STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525405	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Wausau	1010 E Wausau Ave Wausau, WI 54403

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility did not designate a person to serve as the director of food and nutrition services who had completed the minimum qualification requirements for the position. This practice has potential to affect all 32 residents residing in the facility.Dietary Manager (DM) C has been in the position since February 2025 and has not enrolled in a nationally recognized/state approved course. The facility does not have a full-time Registered Dietician (RD) at the facility and has not applied for or received a waiver.On 09/03/25 at 1:21 PM, Surveyor interviewed Dietary Manager (DM) C who reported becoming Dietary Manager in February 2025. When DM C was asked about qualifications, DM C stated she was not a certified dietary manager, certified food service manager, nor had a related associate degree. DM C stated DM C is aware of the need to take the courses but was not currently enrolled. DM C stated Registered Dietician (RD) was at the facility once a month and less than 35 hours per week and the facility does not have and had not requested a waiver.On 2/26/25 at 7:15 AM, Nursing Home Administrator (NHA) A stated the facility did not have 35 hours per week of RD services and DM C is not certified. Staff list confirmed that DM C started as Dietary Manager on 02/11/25, working approximately 7 months without meeting qualifications.

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	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility did not ensure proper sanitation practices to prevent the outbreak of foodborne illness, which had the potential to affect all 32 residents.-The facility did not label 2 opened cartons of soy milk.-The facility did not ensure thermometer probes remained sanitary prior to inserting into food. The facility policy titled, Food Storage - Refrigeration, dated 04/01/16, reads in part: Foods shall be stored in an organized manner and shall be maintained in their original containers unless they are considered a leftover. All leftovers shall be labelled (sp) and dated with expiration dates.The facility policy titled, Food Preparation and Serviced, dated November 2022, reads in part: Cross-contamination can occur when harmful substances, i.e., chemical or disease-causing microorganisms are transferred to food by hands (including gloved hands), food contact surfaces, sponges, cloth towels, or utensils that are not adequately cleaned.On 09/02/25 at 9:22 AM, Surveyor entered the kitchen to complete the initial tour. Surveyor discovered 2 cartons of soy milk with no open dates. Directions on the carton state to shake well and once opened, refrigerate 7-10 days. Surveyor asked Dietary Manager (DM) C to show Surveyor the open date. DM C stated there was not one and they should have one.On 09/03/25 at 11:42 AM, Surveyor observed DM C obtain food temperature checks for lunch. DM C wiped thermometer probe with disinfecting wipes, laid it on the prep table with probe tip touching the table, removed foil on hot food, picked thermometer up, and inserted the probe into chicken carbonara dish. DM C then sanitized the probe again and set it on the prep table. The probe tip again touched the prep table. DM C removed the foil on the next hot item, picked up the thermometer, and inserted the probe tip into the mechanical soft chicken carbonara. Surveyor asked DM C if there were any potential concerns with the thermometer probe touching the prep table. DM C stated that anyone could have come by and touched or coughed on the area. On 09/04/2025 at 1:13 PM, Surveyor interviewed Nursing Home Administrator (NHA) A informing of above findings. NHA A agreed the items in the fridge should have been dated, and the prep table could have the potential for bacteria concerns.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not implement infection prevention and control interventions to provide a safe and sanitary environment to help prevent the development and transmission of infections. This had the potential to affect all 32 residents (R).Staff did not change gloves and wash hands after picking up a soiled item off the floor in the kitchen.Facility staff did not use personal protective equipment (PPE) when administering subcutaneous medication to a resident (R36). Facility staff did not conduct hand hygiene after removal of soiled gloves during cares for R29.Example 1 The facility policy dated 04/01/16, titled, Sanitation - Handwashing, states in part, Employees shall wash their hands: . (5) after handling soiled equipment; (6) as much as possible during food preparation to remove soil and contamination and to prevent cross contamination; (7) when changing tasks; . (10) after engaging in any activity or task which contaminates hands. On 09/03/25 at 11:46 AM, Surveyor observed Dietary Manager (DM) C take a tray of fruit cups from the refrigerator and place it on a prep table. One of the covers on one fruit cup fell off and landed on the floor. DM C had clean gloves on at this time. DM C picked the soiled cover off floor, threw it in garbage, and did not doff gloves or wash hands. DM C then reached into the refrigerator and took a salad out, then reached into clean utensil bin and placed utensils by hot foods. Surveyor asked about hand hygiene and glove change, and DM C stated she forgot. On 09/04/25 at 1:13 PM, Surveyor interviewed Nursing Home Administrator (NHA) A and informed of above findings. NHA A reported that DM C already reported the error of not changing gloves and washing hands after picking item off the floor. NHA A verbalized hand hygiene and glove changes should have occurred. Example 2 The Center for Disease control and Prevention (CDC), Considerations for Blood Glucose Monitoring and Insulin Administration, 8/7/2024, reads in part: The required PPE for administering insulin in a nursing home is disposable gloves. The guidelines are based on Standard Precautions, which apply to the care of all residents. On 09/03/25 at 7:40 AM, Surveyor observed Registered Nurse (RN) E prime R36's insulin pen with 2 units and then set to 32 units at medication cart. RN E entered into R36's room after using hand sanitizer from the medication cart. RN E explained to R36 she was there to give him his insulin. RN E wiped R36's abdomen with alcohol wipe and injected insulin subcutaneously without applying gloves. After leaving R36's room, Surveyor interviewed RN E about the use of gloves with administration of a subcutaneous medication. RN E reported she had looked for gloves in his room and didn't see any, and she should wear gloves when injecting medications. On 9/04/2025 at approximately 12:00 PM, Surveyor interviewed Director of Clinical Services/ RN D, who stated the expectation would be that all facility staff wear gloves during administration of insulin/subcutaneous medication. Example 3 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R29 was admitted to the facility on [DATE]. R29's current diagnoses include altered mental status, cognitive communication deficit, weakness, reduced mobility, and sepsis due to Escherichia coli. On 08/04/25 at 8:07 AM, Surveyor observed Registered Nurse (RN) G and Certified Nursing Assistant (CNA) F provide wound care to R29. On R29's door is a sign for enhanced barrier precautions and to the left of R29's room door is a bin with personal protective equipment. RN G did not sanitize hands and applied a gown and gloves. CNA F sanitized hands and applied gown and gloves. CNA F assisted to position R29 on right side. RN G, with gloved hands, cleansed R29's buttocks of stool. RN G did not remove gloves and touched a paper box of Healx calibrant to remove the adhesive wound marker and placed next to R29's wounds. With the same gloved hands, RN G touched the iPad to assess and measure R29's wounds. RN G removed gloves, did not perform hand hygiene and touched the iPad to continue to assess and measure R29's wounds. RN G removed gown, exited R29's room and RN G used hand sanitizer to cleanse hands. Surveyor interviewed RN G about hand hygiene. RN G stated she did not complete hand hygiene right after removing gloves. On 08/04/25 at 10:34 AM, Surveyor interviewed Director of Nursing (DON) B about proper infection control practices with personal cares for R29. DON B stated education will be provided to staff.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not complete a Significant Change in Status Assessment (SCSA) for 1 resident (R1) of 12 sampled residents reviewed. R1 was admitted to hospice care on 04/10/25. A SCSA was not completed for R1. This is evidenced by: According to the Resident Assessment Instrument (RAI) manual, a significant change in status is required when a resident enrolls in a hospice program. R1 was admitted to the facility on [DATE] and has diagnoses that include Chronic Obstructive Pulmonary Disease (COPD), acute and chronic respiratory failure with hypoxia, quadriplegia, deaf and nonspeaking, unspecified psychosis. R1 has a BIMS score of 13/15, indicating R1 is cognitively intact. R1 is deaf and able to read lips and written communication. R1 verbally expresses self but difficult to understand speech. R1 makes own health care decisions. On 09/03/25, record review noted no SCSA done within 14 days of hospice admission on [DATE]. Most recent Quarterly MDS assessment done 08/26/25. Nursing Progress note dated 04/10/25 stated, Compassus Hospice met with resident this morning along with DON (Director of Nursing) and Social Services, and resident signed up for hospice effective today 4/10/2025. On 09/03/25 at 12:25 PM, Surveyor interviewed Social Worker (SW) K when a SCSA would be done for a resident. SW K stated when a resident was admitted to hospice as an example, and changed from Medicaid to hospice. Surveyor asked SW K if a MDS SCSA was done after R1 was admitted to hospice and SW K stated, No, I do not see one was done.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure discharge Minimum Data Set (MDS) assessment was transmitted in the timeframe prescribed in the Long-Term Care Facility Resident Assessment instrument (RAI)_3.0 User's Manual for 1 of 12 residents (R) R22, reviewed for late Minimum Data Set (MDS) assessments. This is evidenced by:The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2024 documents: Transmitting Data: Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument.Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date.All other MDS assessments must be submitted within 14 days of the MDS completion Date.R22 was admitted to the facility on [DATE] and was discharged on 04/25/25. Review of R22's MDS submissions documented a discharge return not anticipated was created on 04/25/25 and was transmitted on 05/14/25 and then unsubmitted. No further MDS discharge assessment was transmitted. On 09/03/25, Surveyor interviewed Director of Care Services/Registered Nurse (RN) D about the missing transmission of R22's discharge MDS. RN D stated there was a change of staff completing the MDS and R22's MDS was transmitted then retracted and not transmitted again. The discharge MDS should have been transmitted.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure resident (R) care conferences were offered or care plans were revised to provide the needed direction to staff in providing individualized care and services for 2 of 12 residents (R) (R33, R34) reviewed for care planning. The facility did not ensure resident (R33), or their representative had the right to participate in the care planning process.R34's care plan for ambulation was not completed or updated to reflect R34's current ambulation status. The facility's Performance Improvement Project, initiated on 7/28/25, states in part:6. Care Conferences will be conducted upon admission, quarterly, and PRN. Resident/Resident Representative and Interdisciplinary Team (IDT) will review, update, and sign the Comprehensive Care Plan.And Federal Regulations, states in part:Comprehensive Care Plans-483.21(b)(2) A comprehensive care plan must be.(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. Example 1 R33 was admitted to the facility on [DATE] with diagnoses which included acute and chronic respiratory failure with hypercapnianta, cognitive communication deficit, hallucinations, obstructive apnea, chronic pain, fluid overload, anxiety disorder, atrial fibrillation, and pulmonary hypertension. Minimum Data Set (MDS) assessment completed on 7/30/25 indicated R33 is dependent with cares, is independent with repositioning, uses a walker and a wheelchair for mobility. R33 scored a 13/15 on a Brief Interview for Mental Status (BIMS), which indicates her cognition is intact. On 9/3/25 at 9:30 AM, Surveyor interviewed R33, who reports she would like to go to a different facility. R33 is unsure of why she's not able to go to another facility or if she or her family has been invited or involved in any care conferences. On 9/3/25, Surveyor interviewed a facility RN, who reported R33 is often confused and makes false accusations. R33 is not compliant with wearing Bi Pap as ordered, making her more confused. During record review, no documentation was found on care conferencing for R33. Provider had been notified of Bi Pap noncompliance. Most recent MDS indicated R33 was included in her participation and goal setting. However, there is no documentation of a care conference, and no attempts of a care conference were noted. On 9/04/25 at 1:20 PM, Surveyor interviewed Director of Care Services/RN D, who stated there was no care conference done prior to completing R33's MDS assessment. RN D stated this is something the facility is working on and addressed in their Performance Improvement Plan (PIP). Surveyor reviewed facility's PIP, initiated on 7/28/25, and noted R33's MDS was completed on 7/30/25, after the PIP was put into place. The facility did not conduct a care conference for R33 after the deficiency was identified. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 2 R34 was admitted to the facility on [DATE]. R34's current diagnoses include metabolic encephalopathy, muscle weakness, dysphagia oropharyngeal, generalized anxiety disorder, bipolar disorder, Parkinson's disease, and dementia without behavioral disturbance. R34's care plan read in part, Patient to ambulate with nursing staff using 4WW & gait belt and wheelchair follow. Date Initiated: 08/22/2025 Revision on: 08/22/2025. The resident has limited physical mobility date initiated: 08/08/25, Interventions: The resident is NON-WEIGHT BEARING. The resident is WEIGHT-BEARING, AMBULATION: The resident requires (SPECIFY: assistance) by (X) staff to walk (SPECIFY FREQ) and as necessary. Date initiated: 08/08/25.The resident has an ADL self-care performance deficit date initiated: 08/08/25, Interventions .TRANSFER: The resident requires one person assist with gait belt for transfers. Resident to ambulate with one person assist using FWW and gait belt and wheelchair follow. Date initiated: 08/08/25. Surveyor observed during three days of survey, R34 walking the facility independently. On 09/04/25 at 1:51 PM, Surveyor interviewed Certified Nursing Assistant (CNA) J and CNA F about R34's ambulation status. CNA J stated believes R34 always been independent with ambulation. Surveyor asked if there had been changes to R34's ambulation status. CNA J was not able to state when the change occurred. CNA F stated therapy would send a sheet with status change and put in the book. CNA F looked in the therapy book and documented R34 to be an assist of 1 staff. CNA F reviewed CNA assignment sheet, and this documented R34 to be an assist of 1 staff. On 09/04/25 at 1:59 PM, Surveyor interviewed Director of Nursing (DON) B about R34's ambulation status asking why the care plan had not been updated. DON B stated care plans are being reviewed to ensure they are revised.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received care and treatment in accordance with professional standards of practice for 2 of 12 residents (R) reviewed for quality of care (R29, R1).R29 did not receive adequate weekly assessment and monitoring of moisture associated dermatitis wounds. R1 was not repositioned according to R1's care plan and facility policy, which caused R1 pain, the potential for skin shearing, and the potential for shoulder injury by improper repositioning.This is evidenced by: Example 1 R29 was admitted to the facility on [DATE]. R29's current diagnoses include altered mental status, cognitive communication deficit, weakness, reduced mobility, and sepsis due to Escherichia coli. Hospital after visit summary, dated 08/25/25, documented wound care left buttock wounds: Cleanse wound(s) with saline. Apply aquacel ag Cover with thick barrier cream to keep things in place. Change dressing daily and PRN. [NAME] knees of bed to prevent sliding. Keep HOB (head of bed) less than 30 degrees as tolerated by patient. Avoid reclining position in chair and bed and it places pressure on the coccyx and promotes friction from sliding down. Please order a specialty mattress according to the specialty bed surface decision tree. Reposition patient from side to side at least every 2 hours. Limit chair time and use Roho cushion when in chair. Review of facility physician orders for R29 did not have orders for wound care to the left or right buttock wounds. Facility admission assessment conducted on 08/25/25 documented an area to the right buttock measuring 4 cm by 2 cm as a skin ulceration and an area to the left buttock measuring 2 cm by 3 cm as a skin ulceration. No care plan was developed for skin integrity to promote wound healing. On 09/02/25 at 11:04 AM, Surveyor interviewed R29 about open areas to skin. R29 stated she came in from hospital with open areas on buttocks. R29 had a band aid from hospital and took skin off and then barrier cream in the areas and it got stuck to the pad and now they put powder on the areas. On 09/03/2025 at 9:32 AM, Surveyor interviewed Licensed Practical Nurse (LPN) H about R29's wounds. LPN H stated R29 is incontinent of bowel and will not tell staff when R29 had a bowel movement and staff will ask and R29 will deny. The area on R29's buttocks is light pink and chapped. R29 came in that way. R29 will spend most of her day in bed and is not up in wheelchair often. Will educate to reposition and R29 will for about 15 minutes and then put herself back. R29 directs her own care. LPN H feels she may have allergy to the brief and will try a pull up to see if this helps. The order prior was to place barrier cream and a calcium alginate to one area that needs some support. The order is now to just use the barrier cream. Surveyor asked to see the orders, and LPN H was unable to locate the orders. On 09/03/25 at 2:25 PM, Surveyor interviewed Director of Nursing (DON) B about wound orders and a comprehensive assessment for R29's wounds. DON B stated she did not see wound orders for R29. DON B stated there were no open areas. Surveyor reviewed the facility's admission assessment, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 08/25/25, with DON B which documented an area to the right buttock measuring 4 cm by 2 cm as a skin ulceration and an area to the left buttock measuring 2 cm by 3 cm as a skin ulceration and now the assessment was revised with today's date, 09/03/25, and the assessment of the wounds was changed. DON B stated she could not speak to that as DON B asked LPN H to complete the assessment since the assessment was not completed. At 2:43 PM, Surveyor interviewed LPN H asking about why the admission assessment was changed with the measurements being deleted and description of skin ulceration was deleted. LPN H stated the areas were not open and not pressure and the paperwork didn't say pressure. Surveyor asked if LPN H was the admission assessing nurse that documented the measurements and description of the wounds. LPN H stated she was not the admission assessing nurse that day. LPN H stated she saw R29 the next day. Surveyor asked for LPN H's skin assessment from the next day. LPN H stated there are no other wound assessments. Skin assessments are completed every Wednesday or on shower days. Example 2 R1 was admitted to facility on 03/03/25 and has diagnoses of Chronic Obstructive Pulmonary Disease (COPD), deaf, nonspeaking, quadriplegia C1-C4 incomplete, developmental disorder of speech and language, cognitive communication deficit, chronic pain syndrome, cervical stenosis, and was admitted to hospice on 04/10/2025. R1 has BIMS score of 13/15, indicating R1 is cognitively intact. R1 is deaf and reads lips and written communication. R1 makes own health care decisions. Facility policy, titled Repositioning and Safe Lifting and Movement of Residents, date not indicated, states in part: Repositioning the Resident in Bed Step 1: Check the care plan, assignment sheet or the communication system to determine the resident's specific positioning needs including equipment, resident level of participation and the number of staff required to complete the procedure .Step 9: Use two people and a draw sheet to avoid shearing while turning or moving the resident up in bed. Encourage resident to place feet flat on bed and assist with pushing up. Encourage the use of an overhead trapeze if resident is able to use one. Under Safe Lifting and Movement of Residents Policy Interpretation and Implementation .Part 2: Manual lifting of residents shall be eliminated when feasible. R1's care plan, revised on 08/19/2025, states: Self care deficit related to impaired physical mobility, anxiety, and cervical stenosis. Goal is resident will assist with ADL's (Activities of Daily Living) as able. Interventions include .Bed Mobility: Assist of 2 to boost up in bed .HOB (Head of Bed) elevated when in bed due to shortness of breath when lying flat. On 09/03/2025 at 9:44 AM, Surveyor observed R1 in supine position while in bed, slid down with feet resting against foot of bed, and bed in semi-Fowler's position. At this time CNA L was being interviewed by Surveyor regarding ways of communication to R1. CNA L noted improper positioning of R1 during interview and proceeded to lower R1's head of bed into Trendelenburg position without first informing R1. R1 immediately grimaced when bed was lowered and gestured with hands towards his face. CNA L then moved towards HOB, grabbed R1 under the armpits, and pulled R1 up in the bed. CNA L did not call for assistance prior to manually repositioning R1 alone. CNA L did not use mechanical device to assist. CNA L did not use the draw sheet that was under R1. CNA L did not ask R1 to assist with repositioning. CNA L stated, I know, I know, referring to R1's facial grimacing and raised HOB (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	back into semi-Fowler's position. On 09/04/25 at 10:41 AM, Surveyor interviewed Director of Nursing (DON) B about staff expectations and what training is required of staff for repositioning of residents. DON B provided a check off list of CNAs who have completed training that included safe repositioning and transferring of residents. CNA L was not amongst names on the list. DON B acknowledged that not all staff were listed and was unable to produce rest of trainings or competencies at that time.

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Amethyst Health of Wausau	1010 E Wausau Ave Wausau, WI 54403

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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 interview and record review the facility failed to ensure residents received care and treatment based on professional standards of practice related to assessment and monitoring of pressure injuries for 2 of 5 residents (R), R41 and R21, reviewed for pressure injuries. R41's hospital discharge summary noted a pressure injury to right heel that was being treated at outpatient wound care clinic twice weekly. R41's pressure injury was not comprehensively assessed by the facility until 9/3/25. R41's interventions to offload heels when in bed were not implemented and R41 missed wound care appointment on 9/2/25. R21's care plan show shows no updates on new pressure injury versus abscess on left ischium as noted on wound assessment. No staging of area is documented in R21's medical record. No new interventions are in place in care plan. This is evidenced by: Example 1 The National Pressure Injury Advisory Panel (NPIAP) and the Wound, Ostomy and Continence Nurses Society (WOCN) emphasizes patient assessment, the selection of appropriate support surfaces, proper positioning techniques, and avoiding harmful devices. Even with a specialty cushion, patients in a chair or wheelchair should be assisted to reposition at least every hour—or as frequently as every 15 minutes if possible—to shift their weight. admission date: 08/29/2025 Diagnoses: TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA LONG TERM (CURRENT) USE OF INSULIN History of DVT ACQUIRED ABSENCE OF LEFT LEG ABOVE KNEE FRONTAL LOBE AND EXECUTIVE FUNCTION DEFICIT FOLLOWING CEREBRAL INFARCTION PAROXYSMAL ATRIAL FIBRILLATION Pressure Injury. Orientation: Right. Eschar Physician Orders 8/29/25: Patient instructed to keep dressing dry Continue pressure relief measures (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Elevate heel off bed surface with pillow or other pressure relieving device Clean and dress wound as follows: Aquacel AG, ABD, offloading foam to heel, roll gauze, single layer size E Tubigrip, R41's most recent quarterly Minimum Data Set (MDS) with ARD target date of 9/7/25 notes: BIMS 15, no cognitive concerns Uses a wheelchair due to Left leg amputation above knee Can self-transfer from wheelchair Set up and stand by assist for toileting, bathing, and dressing Resident is at risk of developing pressure ulcers/injuries. Braden Skin Assessment 9/2/25 Score: 17 At Risk Primary Areas of concern identified: Mobility and Friction/Shear Wound Evaluation completed by facility on 9/3/25: Length: 2.71cm Width: 2.46cm Area: 5.24cm^2 90% eschar and 10% slough Facility assessed a stage IV pressure injury despite wound being unstageable. Record review included wound dimensions from wound clinic appointments prior to admission. Treatment: Aquacel AG, ABD, offloading foam (to heel,) roll gauze, single layer size E Tubi grip. Care Plan 8/29/25 The resident has potential/actual impairment to skin integrity The resident will maintain or develop clean and intact skin by the review date Encourage good nutrition and hydration in order to promote healthier skin Follow facility protocols for treatment of injury Provide pressure relieving device. Specify (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Turn and position as necessary Of note, the care plan does not include any specific offloading interventions for R41's heel. On 09/02/2025 at 1:37 PM, Surveyor interviewed R41 in bedroom. R41 reported his recent hospitalization for CVA and moderate pain from a skin injury to his right heel. R41 reported that staff have not removed bandage or checked wound since admission. R41 takes Oxycodone most days for pain. R41 stated that facility responds quickly to reports of pain and offers mobility/activity, rest, and finally pain medication as needed. On 09/02/2025 at 1:38 PM, Surveyor observed tubi grip wrapped non facility acquired injury on R41's right heel. Surveyor observed tubi grip on right foot. R41 reported that staff had not removed or adjusted the wrap since he arrived on 8/29/25. R41 reported that wrap is very tight and uncomfortable. R41 lowered grip and Surveyor observed swelling significant enough to leave indents on skin of calf and ankle. Facility has not provided pressure relieving device for use in bed despite intervention noted on care plan. On 09/02/2025 at 2:28 PM, R41 was observed lying in bed without feet elevated. R41 reported attempts to use pillows to lift right foot from bed surface, but it falls to the floor. R41 stated no other devices provided to elevate feet. No other devices were observed in room. On 09/04/2025 at 12:01 PM, Surveyor interviewed Certified Nursing Assistant (CNA) F. CNA F stated that R41 is at facility to rehab after CVA and is able to self-transfer. Surveyor asked about necessary staff observations of R41's pressure injury and interventions for healing of R41's right heel. CNA F stated that no communication had been provided as to specific purpose for wrap, instructions for care of pressure injury or interventions to prevent the pressure injury from worsening. On 09/04/2025 at 12:40 PM, Surveyor interviewed Registered Nurse (RN) G. RN G reported that no information had been provided at unit desk as to specific purpose for wrap, instructions for care of pressure injury or interventions to protect the skin on R41's heel. RN G then requested hospital discharge orders be printed by supervising RN on 9/3/25 for review. RN G reviewed orders and requested skin assessment be completed. Surveyor asked RN G if a facility completed wound evaluation dated 9/3/25 had been reviewed. RN G confirmed review and stated that skin assessment should have been completed by facility on admission on [DATE]. RN G noted that evaluation states that R41's pressure injury is 90% eschar and 10% slough and therefore is not stageable as the wound bed can't be visualized. RN G noted that facility skin assessment referring to a stage 4 pressure injury on R41's right heel is incorrect. RN G reviewed care plan and noted care plan intervention to off load right heel when R41 is in bed. RN G acknowledged there were no devices to offload heel and that offloading of pressure injury is necessary for healing. RN G stated the expectation for offloading device would be a heel boot for the pressure injury to R41's right heel. Surveyor observed RN G change bandage on R41's heel in bedroom. RN G completed proper hand hygiene and wore gloves and gown. The skin on R41's right heel was very dark. RN G gently cleansed area then replaced dressing and completed proper hand hygiene. On 9/4/2025 at 12:52 PM, Surveyor interviewed Director of Nursing (DON B.) DON B stated that (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound assessment and communication to facility staff were not thorough and intervention to offload heel was not on care plan. DON B stated that wound evaluation noting a stage 4 pressure injury was not accurate based on being 90% eschar and 10% slough. Surveyor requested information about ongoing treatment of R41's heel wound. On 9/4/2025 at 1:15 PM, Surveyor reviewed requested discharge records provided by DON B and noticed that R41 missed a scheduled follow up appointment at the wound care clinic scheduled on 9/2/25 on 11:30 a.m. On 9/4/2025 at 2:05 PM, Surveyor interviewed DON B about R41's discharge orders from hospital and asked about follow-up care. DON B acknowledged wound care appointments had been scheduled by the hospital for R41 and that wound care appointment for September 2 at 11:30 a.m. had been missed due to facility not reviewing discharge orders thoroughly. Example 2 R21 was admitted to facility on 01/10/2024 and has diagnoses of muscle weakness, generalized, cognitive communication deficit, other skin changes. R21 has a BIMS score of 15/15, indicating R21 is cognitively intact. R21 makes own health care decisions. R21's care plan, updated on 11/19/2024, with a target date of 07/19/25, states: The resident has potential impairment to skin integrity has history of heel wounds. Goal states The resident will maintain clean and intact skin by the review date. Interventions include .monitor/document location, size and treatment of skin injury . R21's Braden Scale on 08/13/2025 is 15, moderate risk for skin injury. On 09/03/25, record review noted Skin and Wounds Evaluation documentation done on 08/13/25 by Licensed Practical Nurse (LPN) H, indicated a new abscess found on left ischium requiring provider notification and treatment. Registered Nurse (RN) M cosigned wound assessment in medical record. Follow up weekly assessments, dated 08/20/25, 08/27/25, and 09/03/25 assessed and charted by LPN H. On 08/20/25 and 08/27/25, assessments were cosigned by RN M, and 09/03/25, assessment cosigned by RN N. Weekly assessment charting continued to refer to R21 as having an abscess. On 08/21/25, a Nurse Practitioner assessed R21's skin and documents: I was paged about this patient this week as she has new skin breakdown and orders were placed for treatment. She notes that she has redness and skin breakdown to her left buttock fold as well as a small area of erythema to her right buttock. No evidence is documented by the Nurse Practitioner of an abscess. No staging of area is documented in R21's medical record. Orders provided to facility on 08/19/25: Cleanse areas and apply Calcium Alginate and dressing every other day. cleanse wound with wound cleaner and pat dry Apply aquacel ag cut larger than wound and cover with bordered foam Change daily and prn until resolved (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/04/25, record review shows no care plan updates for R21 to include new pressure injury versus abscess on left ischium as noted on wound assessment. No new interventions are in place in care plan. It is unclear if R21 has an abscess or a pressure injury area. Interventions on Skin and Wound Evaluations include mattress with pump, moisture control, padded chair, and repositioning devices. On 09/04/25 at 9:15 AM, Surveyor interviewed R1 about area on left ischium. R1 stated, It is from sitting in my wheelchair for too long. Now I lay down after lunch to let pressure off. Surveyor was unable to observe wound care at that time because it was already done earlier in the morning. On 09/04/25 at 11:09 AM, Surveyor did a phone interview with RN M to clarify wound assessment by LPN H as being an abscess versus a pressure injury. RN M stated she never actually assessed the wound at any point in time and could not comment on status of area being treated. Surveyor asked if RN M cosigned wound assessment performed by LPN H on the three dates indicated and RN M stated, Yes, but I have not seen it. Surveyor asked RN M if area in question was an abscess or a pressure injury, and RN M confirmed it was a pressure injury from R21 sitting extended periods of time in wheelchair.

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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 interview and record review, the facility did not ensure residents (R) with indwelling Foley catheters received care and treatment consistent with professional standards of practice to prevent complications or urinary tract infections (UTI) from the catheter for 1 of 3 residents (R) reviewed, R29.R29 did not have physician orders for the Foley catheter and was not provided appropriate catheter care to prevent transmission of infections.This is evidenced by:Facility's policy titled Enhanced Barrier Precautions dated 03/25/24, read in part. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs tarted gown and gloves use during high contact resident care activities.4. High-Contact resident care activities include:.g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy ventilator tubes.Facility's policy titled Emptying a Urinary Collection Bag read in part. Steps in the Procedure.4. Place a paper towel on the floor beneath the drainage bag. R29 was admitted to the facility on [DATE]. R29's current diagnoses include altered mental status, cognitive communication deficit, weakness, reduced mobility, and sepsis due to Escherichia coli. Hospital Discharge summary dated [DATE] documented in part, Urinary retention, The patient will be discharge with a Foley. Urology follow-up.Review of R29's physician orders did not document the size of Foley catheter, balloon size, or when to change the catheter. Review of R29's care plans identified no Foley catheter plan of care was developed.On 09/03/25 at 2:18 PM, Surveyor interviewed Director of Nursing (DON) B about physician orders for R29's Foley catheter of size, balloon size, and when to change the catheter. DON B stated no physician orders were received, and no nursing follow-up was completed. On 09/03/25 at 10:32 AM, Surveyor observed Certified Nursing Assistant (CNA) I provide catheter care. On R29's door is a sign for enhanced barrier precautions and to the left of R29's room door is a bin with personal protective equipment containing gowns and gloves. CNA I applied gloves and did not apply a gown. CNA I gathered graduate from the bathroom and placed directly on the floor without a barrier. CNA I removed catheter bag from dignity bag and removed catheter port from holder and emptied the urine into the graduate. CNA I used an alcohol wipe to clean catheter port and placed back into holder. CNA I placed the catheter bag back into the dignity bag. CNA I emptied urine into toilet and rinsed graduate with emptying the rinsed contents into toilet. CNA I removed gloves and exited room, sanitizing hands. Surveyor interviewed CNA I and asked what should be done when R29 is on enhanced barrier precautions. CNA I stated a gown should be worn when doing the catheter care. Surveyor asked what should be done when placing the graduate directly on the floor. CNA I stated a paper towel should be on the floor. On 08/04/25 at 10:34 A.M., Surveyor interviewed DON B about proper infection control practices with catheter care for R29. DON B stated education will be provided. Surveyor asked if R29 should have physician orders for the specific size of Foley catheter, balloon size, or when to change the catheter. DON B acknowledge there should be a physician order.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not follow professional standards of practice of care for a resident who received medication through a peripherally inserted central catheter (PICC) for 1 of 1 resident (R) R29, reviewed.This is evidenced by:Facility's policy titled Central Venous Catheter Care and Dressing Changes, revision date March 2022, read in part. 3. Change the dressing if it becomes damp, loosened or visibly soiled and: a. at least every 7 days for TSM (transparent semi-permeable membrane dressing) dressing.5. Assess central venous access devices with each infusion and at least daily: a. visually inspect the entire infusion system (solution, administration set and dressing).d. Palpate and inspect the skin, dressing and securement device for signs of complications .e. Ask the resident if he or she is experiencing pain, tingling or numbness. R29 was admitted to the facility on [DATE]. R29's current diagnoses include altered mental status, cognitive communication deficit, weakness, reduced mobility, and sepsis due to Escherichia coli. Hospital Discharge summary dated [DATE] documented in part, Start taking these medications alteplase 2 MG injection inject 2 mg as directed once for 1 dose, 2mg per dose and may repeat dose in two hours if catheter remains occluded.Normal saline 0.9% injection, inject 5-10 mls into the vein daily. When not in use.Physician orders documented on 08/26/25 CefTRIAXone Sodium Solution Reconstituted 2 GM Use 2 gram intravenously every day shift for 2 days end 8/27/25 until 08/27/2025 23:59Surveyor reviewed R29's physician orders, medication and treatment administration record, and progress notes did not document daily assessments or treatments of R29's PICC line. On 09/02/25 at 11:01 AM, Surveyor interviewed R29 during initial tour. R29 stated the PICC line has not been used since last Wednesday, no one has looked at it and no one has flushed the line. R29 stated R29 will be asking physician today to take out the line. On 09/03/25 at 9:32 AM, Surveyor interviewed Licensed Practical Nurse (LPN) H about orders for PICC line. LPN H stated no orders for treatments for the PICC line were in place.On 09/03/25 at 2:18 PM, Surveyor interviewed Director of Nursing (DON) B about orders for PICC line daily flushes and assessments. DON B stated there were no assessments or orders.