing or choking while eating. Surveyor's observations: 3/30/26: 8:53 AM: meal tray brought into R26's room. 8:55 AM: CNA (Certified Nursing Assistant) left resident's room to get a clothing protector and returned to resident's room 8:56 AM: CNA left resident's room. 3/31/26: 8:31 AM: LPN took meal tray to resident's room. 8:34 AM: LPN left resident's room. 8:35 AM: Surveyor went into R26's room, no staff supervision while R26 eats breakfast. On 3/31/26 at 8:12 AM, Surveyor interviewed APOA K (Activated Power of Attorney). APOA K reported to Surveyor that R26 needs thickened liquids and no straws, but when they were visiting, R26 had thin liquids and straws. APOA K also reported that R26 eats lunch and dinner in the dining room, so R26 is supervised, but always eats breakfast in their room unsupervised and R26 is at risk for choking and pocketing food due to their diagnosis. Surveyor asked APOA K if R26 has had any choking incidents, APOA K stated no. (continued on next page)

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	525380	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun Prairie Senior Living	228 W. Main St. Sun Prairie, WI 53590

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/26 at 8:54 AM, Surveyor interviewed CNA V. Surveyor asked CNA V how often they supervise R26 while eating breakfast, CNA V stated that they were unaware that R26 required supervision until today. On 3/31/26 at 8:57 AM, Surveyor interviewed CNA W. Surveyor asked CNA W if they were familiar with R26, CNA W stated yes. Surveyor asked CNA W how often R26 eats breakfast in their room, CNA W stated every day. Surveyor asked CNA W how they are supervising or watching them eat, CNA W stated that they do frequent checks on them. Surveyor asked CNA W if they are in the room supervising, CNA W stated that they are in the room for a few minutes to make sure R26 is eating. On 3/31/26 at 2:25 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if a resident is supposed to have supervision with meals, would they expect staff to remain with the resident until they are done eating, DON B stated yes. Surveyor asked DON B if staff should be dropping off the resident's tray and leave the room, DON B stated no.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure a resident who requires BiPAP respiratory support was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 1 of 1 resident (R4) reviewed with BiPAP.R4 was admitted to the facility with an order for BiPAP; the order was never transcribed and R4 has not received the BiPAP since admission.Evidenced by:The facility does not have a policy for respiratory care.R4 was admitted to the facility on [DATE] with diagnoses that include end stage renal disease, congestive heart failure, OSA (Obstructive Sleep Apnea), and type 2 diabetes mellitus.R4's most recent MDS (Minimum Data Set) dated 2/25/26 states that R4 has a BIMS (Brief Interview of Mental Status) of 15 out of 15, indicating that R4 is cognitively intact.R4's hospital discharge orders dated 2/2/26 state in part .BiPAP/NPPV (Bilevel positive airway pressure/Non-invasive positive pressure ventilation) Order Comments: Full mask- Use all night and when napping. Order specific questions: Equipment: Home. Bleed in oxygen (LPM (Liters per Minute): 2. IPAP (cm H2O (Inspiratory Positive Airway Pressure) is a critical component of non-invasive ventilation, measured in centimeters of water, used to assist patients with respiratory issues): 16. EPAP (cm H2O (Expiratory Positive Airway Pressure measured in centimeters of water): 12.It is important to note that R4's BiPAP orders were not transcribed at the facility, therefore, R4 has not been using BiPAP at the facility.R4's care plan dated 2/2/26 states in part .Problem: [R4] requires use of: BiPAP d/t (due to): OSA. Goal: Resident will tolerate use of (BiPAP/CPAP/Trilogy Vent) without complications.It is important to note that all Approaches (interventions) were added to R4's care plan on 3/31/26.On 3/29/26 at 9:29 AM, Surveyor interviewed R4. Surveyor noted that R4's BiPAP machine was sitting on the floor. Surveyor asked R4 if their BiPAP machine is always on the floor, R4 stated yes, because they haven't set it up yet. Surveyor asked R4 if they are supposed to wear it every night, R4 stated yes, and it's supposed to be connected to oxygen.On 3/30/26 at 1:19 PM, Surveyor interviewed LPN X (Licensed Practical Nurse). Surveyor asked LPN X if R4 uses their BiPAP, LPN X stated that when R4 first admitted to the facility, they refused it, but they would have to check with the night shift nurse to see if they're using it. Surveyor asked LPN X if R4 refused the BiPAP, would that be documented, LPN X stated that it should be.On 3/30/26 at 1:21 PM, Surveyor interviewed DON B (Director of Nursing), CSRN O (Clinical Support Registered Nurse), and IP/WN C (Infection Preventionist/Wound Nurse). Surveyor asked DON B what they can tell about R4's BiPAP, DON B stated that they know that R4 wears a BiPAP at night. IP/WN C stated that R4 refuses BiPAP. Surveyor asked if R4's physician had been updated on their refusals, DON B stated they would have to look. Surveyor asked why R4's BiPAP machine is on the floor, IP/WN C stated that R4 puts the machine on the floor. Surveyor asked if R4 had an order for BiPAP, CSRN O stated that they did not see an order. Surveyor reviewed R4's hospital discharge orders with staff. Surveyor asked if R4 should have an order for BiPAP, CSRN O stated yes.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that a resident who requires dialysis receives such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 1 sampled resident (R4) reviewed for dialysis. R4 receives dialysis and the facility staff were not fluent in the emergency plan for a resident bleeding from their dialysis access site. This is evidenced by: The facility's policies titled Pre-Dialysis Patient Assessment and Post-Dialysis Assessment dated 12/1/2022 does not include an emergency plan. According to Clinical Journal of the American Society of Nephrology article titled Diagnosis, Treatment, and Prevention of Hemodialysis Emergencies dated February 2017, .Vascular Access Hemorrhage: Hemorrhage from an AV access is an uncommon but potentially fatal complication if it is not recognized promptly and acted on with an appropriate intervention. Most fatal vascular access hemorrhages occur outside of the dialysis facility, but occasionally, they rupture at the dialysis unit (120). Patients and their families should be educated about the recognition and emergent management of a bleeding AV access. In the event of bleeding from vascular access site, direct continuous pressure with a finger for 15-20 minutes is the most effective method of controlling the bleeding. In the event of rupture of a PSA or aneurysm away from dialysis unit or hospital, direct pressure with a finger at the site of bleeding is the best method of controlling bleeding. Patients should be advised to continue holding direct pressure until emergency medical help arrives and avoid applying a tourniquet, towel, or BP cuff to the extremity. https://journals.lww.com/cjasn/fulltext/2017/02000/diagnosis,_treatment,_and_prevention_of.20.aspx R4 was admitted to the facility on [DATE] with diagnoses that include end stage renal disease, congestive heart failure, OSA (Obstructive Sleep Apnea), and type 2 diabetes mellitus. R4 attends dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to) on Mondays, Wednesdays, and Fridays.R4 has a CVC (central venous catheter, a flexible tube inserted into a large vein to provide immediate vascular access for hemodialysis) access site to their right upper chest.R4's care plan dated 2/17/26 states in part: .Problem: Resident has an IV (Intravenous) access site for dialysis. Goal: Resident will not exhibit signs of complications from IV. Approach: Assess for complication from IV (localized infection, systemic infection, electrolyte imbalance, air embolus, dislodgement, infiltration, phlebitis, fluid overload, dehydration) Q (every) shift and PRN (as needed). IV access care as ordered. Notify physician of any complications. Observe IV site for swelling, redness, tenderness, and warmth.It is important to note that R4's care plan does not include an emergency plan for a resident bleeding from their dialysis access site. Additionally, R4's physician orders do not include monitoring of dialysis site, nor instructions for staff regarding an emergency plan. On 3/30/26 at 2:53 PM, Surveyor interviewed CNA Y (Certified Nursing Assistant). Surveyor asked CNA Y what steps they would take if they noticed that R4 was bleeding from their dialysis site, CNA Y stated that they would go get the nurse, put on PPE (Personal Protective Equipment), and assist the nurse. On 3/30/26 at 2:53 PM, Surveyor interviewed LPN M (Licensed Practical Nurse). Surveyor asked LPN M what steps they would take if they noticed that R4 was bleeding from their dialysis site, LPN M stated they would make sure the resident is stable, call the provider to see what to do next, and if a RN (Registered Nurse) was available, they would go get them, and then they would do their best to stop it. On 3/30/26 at 2:58 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what steps they would expect staff to take if they noticed that R4 was bleeding from their dialysis site, DON B stated that they would expect staff to apply pressure and don't let go, call for help, dial 911 and send them to the hospital. Surveyor asked DON B if monitoring of R4's dialysis site should be on the MAR/TAR (Medications Administration Record/ Treatment Administration Record), DON B stated yes.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 (R33) resident based on the review of medication storage in 2 of 3 medication carts.R33 was given oxycodone after the printed expiration date on the medication card.This is evidenced by:The facility's policy, titled General Guidelines for Administration of Medication, effective 12/1/22, states in part: Purpose: To maintain the safety and comfort of the patient regarding the administration of medication. Procedure:.20. Expiration dates for all medication in inventory are recorded and the inventory must be monitored on a monthly basis. This ensures that medication is replaced prior to the expiration date.R33 was admitted to the facility on [DATE] with diagnoses that include encephalopathy (group of conditions that cause brain dysfunction), pain in left hip, and generalized anxiety disorder.R33's physician orders include the following: 1/16/26: Oxycodone - schedule II (2) tablet; 5 mg; amt: 2.5 mg; oral. Every 12 hours - PRN (as needed). On 3/30/26 at 4:00 PM, Surveyor observed the medication cart for rooms 18-46 with RN L (Registered Nurse). Surveyor noted that R33's oxycodone (5 mg tablets) had an expiration date of 3/16/26. There were three oxycodone tablets remaining in the package.RN L confirmed that the oxycodone tablets had expired and should not be in circulation and asked LPN M (Licensed Practical Nurse) to dispose of them with her.R33's Medication Administration Record (MAR) for March 2026 indicates the oxycodone was administered to R33 on 3/19/26 at 3:05 AM and on 3/20/26 at 11:03 PM. On 3/31/26 at 2:25 PM, Surveyor interviewed DON B (Director of Nursing) and CSRN O (Clinical Support Registered Nurse). CSRN O indicated that the pharmacy comes into the facility, audits medications, and disposes of expired medications. Random checks for expired medications are also done by nursing staff. CSRN O indicated nursing staff informed them about the two expired medications that were found in the cart. CSRN O indicated pharmacy staff had been in the facility the week before to go through medication cards, but they must have missed the two expired medications that were found. CSRN O and DON B indicated they would expect both expired medications to have been disposed of.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and interview, the facility did not ensure that all drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles for 2 residents (R5 and R33) based on the review of medication storage in 2 of 3 medication carts.R5's lorazepam tablets were expired.R33's oxycodone tablets were expired.This is evidenced by:The facility's policy, titled Medication Storage, revised on 11/1/22, states in part: .6. SOP (Standard Operating Procedure) Details. E. Inspection of Storage Areas i. The pharmacy must inspect every medication in the pharmacy on a monthly basis for expiration dating, package integrity and storage area cleanliness. ii. Outdated or otherwise unusable medications must be immediately pulled from active inventory and segregated to an area to prevent unintentional use.Example 1On 3/30/26 at 4:00 PM, Surveyor observed the medication cart for rooms 18-46 with RN L (Registered Nurse). Surveyor noted that R5's lorazepam (0.5 mg tablets) had an expiration date of 1/17/26. There were 14 lorazepam tablets remaining in the package.RN L confirmed that the lorazepam tablets had expired and should not be in circulation and asked LPN M (Licensed Practical Nurse) to dispose of them with her.Example 2On 3/30/26 at 4:00 PM, Surveyor observed the medication cart for rooms 18-46 with RN L (Registered Nurse). Surveyor noted that R33's oxycodone (5 mg tablets) had an expiration date of 3/16/26. There were three oxycodone tablets remaining in the package.RN L confirmed that the oxycodone tablets had expired and should not be in circulation and asked LPN M (Licensed Practical Nurse) to dispose of them with her.On 3/31/26 at 2:25 PM, Surveyor interviewed DON B (Director of Nursing) and CSRN O (Clinical Support Registered Nurse). CSRN O indicated that the pharmacy comes into the facility, audits medications, and disposes of expired medications. Random checks for expired medications are also by nursing staff. CSRN O indicated nursing staff informed them about the two expired medications that were found in the cart. CSRN O indicated pharmacy staff had been in the facility the week before to go through medication cards, but they must have missed the two expired medications that were found. CSRN O and DON B indicated they would expect both expired medications to have been disposed of.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 1 of 1 Resident (R24) observed for wound care and 1 of 1 Resident (R35) on transmission based precautions. IP/WN C (Infection Preventionist / Wound Nurse) had breaches in infection control when IP/WN C did not perform hand hygiene after cleansing R24's wound prior to touching clean dressings. R35's is on contact precautions; staff removed a used cup from R35's room. Evidenced by: The facility's Guideline for Handwashing/Hand Hygiene policy, dated 11/18/25, states, in part: The purpose of this policy is to: Handwashing is the single most important factor in preventing transmission of infections. Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). 1. All health care workers shall utilize hand hygiene frequently and appropriately.3. Health Care Workers shall use hand hygiene at times such as: .d. after removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc. The facility's Guidelines for General Wound and Skin Care policy, dated 5/10/17, states, in part: 1. Wash hands before and after resident contact. Observe standard precautions. Important to note: this policy does not include specific directive for when glove change and hand hygiene is needed during a dressing change. Example 1 On 3/30/26 at 10:34 AM, Surveyor observed IP/WN C perform wound care for R24. IP/WN C cleansed, rinsed, and dried the wound, applied skin prep to the periwound (intact skin around the wound) and inserted Collagen into the wound bed. IP/WN C removed gloves, applied a new set of gloves, and applied a bordered dressing. *Important to note: there was no glove change and hand hygiene between cleansing the wound and applying the skin prep / inserting the collage and there was no hand hygiene with the glove change prior to applying the bordered dressing. On 3/30/26 at 10:44 AM, Surveyor interviewed IP/WN C and asked about infection control with wound care. IP/WN C stated need to follow Enhanced Barrier Precautions, do frequent handwashing and glove changes. Hand hygiene/glove change is needed before you begin, after removing dressing, after cleaning, after measurement; anytime going from dirty to clean. Surveyor asked if IP/WN C had changed gloves/performed hand hygiene after cleansing R24's wound. IP/WN C stated no, I should've before the collagen was inserted. Surveyor asked if IP/WN C had performed hand hygiene when gloves were changed prior to applying the bordered dressing. IP/WN C stated no, I should've had sanitizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/26 at 1:49 PM, Surveyor interviewed DON B (Director of Nursing) and asked about infection control with wound care. DON B stated gloves are considered contaminated after cleansing a wound and glove change with hand hygiene is needed after cleansing, prior to applying the treatment. DON B stated hand hygiene is needed after removal of gloves prior to applying new gloves. Example 2: The facility's policy, titled Guidelines for Contact Precaution, revised on 2/28/24, states in part: Procedure 1. Contact Precautions is a method designed to reduce the risk of transmission of microorganisms by direct or indirect methods. b. Indirect contact transmission involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, in the resident's environment. 5. Personal Protective Equipment: a. Wear gloves before contact with the resident or environmental objects. Change gloves and wash hands after having direct contact with the resident, possible infective material, or potentially contaminated environmental objects and between each resident care intervention. R35 was admitted to the facility on [DATE] with diagnoses that include sepsis due to Escherichia coli (systemic inflammatory response due to an E. coli bacterial infection), extended spectrum beta lactamase (ESBL) resistance (bacteria that produce enzymes that are resistant to common antibiotics), and acute pyelonephritis (bacterial infection causing inflammation of the kidneys). R35 was placed on contact precautions at the facility due to her ESBL infection and had a sign on her door indicating contact precautions were in place. On 3/29/26 at 3:10 PM, Surveyor observed LPN N (Licensed Practical Nurse) standing in the doorway of R35's room wearing PPE (personal protective equipment), which included a gown and gloves. LPN N asked a CNA (certified nursing assistant) walking down the hallway to get R35 some soda and handed her R35's drinking cup. The CNA took the cup down the hallway to refill it. The cup still had a small amount of soda in it. On 3/29/26 at 3:18 PM, Surveyor observed the CNA bring R35's cup back down the hallway and set it on top of the medication cart that LPN N was using in the hallway. The cup had the same amount of soda in it as when it was taken out of the room. Surveyor asked LPN N if she should have taken the cup out of R35's room if she is on contact precautions. LPN N indicated that she should have asked the CNA to bring soda to R35's room instead of taking her drinking cup out of the room. On 3/31/26 at 2:25 PM, Surveyor interviewed DON B (Director of Nursing) and CSRN O (Clinical Support Registered Nurse) and asked if drinking cups should be removed from a resident's room, refilled, and brought back into the room if he or she is on contact precautions. CSRN O said no, it should not be.