STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525387	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - West Eau Claire	1405 Truax Blvd Eau Claire, WI 54703

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 notify the Ombudsman of resident transfer to the hospital for 4 of 5 residents (R76, R51, R30, and R1) reviewed.R76 was transferred to the hospital on [DATE]. The Ombudsman was not notified of this transfer.R51 was transferred to the hospital on [DATE]. The Ombudsman was not notified of this transfer.R30 was transferred to the hospital on [DATE], 04/11/26, 04/17/26, 5/15/26, 5/22/26, and 5/29/26. The Ombudsman was not notified of these transfers.R1 was transferred to the hospital on [DATE] and 05/30/26. The Ombudsman was not notified of these transfers. This is evidenced by: Facility policy titled, Transfer and Discharge, with a revised date of 11/2025, states: .10. Emergency Transfers to Acute Care. h. Transfer notices will be provided to the Ombudsman. They may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices. Example 1 R76 was admitted to the facility on [DATE]. On 03/05/26, R76 was transferred to the hospital. No documentation of Ombudsman notification was noted. On 06/09/26, Surveyor reviewed facility's documentation of Ombudsman notification of transfers for March 2026. The fax submitted to the Ombudsman, dated 04/01/26, did not include R76. On 06/09/26 at 3:27 PM, Surveyor interviewed Social Worker (SW) E regarding Ombudsman notification. SW E stated the list provided to the Surveyor was accurate and included all residents transferred and discharged . Surveyor asked SW E to find R76 on the provided documentation. SW E was unable to find R76 on list. On 06/10/26 at 7:54 AM, Surveyor interviewed SW E about Ombudsman notification. SW E stated being unsure what had happened, but R76, R51, R30, and R1 were somehow not on the list, and the Ombudsman was not notified of their transfers. Example 2 R51 was admitted to the facility on [DATE]. (continued on next page)

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

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/20/26, R51 was transferred to the hospital. No documentation of Ombudsman notification was noted. On 06/09/26, Surveyor reviewed facility's documentation of Ombudsman notification of transfers for March 2026. The fax submitted to the Ombudsman, dated 04/01/26, did not include R51. Example 3 On 06/09/26, Surveyor reviewed R30's medical record regarding hospitalizations and noted: On 04/03/26, R30 was transferred to the hospital. No noted documentation of ombudsman notification. On 04/11/26, R30 was transferred to the hospital. No noted documentation of ombudsman notification. On 04/17/26, R30 was transferred to the hospital. No noted documentation of ombudsman notification. Surveyor reviewed ombudsman notifications for April 2026, and R30 was not included. On 05/15/26, R30 was transferred to the hospital. No noted documentation of ombudsman notification. On 05/22/26, R30 was transferred to the hospital. No noted documentation of ombudsman notification. On 05/29/26, R30 was transferred to the hospital. No noted documentation of ombudsman notification. Surveyor reviewed ombudsman notifications for May 2026, and R30 was not included. Example 4 R1 was admitted to the facility on [DATE]. On 02/10/26, R1 was transferred to the hospital. No documentation of Ombudsman notification was noted. On 06/09/26, Surveyor reviewed facility's documentation of Ombudsman notification of transfers for February 2026. The fax submitted to the Ombudsman, dated 03/04/26, did not include R1. On 06/09/26 at 3:27 PM, Surveyor interviewed SW E regarding Ombudsman notification. SW E stated that the list provided to the Surveyor was accurate and included all residents transferred and discharged . Surveyor asked SW E to find R1 on the provided documentation. SW E was unable to find R1 on list. On 05/30/26, R1 was transferred to the hospital. No documentation of Ombudsman notification was noted. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/09/26, Surveyor reviewed facility's documentation of Ombudsman notification of transfers for May 2026. The fax submitted to the Ombudsman, dated 06/03/26, did not include R1. On 06/09/26 at 3:27 PM, Surveyor interviewed SW E regarding Ombudsman notification. SW E stated that the list provided to the Surveyor was accurate and included all residents transferred and discharged . Surveyor asked SW E to find R1 on the provided documentation. SW E was unable to find R1 on list.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility did not ensure a resident (R) had the right to refuse a medication for 1 of 4 residents (R76).-R76 gave non-verbal indications regarding placement of a Scopolamine patch, and Medication Aide (MA) H continued to place the patch on R76.Findings include:On 06/09/26 at 8:50 AM, Surveyor observed Medication Aide (MA) H administering medications to R76. MA H did not explain to R76 what MA H was going to do before attempting to apply a Scopolamine patch behind R76's left ear. While trying to apply the patch, Surveyor observed R76 grimacing and pulling R76's head away. R76 was jerking R76's head from side to side. MA H asked R76 if it was ok for MA H to try again, and R76 shook their head, indicating no. MA H gently held R76's face with the left hand and placed the patch behind R76's left ear with the right hand. R76 was observed to pull away from MA H. MA H placed the patch behind R76's left ear.On 06/09/26 at 9:43 AM, Surveyor interviewed MA H regarding placement of the patch. MA stated R76 does not usually refuse the patch and acknowledged MA H should have explained the procedure prior to attempting to place the patch or reapproached.On 06/10/26 at 8:41 AM, Surveyor interviewed Registered Nurse (RN) L regarding indications a non-verbal resident was refusing medications. RN L stated non-verbal indicators such as shaking their heads, shutting their mouth, swatting you away, and other motions/actions would give the indication of refusal. RN L stated they would try to educate and help a resident understand why the medication is important, reapproach if necessary, and document any refusal. The provider and case manager would then be updated.On 06/10/26 at 11:44 AM, Surveyor interviewed Director of Nursing (DON) B about residents' rights to refuse medications. Surveyor made DON B aware of Surveyor's observation regarding the Scopolamine patch for R76. DON B acknowledged MA H did not follow standards of care and should have approached the situation differently.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility did not ensure the timeliness of revisions for each resident's person-centered, comprehensive care plan for 1 of 18 residents (R) reviewed (R66).-R66 had tracheostomy removed on 11/12/25 and care plan currently includes interventions related to trach care.-R66 now takes food orally and is on a mashable texture. Care plan states all nutrition is administered via gastrostomy tube and is full liquid.Findings include:The facility policy titled, Comprehensive Care Plan, last revised on 03/10/25, includes: The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment. The comprehensive care plan will describe.the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.On 06/08/26 at 10:07 AM, Surveyor interviewed R66 and Family Member (FM) W regarding care received by the facility. Surveyor observed R66 no longer had a tracheostomy. FM W stated R66 had the tracheostomy removed in November 2025. When asked about R66's nutrition, FM W stated R66 took all food by mouth, but it must be very soft.On 06/09/26, Surveyor reviewed R66's care plan regarding tracheostomy care. The care plan includes ensuring the trach ties are secured at all times.On 06/09/26, Surveyor reviewed R66's care plan regarding nutrition. The care plan states R66 requires tube feeding as R66 is unable to obtain adequate nutrition orally. The care plan states R66 receives a full liquid diet.On 06/09/26, Surveyor reviewed R66's physician orders, which indicate R66 has a regular diet with fork-mashable texture, and thin liquids.On 06/10/26 at 8:41 AM, Surveyor interviewed Registered Nurse (RN) L about care plan revisions. RN L stated care plans are updated with a combination of nursing staff, management, therapy, and other members of the care team as changes happen.On 06/10/26 at 11:44 AM, Surveyor interviewed Director of Nursing (DON) B about care plans. DON B stated care plans are updated by the members of the interdisciplinary team and departments including nurse managers, nurses, social services, therapy, dietary, activities, and infection control. Nursing staff are then made aware of changes. Surveyor made DON B aware of updates not made to R66's care plan regarding tracheostomy care and nutrition, as R66 has had 2 quarterly MDS assessments since the tracheostomy was removed and 1 since diet was changed. DON B acknowledged and stated the updates would be made.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that 1 of 4 residents (R) reviewed for pressure injuries (PI) (R1) received care consistently with professional standards of practice to prevent further deterioration and promote healing of an existing PI. R1 was at risk for PI development and had 2 existing PIs. The facility failed to provide adequate wound care treatment to R1's PI on coccyx.Findings include: Facility policy titled, Pressure Injury Prevention and Management, dated last revised 01/26, states: .4. Interventions for prevention and to promote healing; c. ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination. R1 was re-admitted to the facility on [DATE], with diagnoses including unspecified dementia, asthma, chronic respiratory failure, severe sepsis with septic shock, infection reaction due to indwelling urethral catheter, type 2 diabetes mellitus, pressure ulcer of sacral region stage 3, and benign prostatic hyperplasia. A suprapubic foley catheter was in place prior to admission. R1's Minimum Data Set (MDS) assessment, dated 04/17/26, identified R1 was at risk for PIs with 1 stage 3 PI. R1's care plan, dated 02/13/26, with revision date of 05/16/26, states: [R1] have a history of pressure injuries to coccyx and left and right heel. History of MASD to buttocks, gluteal cleft, and upper thigh area. Interventions include administer treatments as ordered and monitor for effectiveness. R1's orders:On 05/21/26 Wound care: Sacrum 1. Cleanse areas with wound wash and gauze. 2. Apply skin prep to peri wound/buttock. 3. Apply calcium alginate with silver to wound bed and cover with foam dressing. 4. Change daily and as needed for soiling/dislodgement/saturation every day shift for wound healing. On 06/09/26 at 2:16 PM, Surveyor observed Registered Nurse (RN) P enter R1's room to provide wound dressing care to R1's PI on sacrum and assess R1's new open area on scrotum. Surveyor observed RN P don personal protective equipment (PPE) gown and walk into R1's room. RN P did not observe RN P sanitize hands upon entering R1's room. RN P placed all wound care supplies on R1's counter near the sink and reached into R1's cabinets looking for more supplies. RN P grabbed scissors with contaminated bare hands out of R1's wound care bucket in cabinet and walked over to R1's bed. RN P placed all wound care supplies including scissors directly on R1's end table on top of R1's personal belongings such as a shirt, napkin, and wedge at the foot of R1's bed. Surveyor did not observe RN P sanitize R1's end table before placing wound care supplies on end table. RN P donned gloves and then RN P and Certified Nurse Assistant (CNA) Q uncovered and rolled R1 to the right towards RN P. CNA Q removed R1's sacrum dressing and placed it in the trash. Surveyor observed RN P and CNA Q roll R1 towards CNA Q. RN P grabbed saline and gauze and gently cleansed R1's sacrum PI. RN P grabbed adhesive prep wipe and began wiping around R1's sacrum PI. RN P did not doff contaminated gloves prior to prepping R1's skin. RN P grabbed contaminated scissors with RN P's contaminated gloves and cut new piece of foam border from packaging. RN P grabbed foam border with contaminated gloves and placed contaminated foam border into R1's open PI on R1's sacrum. RN P picked up Mepilex dressing and placed it over the contaminated foam border. RN P labeled Mepilex. On 06/09/26 at 2:36 PM, Surveyor interviewed RN P and asked if they should have sanitized R1's end table and placed a protective border between R1's wound care supplies and R1's belongings on end table. RN P reported to Surveyor that they should have cleansed R1's end table prior to placing wound care supplies on end table. Surveyor asked RN P what the process is for performing hand hygiene and changing gloves often during a wound dressing change going from dirty to clean. RN P reported to Surveyor they missed several opportunities to change contaminated gloves and sanitize hands when performing glove changes and when entering and exiting R1's room. Surveyor asked RN P if it was important to doff contaminated gloves when cleansing the open PI then prepping skin for the clean dressing. RN P reported to Surveyor they should have doffed gloves, sanitized hands, and then donned new pair of clean gloves. On 06/09/2026 at 3:06 PM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectation is for hand hygiene and keeping wound care supplies during a wound care (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressing change. Surveyor informed DON B, RN P missed several opportunities to perform hand hygiene and to sanitize R1's end table prior to placing wound care supplies on end table. DON B reported to Surveyor, RN P was nervous, but DON B's expectation is RN P should have sanitized hands prior to entering R1's room. RN P should have sanitized or created a clean barrier between R1's end table and R1's wound care supplies. DON B reported to Surveyor RN P should have doffed contaminated gloves, sanitized hands, and donned clean gloves prior to prepping R1's skin for new wound dressing. DON B reported there will be further education for RN P.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents with an indwelling foley catheter received care and treatment consistent with professional standards of practice to prevent complications or urinary tract infections (UTI) for 2 of 4 residents (R) reviewed (R76 and R1) .R76 had an indwelling foley catheter which was not secured to prevent trauma or movement of catheter tubing.R1's foley catheter bag was leaking. Facility staff placed leaking catheter bag in bin placed on floor to collect the leaking urine. This is evidenced by: Facility policy titled, Catheter Care, with a revised date of 02/2026, states: Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use.10. Ensure the catheter tubing is secured by use of stat lock or leg secure device.11. Report abnormal findings to the nurse and document any care that needs to be in the resident record. Example 1 R76 was admitted to the facility on [DATE] with acute pyelonephritis and urinary retention. An indwelling foley catheter was in place prior to admission. R76's care plan, dated 02/16/26, with a target date of 08/11/26, states: [R76] has indwelling foley catheter with a goal to show no signs or symptoms of urinary infection. Interventions include ensure stat lock or cath secure in place. R76's orders: 03/16/26 cath secure: check placement every shift 05/28/26 cath secure: alternate location of cath secure device every 3 days and as needed. Use foley strap instead of adhesive. On 06/08/26 at 10:29 AM, Surveyor observed R76 lying supine in bed with foley catheter bag hanging under the bed. Foley tubing was not secured by leg strap to R76. A blue clip on the foley tubing was clipped to R76's bed sheet. Surveyor asked Certified Nursing Assistant (CNA) C if R76 was supposed to have a foley securement device. CNA C stated no because R76 has an issue with adhesives so they can't use a securement device. On 06/09/26 at 8:17 AM, Surveyor observed R76 lying in bed with no foley securement device in place and tubing clipped to R76's bed sheet. Surveyor asked CNA C if there was supposed to be a foley securement device. CNA C stated a Velcro strap is used if R76 is up in the wheelchair, but nothing used when R76 is in bed. Surveyor asked CNA C why a securement device wasn't used in bed. CNA C stated that is what another CNA had told them because of skin irritation related to adhesives. On 06/09/26 at 9:17 AM, Surveyor interviewed Nurse Tech (NT) F regarding R76's foley securement device. NT F that there should be a Velcro strap in place, but the floor nurse might have more (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information. On 06/09/26 at 9:31 AM, Surveyor interviewed Registered Nurse (RN) G regarding R76's foley securement device. RN G stated R76 should have a securement strap in place and did not know why there was not one being used. On 06/09/26 at 11:20 AM, Surveyor interviewed Director of Nursing (DON) B regarding R76's foley securement. Surveyor asked DON B the expectations related to residents with foley catheters and securement devices. DON B stated that a securement device should be in place. Example 2 R1 was re-admitted to the facility on [DATE] with diagnoses including unspecified dementia, asthma, chronic respiratory failure, severe sepsis with septic shock, infection reaction due to indwelling urethral catheter, type 2 Diabetes Mellitus, pressure ulcer of sacral region stage 3, and benign prostatic hyperplasia. A suprapubic foley catheter was in place prior to admission. R1's care plan, dated 11/26/25, with revision date of 02/16/26, states: [R1] has suprapubic catheter for obstructive uropathy with a goal to be/remain free from catheter-related trauma. Interventions include ensuring stat lock or catheter secure in place and report abnormal findings to the nurse during catheter care. Proper placement of leg strap/stat lock checked every shift. R1's orders: 02/16/26 Change catheter drainage graduate/container every night shift 06/03/26 Foley catheter: Suprapubic size: 16 Fr balloon: 5cc-ok to inflate 10cc Change foley catheter monthly or with occlusion and as needed. Chart in progress notes if foley is changed every hour as needed. On 06/08/26 at 10:21 AM, Surveyor observed R1 sitting in wheelchair in room with a pink basin under R1's wheelchair. Surveyor observed R1's catheter bag sitting inside the pink basin. On 06/09/26 at 7:33 AM, Surveyor observed R1 sitting in wheelchair sleeping in room. Surveyor observed R1's catheter bag lying on the floor with no privacy bag on. Surveyor observed R1's room in disarray with a pink basin under R1's bed. On 06/09/26 at 8:01 AM, Surveyor observed R1 sitting in wheelchair in room eating breakfast. Surveyor observed pink basin under R1's wheelchair with their catheter bag sitting inside the pink basin. On 06/09/26 at 9:07 AM, Surveyor overheard Nursing Support (NS) S say to R1, Oh my, I almost slipped. Not sure what that is in the corner of your room. It is very slippery. Surveyor entered R1's room and observed NS S picking up R1's floor mat. Surveyor observed some type of liquid dripping down R1's fall mat. Surveyor interviewed NS S and asked what the liquid was in the corner of R1's room. Surveyor smelled strong urine in R1's room. Surveyor asked NS S if they were aware staff were placing a pink basin under R1's catheter while they were in wheelchair. NS S reported to Surveyor they were unaware staff were doing that and did not know what was going on with the pink basin. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked NS S what the liquid observed smelled like. NS S stated, Smells mixture of sweat and urine, but I don't know for sure. I will call for sanitation to thoroughly clean [R1's] floor. NS S reported to Surveyor they will have to get another floor mat as R1's floor mat is saturated with some kind of liquid substance. NS S walked out of R1's room with contaminated floor mat in a plastic bag. On 06/09/26 at 9:13 AM. Surveyor observed NS S enter R1's room and began talking with R1. NS S stated to R1, I am going to have sanitation come clean as I almost slipped in whatever is in the corner of your bedroom. Surveyor observed NS S exit R1's room again. On 06/09/26 at 9:14 AM, Surveyor observed NS S walk down hallway to let Environmental Services (EVS) know about R1's floor being slippery and needing it to be thoroughly cleaned in the corner near bed and under bed. On 06/09/26 at 9:26 AM, Surveyor observed Certified Nurse Assistant (CNA) N enter R1's room to take R1 to exercise activity. Surveyor interviewed CNA N and asked if they could double check that R1's catheter bag was clamped tight and not leaking. CNA N grabbed catheter bag and checked the clamp. Surveyor asked CNA N if they knew why the pink basin on the floor keeps being placed under R1's catheter bag. Surveyor observed catheter bag to be labeled 06/08/26 and CNA N reported to Surveyor, R1's catheter bag was clamped and did not have pink basin under catheter bag anymore. On 06/09/26 at 9:36 AM, Surveyor interviewed CNA U and asked them if they were aware of any catheter leaking concerns for R1's suprapubic catheter. CNA U reported to Surveyor they oversee showers but unsure about R1. Surveyor asked CNA U who was R1's CNA. CNA U reported to Surveyor at this time CNA U is R1's CNA but are unsure of any leak concerns at this time. Surveyor asked CNA U why someone keeps placing a pink basin under R1's catheter. CNA U reported to Surveyor some aides must be placing basin under instead of hanging from R1's wheelchair or bed. On 06/09/26 at 9:43 AM, Surveyor interviewed NS S and asked if they figured out what the liquid was on R1's floor mat and all over floor. NS S reported to Surveyor after cleaning R1's floor mat, it smelled and looked as if it was old urine sitting under the floor mat. Surveyor asked NS S if R1's catheter was leaking. NS S reported to Surveyor they are unsure but will report this to the nurse on duty. On 06/09/26 at 9:48 AM, Surveyor interviewed Registered Nurse (RN) P and asked if they had knowledge about R1's catheter bag leaking. RN P reported to Surveyor that they checked R1's medical record and could not find if catheter bag was changed or leaked. Surveyor reported to RN P, Surveyor observed R1's catheter bag labeled 06/08/26 and a puddle of urine in the corner of R1's room. RN P reported to Surveyor staff must have changed it due to potential leak. RN P stated, Staff use the pink basins sometimes to make sure catheter bags do not touch the floor. Surveyor asked RN P if the facility utilizes privacy catheter bags, so they don't touch floor as well. RN P reported to Surveyor the facility does use privacy bags for catheters and will get one for R1 right away. On 06/09/26 at 2:28 PM, Surveyor interviewed RN P and asked for details about R1's catheter change. RN P reported to Surveyor staff reported to RN P catheter bag and tubing was changed due to a leak yesterday on 06/08/26. Surveyor asked RN P where the catheter bag was leaking. RN P reported to Surveyor they were unsure as they did not get much detail, and the catheter bag change was not documented in R1's medical record. On 06/09/26 at 3:35 PM, Surveyor interviewed Director of Nursing (DON) B and asked if they knew why staff were putting a pink basin under R1's catheter when in bed or wheelchair. DON B reported to (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor DON B spoke with Regional Resource V who reported staff were using the pink basin as a barrier between the floor and R1's catheter bag. Surveyor asked DON B if they knew R1's catheter bag was leaking. DON B reported to Surveyor this is the first DON B has heard about R1's catheter. Surveyor reported to DON B Surveyor's observation of R1's catheter bag leaking. Surveyor asked DON B what the expectation is for staff documenting in R1's medical record with concerns of leaking catheter or catheter changes. DON B reported to Surveyor they are still reaching out to staff to determine what happened with R1's catheter. DON B reported the next steps would be to follow up with urology.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications for 1 of 3 residents (R) reviewed (R76).Facility did not ensure R76's percutaneous gastrostomy (PEG) tube was properly placed prior to administering medications.This is evidenced by:Facility policy titled, Care and Treatment of Feeding Tubes (Enteral Tubes), with a revised date of 05/05/25, states: .6. In accordance with facility protocol, licensed nurses will monitor and check that the feeding tube is in the right location: a. Tube placement will be verified before beginning a feeding and before administering medications.R76 was admitted to the facility on [DATE] with dysphagia following cerebral infarction. A PEG tube was in place on admission to administer enteral feeding and medication administration.On 06/09/26 at 8:54 AM, Surveyor observed Medication Aide (MA) H disconnect R76's tube feeding to administer medications. Surveyor observed MA H attach syringe to R76's PEG tube and pull back on the plunger. Surveyor asked MA H to explain what assessment is being completed prior to administering medications. MA H stated that she is a MA and cannot do assessments, only administer the medications. Surveyor asked MA H if a nurse had assessed R76's PEG tube placement prior to MA H administering these medications. MA H stated yes sometime this morning before 7 AM by Registered Nurse (RN) G.R76's medical record did not note a PEG tube assessment documentation for 06/09/26.On 06/09/26 at 9:31 AM, Surveyor interviewed RN G regarding assessment of R76's PEG tube. Surveyor asked RN G if they had assessed R76's PEG tube placement today. RN G stated no, they had not had time yet. Surveyor asked RN G if a Medication Aide can administer medications via PEG tube without a nurse assessing for placement first. RN G stated no, and they are expected to get the nurse first to do the assessment.On 06/09/26 at 11:15 AM, Surveyor interviewed Director of Nursing (DON) B regarding R76's PEG tube assessment. Surveyor asked DON B if Medication Aides are expected to do an assessment prior to administering medications via PEG tube. DON B stated no, only the RN can do an assessment. Surveyor asked DON B if the expectation is for the nurse to complete an assessment prior to administering medications via PEG tube. DON B stated yes.

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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 record review and interview, the facility did not ensure that 1 of 1 resident (R) reviewed received appropriate respiratory care during administration of respiratory therapy (R1). Registered Nurse (RN) P did not perform post respiratory assessments for R1 when administering nebulizer treatments.Findings include: The facility policy titled Specific Medication Administration Procedures for Oral Inhalation Administration, dated 05/18, in part: .L. Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer. M. Approximately five minutes after treatment begins (or sooner if clinical judgement indicates) obtain the resident's pulse. T. Obtain post-treatment pulse, respiratory rate, and lung sounds and document findings in the medical record if indicated by facilities policy and procedures. R1 was re-admitted to the facility on [DATE] diagnoses including unspecified dementia, asthma, chronic respiratory failure, severe sepsis with septic shock, infection reaction due to indwelling urethral catheter, type 2 Diabetes Mellitus, pressure ulcer of sacral region stage 3, and benign prostatic hyperplasia. R1's orders:06/03/26 Budesonide inhalation suspension 0.5MG/2ML, inhale 2ml orally via nebulizer two times a day for asthma. Ensure complete pre and post assessments. Rinse mouth with water after. Ok to mix with DuoNeb.06/03/26 Pre respiratory evaluation: Document lung sounds for left and right lungs. For lung sounds: D=Diminished, C=Crackles, R=Ronchi, CL=Clear, RA=Rales, W=Wheezes. Document respiratory, pulse, and O2 saturations percent. Add number of minutes for assessment, four times a day.06/03/26 Post respiratory evaluation: Document lung sounds for left and right lungs. For lung sounds: D=Diminished, C=Crackles, R=Ronchi, CL=Clear, RA=Rales, W=Wheezes. Document respiratory, pulse, and O2 saturations percent. Add number of minutes for assessment, four times a day. On 06/09/26 at 8:30 AM, Surveyor observed RN P enter R1's room with nebulizer treatment. Surveyor observed RN P place it on R1's face and turn machine on. RN P exited R1's room and told R1 they would be back soon. Surveyor did not observe R1's pre-nebulizer treatment performed. On 06/09/26 at 8:57 AM, Surveyor observed Nursing Support (NS) S enter R1's room. NS S announced themselves and began removing nebulizer mask from R1's face. NS S exited R1's room. Surveyor did not observe R1's post nebulizer treatment performed. On 06/09/26 at 9:48 AM, Surveyor reported to RN P, Surveyor did not observe a pre and post nebulizer treatment. RN P reported to Surveyor they completed pre nebulizer treatment assessment but did not perform post nebulizer assessment. Surveyor asked RN P if it is normal process for R1 to have a pre and post assessment completed during nebulizer treatment. RN P reported to Surveyor that R1 should have had pre and post completed as R1's order states to perform prior to neb treatment and post treatment. Surveyor asked RN P their time frame to recheck on R1's nebulizers after starting it. RN P reported to Surveyor they usually go back within 30 minutes after starting nebulizer, but RN P did not. On 06/09/26 at 11:14 AM, Surveyors interviewed Director of Nursing (DON) B and asked what the expectation is for staff, who is responsible for completing pre and post assessments. DON B reported to Surveyor DON B's expectation is RNs are the only ones who perform lung assessments with expectation to perform the lung assessment within 15 minutes pre and post nebulizer treatment.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure medication error rates are not 5 percent or greater for 2 of 4 residents (R) observed (R76, R73).-Nursing staff did not measure Voltaren gel prior to administration for R73.-Nursing staff splashed and spilled medications prior to administration via gastrostomy tube for R76.-Nursing staff did not flush the correct amount of water between medications for R76.-Nursing staff administered sublingual medication via gastrostomy tube for R76.Findings include:The facility policy titled, Medication Administration, last revised 01/01/25 states: Ensure that the six rights of medication administration are followed including right dose and right route.Example 1On 06/09/26 at 7:26 AM, Surveyor observed Medication Aide (MA) H administer medications to R73. R73 has an order for Voltaren gel 1% apply to right shoulder topically one time a day for pain. Apply 4 grams. Surveyor observed MA H open the tube, place two dime-size amounts of gel onto MA H's gloved hand and then use the other gloved hand to rub the Voltaren gel onto R73's left hip. MA H placed another nickel-size amount on the left gloved hand and proceeded to rub the gel on the back of R73's neck and bilateral shoulders.On 06/09/26 at 7:30 AM, Surveyor interviewed MA H about the dosage for Voltaren gel. MA H stated there wasn't a set amount. Surveyor asked MA H to review the order in R73's medication administration record, which indicated the amount as 4 grams. Surveyor asked MA H how they knew 4 grams were administered. MA H replied, I guess I should have measured it.Example 2The facility policy titled, Medication Administration via Enteral Tube, last revised 02/2026, includes: Intent-To ensure medications administered [NAME] enteral tubes are given safely and correctly to prevent harm, maintain tube patency, and achieve intended therapeutic effects.sublingual medication will not be administered through enteral tube.flush enteral tube with at least 15ml of water to ensure drug delivery and clear the tube.On 06/09/26 at 8:50 AM, Surveyor observed MA H administering medications to R76 via gastrostomy tube. MA H crushed each of the following medications and placed them in their own medication cup:-Aspirin 81mg chewable tablet give one tablet via percutaneous endoscopic gastrostomy (PEG)-tube-Esomeprazole Magnesium Oral Capsule Delayed Release give 20mg via PEG-tube-Finasteride oral tablet 5mg give one tablet enterally-Losartan Potassium oral tablet give 50mg enterally-Multivitamin oral tablet give one tablet via PEG-tube-Rosuvastatin Calcium oral tablet 20mg give one tablet enterally-Hyoscyamine Sulfate oral tablet 0.125mg give 1 tablet sublinguallySurveyor observed MA H add unmeasured, uneven amounts of water to each cup to dissolve the medication. Surveyor asked how much water should be added, MA H stated enough to help dissolve it for administration. MA H then used a syringe to flush the tube prior to medication administration. MA H took the syringe to the first medication cup, drew most of it up into the syringe, and then squirted it back into the medication cup as a way to mix it. This was repeated a couple of times with each medication causing some to splash out onto the table. When drawing the medication up each final time before administering via gastrostomy tube, MA H held the syringe into a washcloth to remove the access air. This caused some of the medication to remain in the washcloth and in one instance, some was splashed onto R76's sheet. Surveyor observed MA H administer water flushes between each medication of different amounts. Surveyor asked MA H how MA H knows how much water to flush with in between medications, and MA H replied, About 10. Surveyor observed that 10ml was not administered each time.On 06/09/26 at 9:30 AM, Surveyor interviewed MA H about the order for Hyoscyamine stating to administer sublingually. MA H stated MA H would have to look into it as most medications for R76 were supposed to be administered via gastrostomy tube.On 06/10/26 at 11:44 AM, Surveyor interviewed Director of Nursing (DON) B about medication administration. Surveyor made DON B aware of Surveyor's observations of wrong Voltaren dose for R73 and medications spilling, wrong route, and the amount of water flushed in between medications when administering via PEG tube for R76. DON acknowledged this is not professional standard of practice. DON B acknowledged due to spilling of each medication, there was no way to (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	know exactly how much of each medication was administered. DON B stated staff were provided education on medication administration in January 2026 and the education included using a minimum of 15ml of water between each medication.

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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. Based on observation, interview, and record review, the facility did not provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 2 of 18 residents (R) reviewed (R66, R76).-Certified Nursing Assistant (CNA) N performed restorative tasks for R66 without wearing Personal Protective Equipment (PPE). R66 is on enhanced barrier precautions.-Medication Aide (MA) H did not change gloves and perform appropriate hand hygiene prior to and during medication administration involving R76's feeding tube.Findings include:The facility policy titled, Enhanced Barrier Precautions, last revised January 2025, includes: Personal Protective Equipment (PPE) is necessary when performing high-contact care activities.Example 1On 06/08/26, Surveyor reviewed R66's medical record related to precautions. R66 was noted to be on Enhanced Barrier Precautions (EBP) related to indwelling Foley catheter.On 06/08/26 at 10:12 AM, Surveyor observed CNA N enter R66's room to perform restorative care. CNA N did not don any Personal Protective Equipment (PPE) prior to contact with R66.On 06/08/26 at 11:13 AM, Surveyor interviewed CNA N about restorative care and EBP. When asked if CNA N wears PPE when providing restorative care to residents on EBP, CNA N replied, No, was I supposed to? CNA N stated they thought PPE was only required for performing personal area cares. When asked if education for EBP was provided to CNA N, CNA N stated yes.Example 2The facility policy titled, Medication Administration via Enteral Tube, last revised 02/2026, includes: place needed supplies on the bedside stand or overbed table, arranging so they can be easily reached .perform hand hygiene and apply gloves.On 06/09/26 at 8:50 AM, Surveyor observed MA H administering medications to R76 via gastrostomy tube (G-tube). Prior to administration, Surveyor observed MA H don gloves, remove soiled linens from a bedside table and place it in a bag, remove other items from the table, grab the bathroom handle to enter and retrieve water, and unhook the tube supplying nutrition to the G-tube. Surveyor observed MA H then administer medications via G-tube, remove an old Scopolamine patch, place a new patch, and administer insulin to R76. MA H did not change gloves or perform hand hygiene throughout the entire process.On 06/09/26 at 9:43 AM, Surveyor interviewed MA H about hand hygiene and glove changing. MA H stated MA H should have changed gloves and performed hand hygiene prior to medication administration and between each type of task.On 06/10/26 at 11:44 AM, Surveyor interviewed Director of Nursing (DON) B about EBP, PPE, and hand hygiene. Surveyor made DON B aware of observations of CNA N not donning PPE to perform restorative care to R66 and the lack of hand hygiene provided by MA H when administering medications to R76. DON B acknowledge these events are not standards of practice. DON B stated precaution education is provided to all staff upon hire, annually, and more often when needed. DON B stated the most recent education was provided in January 2026 during the skills fair.