STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525418	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evansville Manor Nursing and Rehab, LLC	470 Garfield Ave Evansville, WI 53536

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 30992 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported to the administrator and other officials in accordance with State law through established procedures for 1 of 9 residents (R8 and R9) reviewed for abuse. A friend of MR O (Medical Records) observed DA P (Dietary Aide) post a photo of R8 and R9 on her personal Snapchat account with text indicating Hanging with my homies. The friend of MR O forwarded the photo to MR O, who is employed at the facility. MR O did not immediately report this allegation of abuse to the facility. This is evidenced by: The Facility's Vulnerable Adult Abuse and Neglect Prevention Policy and Procedure, revised 3/25/25, documents in part: .It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, neglect, mistreatment or exploitation. The facility will follow the federal guidelines dedicated to the prevention of abuse .Additionally, residents and staff will be protected from abuse, neglect, and harm while they are residing at the facility. There is zero tolerance for abuse or harm of any type. Residents and staff will be monitored for protection. The facility will strive to educate all participants in techniques to protect all parties. Vulnerable Adult is generally defined as an individual who is at increased risk of harm, abuse, neglect, or exploitation due to physical, cognitive, or emotional limitations. Adults with Cognitive Impairments - Individuals who have conditions like dementia, Alzheimer's disease, or other cognitive disorders that make it difficult for them to understand or respond appropriately to their environment. Alleged Abuse: is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated and, if verified, could be non compliance with the Federal requirements related to mistreatment, exploitation, neglect or abuse . Reporting of Incidents: All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's designee. The facility must report to the State Agency immediately, but no 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 alleged violation involves, neglect, misappropriation of resident property, or exploitation and involves not serious bodily injury. Per Facility's Self-Report the following was documented: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date Occurred: 1/7/25 Time Occurred: 3:30 PM Is occurred date and time estimated: Yes Date discovered 1/7/25 Brief Summary of Incident: DA P posted picture of R8 and R9 on her personal Snapchat account. DA P suspended pending investigation. Management and Interim Nursing Home Administrator updated. DON (Director of Nursing) updated. Police Department contacted. Investigation initiated. AHCPOA (Activated Health Care Power of Attorney) for R9 and Guardian for R8 updated. Explain what steps the entity took upon learning of the incident to protect the affected person(s) and other from further potential misconduct. DA P (Dietary Aide) suspended and ultimately terminated due to not following company policy. On 5/14/25 at 10:20 AM and 1:45 PM, Surveyor spoke with NHA A (Nursing Home Administrator). Surveyor asked NHA A, who reported R8 and R9's photo on Snapchat to you. NHA A stated, MR O. NHA A added, she looked at this as an isolated incident when DA P used poor judgement. NHA A stated, the facility has no tolerance for staff taking photos of residents so DA P was terminated immediately. Surveyor asked NHA A, when did MR O see the photo. NHA A stated, she does not know. NHA A added, she was made aware in the morning (Note, MR O did not notify the facility until the following day.) NHA A stated, she though MR O contacted the facility right away vs waiting. NHA A stated, she was not aware of the timeline she just reported it. On 5/14/25 at 10:35 AM, Surveyor spoke with MR O. Surveyor asked MR O, when did you become aware of the photo of R8 and R9 posted on DA P's personal Snapchat account. MR O stated, she became aware of the photo when she was at home (evening). MR O stated, a friend of hers forward the photo posted by DA P to her personal Snapchat account to MR O. Surveyor asked MR O, when did you report this to NHA A (Nursing Home Administrator). MR O stated, she thinks it might have been the next day because she was deciding what to do with it. Surveyor asked MR O, how soon should you have reported this to NHA A. MR O stated, Right away.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 30992 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported to the administrator and other officials in accordance with State law through established procedures for 1 of 9 residents (R8 and R9) reviewed for abuse. A friend of MR O (Medical Records) observed DA P (Dietary Aide) post a photo of R8 and R9 on her personal Snapchat account with text indicating Hanging with my homies. The friend of MR O forwarded the photo to MR O, who is employed at the facility. The facility did not interview other residents to determine the scope of the concern or educate staff regarding timely reporting. This is evidenced by: The Facility's Vulnerable Adult Abuse and Neglect Prevention Policy and Procedure, revised 3/25/25, documents in part: .It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, neglect, mistreatment or exploitation. The facility will follow the federal guidelines dedicated to the prevention of abuse and timely and thorough investigations of allegations Additionally, residents and staff will be protected from abuse, neglect, and harm while they are residing at the facility. There is zero tolerance for abuse or harm of any type. Residents and staff will be monitored for protection. The facility will strive to educate all participants in techniques to protect all parties. Vulnerable Adult is generally defined as an individual who is at increased risk of harm, abuse, neglect, or exploitation due to physical, cognitive, or emotional limitations. Adults with Cognitive Impairments - Individuals who have conditions like dementia, Alzheimer's disease, or other cognitive disorders that make it difficult for them to understand or respond appropriately to their environment. Alleged Abuse: is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated and, if verified, could be non compliance with the Federal requirements related to mistreatment, exploitation, neglect or abuse . Investigation: Upon receiving a complaint of alleged maltreatment, the Administrator must be notified immediately and they, the Director of Nursing, or assigned designee, will coordinate an investigation, which will include completion of witness statements. All parties involved including two of the following - staff, residents or visitors who were potentially involved, or observed the alleged incident are to be interviewed by the DON, Director of Social Services, or their designees .If it appears that maltreatment .Education will be provided as needed to all parties involved. Per Facility's Self-Report the following was documented: Date Occurred: 1/7/25 Time Occurred: 3:30 PM Is occurred date and time estimated: Yes Date discovered 1/7/25 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Brief Summary of Incident: DA P posted picture of R8 and R9 on her personal Snapchat account. DA P suspended pending investigation. Management and Interim Nursing Home Administrator updated. DON (Director of Nursing) updated. Police Department contacted. Investigation initiated. AHCPOA (Activated Health Care Power of Attorney) for R9 and Guardian for R8 updated. Explain what steps the entity took upon learning of the incident to protect the affected person(s) and other from further potential misconduct. DA P suspended and ultimately terminated due to not following company policy. On 5/14/25 at 10:20 AM and 1:45 PM, Surveyor spoke with NHA A (Nursing Home Administrator). Surveyor asked NHA A, who reported R8 and R9's photo on Snapchat to you. NHA A stated, MR O. Surveyor asked NHA A, did you interview other residents regarding staff taking potos of them. NHA A stated, no. NHA A stated, she thought it was an isolated incident. Surveyor asked NHA A, should you have interviewed other residents to determine the scope of the concern. NHA A stated, yes, we could have. NHA A added, she looked at this as an isolated incident when DA P used poor judgement. NHA A stated, the facility has no tolerance for staff taking photos of residents so DA P was terminated immediately. Surveyor asked NHA A, when did MR O see the photo. NHA A stated, she does not know. NHA A added, she was made aware in the morning (Note, MR O did not notify the facility until the following day.) Surveyor asked NHA A stated, she though MR O contacted the facility right away vs waiting. NHA A stated, she was not aware of the timeline she just reported it. Surveyor asked NHA A, if you would have been aware that MR O was made aware of the photo the evening before would have educated all staff regarding timely reporting. NHA A stated, yes. On 5/14/25 at 10:35 AM, Surveyor spoke with MR O. Surveyor asked MR O, when did you become aware of the photo of R8 and R9 posted on DA P's personal Snapchat account. MR O stated, she became aware of the photo when she was at home (evening). MR O stated, a friend of hers forward the photo posted by DA P to her personal Snapchat account to MR O. Surveyor asked MR O, when did you report this to NHA A. MR O stated, she thinks it might have been the next day because she was deciding what to do with it. MR O stated, she is not friends with DA P on Snapchat. Surveyor asked MR O, how soon should you have reported this to NHA A. MR O stated, Right away. The facility did not interview other residents to determine the scope of the concern or educate staff.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on observation, interview, and record review, the facility did not ensure adequate supervision and safety to prevent accidents from occurring for 2 of 3 residents (R6 and R15) reviewed for falls and 4 of 5 residents (R12, R18, R19, and R20) reviewed for Hoyer transfers. R6 is being cited at severity level 3 (actual harm). R15, R12, R18, R19, and R20 are being cited at severity level 2 (potential for more than minimal harm). R6 was left in her bed with the bed in the high position. R6 fell out of bed landing face down resulting in a nasal fracture and lacerations to her forehead and lip that required sutures. R12, R18, R19, and R20 were being transferred with a Hoyer lift and only one staff present, resulting in R12 sustaining a skin tear to his toe. R15's care planned interventions were not being followed, resulting in a possible hand fracture. This is evidenced by: Facility policy titled, Fall Reduction Policy dated 8/1/15 with last revision date of 10/13/23, states in part: Purpose: To provide an environment that remains as free of accident hazards as possible .To promote a systematic approach and monitoring process for the care of residents who have fallen and/or those who are determined to be at risk . Risk Identification and Assessment: 1. A systematic approach data collection to evaluate and identify the presence if risk factors, related causes, and complications . Prevention and Treatment Guidelines: 1. These risk factors include, but are not limited to: a. Mental status . c. Ambulation and elimination status . Example 1: R6 was admitted to the facility on [DATE] with diagnoses that include Anxiety Disorder, unspecified, Posttraumatic Stress Disorder, unspecified, Unspecified Symptoms and Signs Involving Cognitive Function and Awareness, Unspecified Intellectual Disabilities, Mild Cognitive Impairment of Uncertain or Unknown Etiology, Bipolar Disorder, and Unspecified Dementia. R6's most recent Minimum Data Set (MDS) dated [DATE] states that R6 has a Brief Interview of Mental Status (BIMS) of 8 out of 15, indicating that R6 has moderate cognitive impairment. Section GG of the MDS, states that R6 requires total dependence on staff for all Activities of Daily Living (ADLs) including toileting, hygiene, dressing, showering, transfers, and bed mobility. R6's Comprehensive Care Plan states, in part: -Focus: The resident is at risk for falls R/T (related to) immobility, use of psychotropic medications-1/19/23-Fall with injury - sent to ER 2/20/25 UWF (Unwitnessed Fall) Date Initiated: 01/13/23 Revision on: 02/20/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Goals: Resident will be free from further serious injury related to falls through the next review date. Date Initiated: 01/21/24 Revision on: 02/28/25 Target Date: 05/29/25. Interventions: 2/20/25 Ensure Resident's bed is lowered when leaving room. Date Initiated: 02/24/25 . 2/20/25 UWF Fall mat by bed and soft touch call light. Date Initiated: 02/20/25 Revision on: 02/24/25 . 2/21/25 Bari bed with a Bari air mattress. Date Initiated: 02/24/25 . CANCELLED: For fall on 1/19/23 - Ensure that she is positioned in middle of bed (air mattress) Resolved: 1/23/24. -Focus: The resident has limited physical mobility R/T (related to) low back pain, poor balance and gait -GG task items removed from POC (Point of Care) charting for walking: Resident not ambulatory, Sitting edge of bed: Resident not able to sit at edge of bed, Toileting: resident does not use toilet or commode, Wheelchair: Resident does not use standard w/c (wheelchair)- uses a Broda. Date Initiated: 01/13/23 Revision on: 02/18/24. -Goal: The resident will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury through the next review date. Date Initiated: 07/05/23 Revision on: 02/17/25 Target Date: 05/29/25. -Interventions: Ambulation/Locomotion- Broda Chair - Manual -one assist-use pedals. Date Initiated: 01/13/23 Revision on: 12/22/23 . Bed Mobility Assist - One. Date Initiated: 01/23/23 . Resolved: Bed mobility assist of two. Resolved: 1/23/23 . Transfer Assist - Full body lift - Assist Two -Hoyer. Date Initiated: 01/13/23 Revision on: 01/13/23. R6's Certified Nursing Assistant (CNA) Kardex states, in part: Bed Mobility: *2/20/25 Ensure Resident's bed is lowered when leaving room * Bed Mobility Assist - One Mobility/Transfer: *Ambulation/Locomotion - Broda Chair - Manual * Transfer Assist - Full Body Assist - Assist Two -Hoyer Safety/Monitor: * 1/19/24 slightly recline Broda chair for comfort and positioning * 2/20/25 UWF Fall mat by bed and soft touch call light * 2/21/25 Bari bed with a Bari air mattress (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R6's Fall Report dated 2/20/25 at 7:30 AM, states, Writer called to resident's room by NOC (overnight) shift nurse. 200 LPN (Licensed Practical Nurse) in with resident. Resident lying face down on floor perpendicular to bed. Substantial amount of blood on floor, laceration noted to right forehead and upper lip, nose bleeding. 911 had been called. An addendum to this fall incident entered by DON B (Director of Nursing), States, IDT met to review fall from 2/20. Staff were in room a few minutes prior getting resident cleaned up for the day. Resident was found laying face down on the floor. Resident was assessed by the nurse and was decided to send out due to lacerations and bloody nose. Provider, hospice, and POA (Power of Attorney) updated. Resident provided a soft touch call light and fall mat next to bed. R6's emergency room (ER) After Visit Summary, dated 4/20/25, states, in part: Dx (Diagnosis): Fall, initial encounter, Facial laceration, initial encounter, Bilateral hand pain, Closed fracture of nasal bone, initial encounter, Hospice care patient, Epistaxis (nosebleed). Chief Complaint: Fall. Pt (patient) was reaching for call light when she fell out of bed unwitnessed. Pt is on C-Collar (cervical collar to support and stabilize the neck). Pt has a bloody nose and hematoma (a pool of mostly clotted blood that forms in the tissues) to forehead . Procedure: Laceration Repair to Forehead (2.6 cm X 7.5 cm X 3 cm). One layer suture closure. 6 sutures placed. Procedure: Lip Laceration (less than 2.5 cm X 3.5 cm). One layer suture closure. 7 sutures placed Progress Note: Resident presented after fall out of bed. Noted to have a large lip laceration as well as a laceration above her right eye which are bleeding. Significant blood in bilateral nostrils and nasal bridge swelling. Also question a laceration to the nasal septum on the right side. She is in a cervical collar and will maintain C-spine precautions Laceration repair needed to her face. Will place Afrin and cotton into her nostrils in order to try to obtain hemostasis (cessation of bleeding) . On 5/12/25 at 10:25 AM, Surveyor interviewed CNA I (Certified Nursing Assistant) and asked her what R6's current fall interventions were. CNA I stated that R6's bed was to be all the way to the ground, a fall mat in place next to the bed, don't leave her unattended when the bed is in high position, make sure call light is within reach, and make sure she has everything she needs before you leave the room. Surveyor asked CNA I if R6 ever attempted to self-transfer or get out of bed on her own. CNA I stated that R6 does not self-transfer or attempt to get out of bed on her own. Surveyor asked CNA I to accompany her to R6's room. Surveyor asked CNA I where R6's call light was. CNA I retrieved the call light from behind R6's bed and placed it next to her on the bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/13/25 at 10:30 AM, Surveyor interviewed LPN E (Licensed Practical Nurse) and asked her what time the incident involving R6. LPN E stated the incident happened at approximately 7:00 AM. LPN E stated that it had to have happened pretty early, since NOC (overnight) shift was still there. LPN E stated she was in the process of preparing her medication cart when RN H (Registered Nurse) told her that R6 had fallen. LPN E said she went to R6's room and saw that she was laying on the floor facedown. LPN E stated that she didn't want to move her. LPN E stated that she thought that LPN G was the one that called 911. LPN E stated that she asked R6 what happened and R6 indicated that she had been reaching for her call light. LPN E stated that R6 was crying but consolable. LPN E stated that she noted that the bed was up at waist high level and that she was able to lean her hip into it when she bent down to get closer to R6. On 5/13/25 at 12:49 PM, Surveyor interviewed CNA F about the incident involving R6. CNA F stated that she got R6 dressed and put the Hoyer sling under her, then went to another room to get clothes for someone else when she heard R6 yelling for help. CNA F indicated that when she returned to R6's room she was on the floor face down and bleeding. CNA F stated that she ran and got the nurses for help, and they helped her roll R6 onto her back. CNA F indicated that they all stayed with R6 until the ambulance arrived. Surveyor asked CNA F what time the fall took place. CNA F stated that it happened around 7:10 AM. CNA F stated that R6 was crying and in a lot of pain. CNA F stated that R6 doesn't even roll by herself, so it was a freak accident, and she wasn't even sure how it happened. (Of note, R6's bed was at waist height per LPN E's interview, CNA F indicated she left R6 to attend to another resident.) On 5/13/25 at 1:03 PM, Surveyor interviewed RN H about the incident involving R6. RN H stated that he thought it happened around the change of shift, sometime between 6:30 AM and 7:00 AM. RN H stated that he worked the NOC shift and was giving report to the nurse who had come in that morning. RN H stated that he saw CNA F come down the hall saying that R6 had fallen out of bed. RN H stated he went to R6's room and noted her on the floor laying on her back with a gash in her face. On 5/14/25 at 7:59 AM, Surveyor interviewed LPN M and asked her if R6 was able to roll over by herself. LPN M stated no, she had never seen R6 roll over by herself. On 5/14/25 at 8:38 AM, Surveyor interviewed CNA L and asked her if R6 was able to roll over by herself. CNA L stated no, she had never seen R6 roll over by herself. On 5/14/25 at 8:40 AM, Surveyor interviewed CNA J and asked if R6 was able to roll over by herself. CNA J stated no, that R6 was a full heavy assist. CNA J stated that maybe if R6 were propped up on her side then maybe she could roll over the rest of the way, but she could not completely roll over by herself. On 5/14/25 at 8:47 AM, Surveyor interviewed CNA K and asked if R6 was able to roll over by herself. CNA K stated no, that R6 was a full assist for transfers and turning in bed. On 5/14/25 at 8:52 AM, Surveyor interviewed MD N (Maintenance Director). Surveyor asked MD N to measure a bed which was at waist high position. MD N measured this to be approximately 35 inches from the floor. MD N stated that beds should only be that high for the staff to perform cares on the residents and they should not be left in that position. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/14/25 at 9:56 AM, Surveyor interviewed RN C and asked her if R6 was able to roll over by herself. RN C stated no, she had never seen R6 roll over by herself. On 5/14/25 at 10:01 AM, Surveyor interviewed LPN G about the incident involving R6. LPN G stated that she heard CNA F yelling for assistance. LPN G indicated that when she entered R6's room she saw she had fallen and was lying face down. LPN G stated that with the assistance of two other nurses, they stabilized R6's neck, holding her head in place, and log rolled her over onto her back to see where the blood was coming from. LPN G stated that she applied pressure to R6's forehead and lip and tried to wipe her nose to clear the clots that were coming out of her nose. LPN G stated that she couldn't remember the exact time of the incident, but that it was early and around shift change. Surveyor asked LPN G if R6 was able to roll over by herself. LPN G replied no, that R6 cannot roll by herself. On 5/14/25 at 12:11 PM, Surveyor interviewed DON B (Director of Nursing) about the incident involving R6. DON B stated that CNA F had been doing cares with her and she's a Hoyer, so CNA F left the room to start cares on another two-assist person and heard R6 yelling for help. CNA F went into R6's room and she was laying on her face. CNA F called the nurses to the room for help. The nurses called 911 because R6 was bleeding from her face. Surveyor asked DON B if she would expect that the CNAs would not leave residents unattended with the bed in high position. DON B stated yes, that was her expectation. R6 was left in bed in the high position resulting in a fall with a nasal fracture and laceration(s) requiring sutures. Example 2: Facility policy titled, Total Mechanical Transfer dated 8/1/15 with a revision date of 8/22/23, states, in part: Purpose: To safely transfer residents who have been assessed per the Safe Patient Handling program to require the use of a total mechanical lift . Procedure: . 2. The total mechanical lift must have two staff members present. Staff members include nurses, aides, PT (Physical Therapy) and OT (Occupational Therapy) . R12 was admitted to the facility on [DATE] with diagnoses that include Hemiplegia (paralysis that affects one side of the body) and Hemiparesis (one sided muscle weakness) following Cerebral Infarction (a stroke resulting from disrupted blood flow to the brain) affecting Right Dominant side and Type 2 Diabetes Mellitus with Diabetic Polyneuropathy (malfunction of many peripheral nerves throughout the body). R12's most recent BIMS dated 5/7/25 states that R12 has a BIMS of 15 out of 15, indicating that R12 is cognitively intact. R12's Comprehensive Care Plan states, in part: -Focus: [Resident Name] is at risk for falls R/T (related to) DM (Diabetes Mellitus), non-ambulatory status. Date Initiated: 05/09/22 Revision on: 12/18/23. Goal: [Resident Name] will be free from incident/ falls though the review date. Date Initiated: 05/09/22 Revision on: 04/21/25 Target Date: 07/29/25. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Interventions: Assist of 2 with Hoyer (For incident on 6/9/22) Date Initiated: 06/10/22. -Focus: I am at risk for alteration in skin integrity R/T decreased mobility due to right sided weakness after a Stroke; risk for fluid volume overload due to CHF (Congestive Heart Failure) . history of previous skin integrity issues . structural foot changes . 12/16 Skin abrasion noted to left superior first toe and third toe. Date Initiated: 05/09/22 Revision on: 12/17/24 Goal: I will be free from further skin breakdown through the review date. Date Initiated: 05/09/22 Revision on: 04/21/25 Target Date: 07/29/25 Interventions: 12/16 Skin abrasion noted to left superior first toe and third toe. Intervention: Ensure proper foot positioning when transferring patient. Date Initiated: 12/17/24. R12's CNA Kardex states, in part: Mobility/Transfer: *Resident is non ambulatory and unable to transfer without a Hoyer and 2 assist. Walking will be removed from POC charting as this is not applicable. He is a right hemi from a previous CVA (Cerebral Vascular Accident). * Transfer Assist - Assist of 2 with Hoyer Watch placement of feet with transfers and when sitting in the recliner Safety/Monitor: *Assist of 2 with Hoyer (For incident on 6/9/22) * 12/16 Skin abrasion noted to left superior first toe and third toe. Intervention: Ensure proper foot positioning when transferring patient. R12's Clinical Progress Notes, state, in part: On 12/16/24 at 4:14 PM, CNA reports while transferring resident from bed to shower chair clipped resident's toes/feet on Hoyer lift. On 12/16/24 at 4:35 PM, Skin abrasion noted to left superior first toe and third toe less than 1 CM in length and width not actively bleeding at this time. Res. (Resident) reports abrasion occurred during transfer. Res. states he feels safe at this time, and it was an accident. Education reinforced on transfer safety to assisting CNA. NP (Nurse Practitioner), POA (Power of Attorney) and ADON (Assisted Director of Nursing) updated. NP instructed to cont. (continue) to monitor update with any changes. On 5/12/24 at 10:31 AM, Surveyor interviewed R12 who stated that usually the staff are pretty good about getting two staff members to use the Hoyer lift and that he thought that the CNA did not mean any harm when she transferred him alone. (continued on next page)

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	525418	A. Building B. Wing	05/15/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/13/25 at 12:09 PM, Surveyor interviewed DON B and asked her if she expected the staff to follow the safe mechanical transfer policy. DON B stated yes, she expected the staff to follow the facility policy for safe transfers using the Hoyer with two staff members. On 5/14/25 at 4:42 PM, Surveyor interviewed CNA Q about the incident with R12. CNA Q stated that it was a PM shift, before dinner, and she was planning on giving R12 a shower. CNA Q stated that she radioed for help three times in the span of 20 minutes and did not receive any reply. CNA Q stated she then went out into the hallway looking for someone to help her transfer R12 but couldn't find anyone. CNA Q stated that with the stress of trying to get R12's shower done before dinner, she took it upon herself to transfer R12 by herself and he sustained a cut on his toe. On 5/14/25 at 3:00 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked her if she expected staff to follow facility policies regarding safe transfers. NHA A stated yes, she expected the policy to be followed for Hoyer transfers and that they would always have two staff members to assist when using the Hoyer. Example 3: R18 was admitted to the facility on [DATE] with diagnoses that include Hereditary Spastic Paraplegia (weakness, stiffness, and paralysis in the leg muscles), Generalized Anxiety Disorder, Depression, unspecified, and Cognitive Communication Deficit. R18's most recent MDS dated [DATE] states that R18 has a BIMS of 8 out of 15, indicating that R18 is moderately impaired. R6's Comprehensive Care Plan states, in part: -Focus: The resident has limited physical mobility R/T paraplegia . Sit to stand, toilet transfer, steps, stairs, ambulation and picking up objects not applicable and will be removed from POC (Point of Care) charting. Date Initiated: 9/6/24. Revision on 3/23/25. -Goal: The resident will improve current level of mobility through next review date. Date Initiated: 9/6/24 Revision on: 9/12/24 Target Date: 6/5/25. -Intervention: Ambulation: The resident is non-ambulatory. Date Initiated: 9/6/24. Bed Mobility Assist - Two. Date Initiated: 9/6/24 . Transfer Assist - Full Body Lift - Assist Two. Date Initiated: 9/6/24. On 5/14/25 at 8:15 AM, Surveyor interviewed R18 who stated that they use the lift to hoist me out of bed. R18 stated there is usually two people using the Hoyer lift to transfer him, but occasionally they will only have one staff. Example 4: R19 was admitted to the facility on [DATE] with diagnoses that include Depression, unspecified, Permanent Atrial Fibrillation (an irregular and chaotic heartbeat), Chronic Respiratory Failure with Hypoxia (insufficient oxygen to the tissues), and Chronic Kidney Disease. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R19 had not had a BIMS completed yet at time of survey. R19's Comprehensive Care Plan states, in part: -Focus The resident has limited physical mobility R/T obesity, metatarsal fxs (foot fractures). Date Initiated: 5/12/25. Revision on 5/12/25. -Goal: The resident will improve current level of function in transferring through next review date. Date Initiated: 5/12/25 Target Date: 8/7/25. -Intervention: Ambulation/Locomotion - Wheelchair - manual. Date Initiated: 5/12/25. Bed Mobility Assist - Two. Date Initiated: 5/12/25 . Transfer Assist - Full Body Lift - Assist Two. Date Initiated: 5/12/25. Revision on 5/13 /25. On 5/14/25 at 8:39 AM, Surveyor interviewed R19 who stated that the facility is using the Hoyer lift to transfer her. R19 stated that they use one to two staff members to assist her when using the Hoyer lift. Example 5: R20 was admitted to the facility on [DATE] with diagnoses that include Hemiplegia and Hemiparesis following Cerebral Infarction affection left non-dominant side, Unspecified Dementia without behavioral disturbance, Depression, unspecified, and Other Symptoms and Signs involving Cognitive Functions and Awareness. R20's most recent MDS dated [DATE] states that R20 has a BIMS of 10 out of 15, indicating that R20 is moderately impaired. R20's Comprehensive Care Plan states, in part: -Focus The resident has limited physical mobility R/T (related to) weakness/deconditioning, personal hx (history) of CVA (Cereberal Vascular Accident) with left sided weakness. Date Initiated: 11/1/24. Revision on 11/15/24. -Goal: The resident will remain free of complications related to immobility, including contractures, thrombus formation, skin breakdown, fall related injury through next review date. Date Initiated: 4/17/25 Target Date: 7/2/25. -Intervention: Ambulation/Locomotion - Wheelchair - manual one assist as needed. Date Initiated: 11/1/24. Bed Mobility Assist - Two. Date Initiated: 1/3/25. Transfer Assist - Full Body Lift - Assist Two. Date Initiated: 11/1/24. Revision on: 1/3/25. On 5/14/25 at 8:34 AM, Surveyor interviewed R20 who stated that they put me on this machine and lift me up. R20 indicated that mainly they use two staff members when using the Hoyer but that they don't always have enough workers so sometimes they just use one. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/14/25 at 3:00 PM, Surveyor interviewed NHA about her expectation for staff using the Hoyer lift for resident transfers. NHA stated that it was her expectation that staff would always have two people assisting when using the Hoyer lift. Example 6: R15 was admitted to the facility on [DATE] with diagnoses that include, in part: Type 2 Diabetes Mellitus, Peripheral Vascular Disease (a progressive circulation disorder caused by narrowing and blockage in the blood vessels), Congestive Heart Failure, Chronic Pain, Uncomplicated Anxiety disorder, Acquired Absence of Right Leg Below Knee amputation, Gangrene Left Leg, Chronic Kidney Disease, and Adult Failure to Thrive. R15's most recent MDS dated [DATE] states that R15 has a BIMS of 3 out of 15, indicating that R15 has severe cognitive impairment. Section GG of R15's MDS indicates that R15 is totally dependent upon staff for bed mobility, toileting, and transfers. R15's Comprehensive Care Plan states, in part: -Focus: The resident is low risk for falls 4/26/25 Unwitnessed fall Date Initiated: 03/18/25 Revision on: 04/28/25. -Goal: I will be free from further incident/ falls though the review date. Date Initiated: 03/18/25 Target Date: 06/15/25 -Interventions: 4/26/25 Unwitnessed fall--Lay resident down after all meals. Date Initiated: 04/28/25. -Focus: The resident has limited physical mobility r/t Atherosclerosis of Native Arteries of Extremities with Gangrene, Left Leg. Date Initiated: 03/18/25 Revision on: 03/18/25 -Goal: The resident will improve current level of function in transferring through next review date. Date Initiated: 03/18/25 Target Date: 06/15/25. -Interventions: Ambulation/Locomotion - Wheelchair - Manual -dependent Date Initiated: 03/18/25. Bed Mobility Assist - Two. Date Initiated: 03/18/25. Transfer Assist - Full Body Lift - Assist Two. Date Initiated: 03/18/25. R20's CNA Kardex, states, in part: Bed Mobility: *Bed Mobility Assist - Two Mobility/Transfer: *Ambulation/Locomotion - Wheelchair- Manual -dependent *Transfer Assist - Full Body Lift - Assist Two (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Safety/Monitor: * 4/26/25 Unwitnessed fall--Lay resident down after all meals. *Assist resident to meet needs and maintain safety: keep call light within reach. keep personal effects in easy reach, remind to avoid sudden position changes that may cause increased pain. R15's Incident Report for Unwitnessed Fall states the following: On 4/26/25 at 7:00 PM, At about 1900 hrs. (7:00 PM), writer was called to resident's room by CNA stating that resident was on the floor. Upon arrival, writer found resident on the floor on her left side. resident did not appear to be in pain. resident was conversing with staff in her normal tone, moving both upper extremities. Resident was on the floor left side facing bed, wheelchair behind her. Call light was not on at this moment. Resident stated that she might have been sleeping and declined having pain at this moment No injuries sustained from this fall; resident declined having pain. Full ROM (Range of Motion) noted to all extremities . R15's Incident Report for Injury of Unknown Origin states the following: On 4/29/25 at 12:00 PM, Res (resident) right hand swollen placed call to primary at UW [NAME] left message called POA . update given decision made to send to Mertier for eval (evaluation) transported via stretcher van .Sent to ER for x-ray. Results have conflicting information about chronic or new fracture in hand. DON and NHA (Nursing Home Administrator) notified . R15's ER Note dated 4/28/25 states, in part: Chief complaint: Hand pain History: Presents to the ER for right wrist pain and swelling. Here by private ambulance from SNF. Patient states that on Friday, she tripped and fell in doorway. Since then she has had some pain in the dorsum of her right hand. Staff only noted the swelling today. X-ray imaging results: 3 view Findings: No displaced fracture or dislocation. Alignment anatomic. Joint spaces maintained. Findings of remoted healed fracture of the base of the 5th metacarpal. Diagnosis: Fall from standing, initial encounter. Closed displaced fracture of shaft of fifth metacarpal bone of right hand, initial encounter. Likely acute or chronic fracture. Splint application. Refer to orthopedics. Please note, there is disagreement in the ER encounter, with the radiologist stating that there was no new fracture to the hand, while the ER doctor was undecided if it was an acute or chronic fracture. On 5/1/25 the Interdisciplinary Team (IDT) review states: Unwitnessed fall. Root cause: Asleep in w/c (wheelchair). Intervention: Lay dawn after meals. Intervention is effective. Signed by NHA on 5/1/25 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/12/25 at 10:40 AM, Surveyor observed R15 in her room asleep in her wheelchair. On 5/15/25 at 9:16 AM, Surveyor observed R15 in her room asleep in her wheelchair. On 5/15/25 at 9:33 AM, Surveyor interviewed CNA Y and asked her about laying R15 down after meals. CNA Y stated that she asked R15 that morning and that she refused. Surveyor asked CNA Y where she documents R15's refusals. CNA Y indicated that there was no place to document refusals. CNA Y stated that she didn't think that R15 had much of a fall plan because she has only had the one fall, during which she was grabbing for something, and they gave her a grabber. CNA Y stated that she had asked R15 twice to lay down after breakfast and she had refused. CNA Y indicated that she had reported the refusal to RN C. On 5/15/25 at 9:36 AM, Surveyor interviewed RN C about laying R15 down after meals. RN C stated that R15 does refuse to lay down about 50% of the time, but that CNA Y had not reported any refusals to her that morning. Surveyor asked RN C where the refusals are documented. RN C stated that she would normally enter a progress note. On 5/15/25 at 9:40 AM, Surveyor interviewed CNA Z about laying R15 down after meals. CNA Z stated that R15 will refuse to lay down after breakfast a lot, so she really encourages R15 to lay down after lunch because there is such a long time between lunch and dinner. Surveyor asked what she would do if R15 refuses to lay down. CNA Z stated that she would tell the floor nurse and the DON. On 5/15/25 at 9:45 AM, Surveyor interviewed R15 who was sitting in her room in her wheelchair. R15 stated that the staff do ask her to lie down and sometimes she does, and sometimes she doesn't. R15 indicated that staff had talked to her about the importance of laying down and that she shouldn't spend so much time sleeping in her wheelchair, but that she doesn't want to spend all day in bed. On 5/15/25 at 11:03 AM, Surveyor reviewed the Treatment Administration Record (TAR) with RN C and asked her how she knew that R15 refused to lay down 50% of the time, since it was not being documented as such. RN C stated it was just what she had heard. RN C indicated that today was the first time that the CNAs told her that R15 had refused to lay down after breakfast. Surveyor asked how she would find out if R15 refused. RN C indicated that she would rely on the CNAs to report that information to her. On 5/15/25 at 11:21 AM, Surveyor interviewed RN X about laying down R15 after meals. RN X stated that R15 will refuse to lay down about 50% of the time, especially after breakfast. Surveyor asked RN X if those refusals are documented anywhere. RN X stated that she was not sure she had ever documented a refusal. Surveyor asked RN X if refusals should be documented. RN X stated that yes, refusals should be documented either in the MAR (Medication Administration Record) or TAR or put in a progress note. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/15/25 at 2:22 PM, Surveyor interviewed DON B about laying down R15 after meals. DON B stated it should be on her care plan. DON B indicated that she didn't think that they triggered it for the CNAs to be able to chart on it, so she would expect the nurses to enter a progress note into the electronic health record. DON B stated that she would expect the nurse and CNA to collaborate, either the nurse to check or the CNA to tell the nurse that she refused to lay down. DON B stated that she did complete a risk versus benefits with R15 today about her being up in her chair more than an hour at a time, but that she was unaware that she was refusing to lay down after meals. Surveyor asked DON B if repeated refusals was something that she would expect the staff to communicate to her. DON B stated yes, she would have expected the staff to communicate that with her before today. Surveyor asked DON B how they are keeping R15 safe if she is asleep in her wheelchair. DON B stated that the CNAs do rounds and are checking on her throughout the day. Surveyor asked DON B if laying down after meals was an effective intervention for falling asleep in the wheelchair if she continues to refuse. DON B indicated no, that would not be an effective intervention and that they would have to talk to the staff and meet as an IDT team to revise the intervention. The facility failed to protect Residents from being transferred unsafely, failed to ensure staff are following care planned interventions or reviewing and revising the care plan to ensure interventions are appropriate.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on interview and record review, the facility did not ensure adequate monitoring for medications for 1 of 4 Residents (R3) reviewed for unnecessary medications. R3 was receiving Metoprolol (blood pressure medication) without evidence of R3's blood pressure being monitored per physician orders. Evidenced by: The facility policy, entitled Administering Medications, dated 1/22/24, states, in part: . Purpose: To ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. Procedure: . 4. Medications shall be administered per provider's (Medical Doctor, Nurse Practitioner. Physician Assistant) written/verbal orders upon verification of the right medication, dose, route, time . R3 was admitted to the facility on [DATE] and discharged on [DATE]. R3 has diagnoses that include hypertension (high blood pressure, a condition in which the force of the blood against the artery walls is too high) and paroxysmal atrial fibrillation (a type of irregular heartbeat where episodes of AFIB (an irregular, often rapid heart rate that commonly causes poor blood flow) occur intermittently and usually stop on their own within a week.) R3's Quarterly Minimum Data Set (MDS) Assessment, dated 3/28/25, shows R3 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R3 is cognitively intact. R3's Physicians Orders for January, February, March and April of 2025, states, in part: . Metoprolol Succinate ER Oral Tablet Extended Release 24 hour 25 milligrams (mg)- Give 1 tablet by mouth one time a day for HTN (hypertension) hold for systolic less than 110 . R3's January, February, March, and April Medication Administration Records (MAR) state, in part: . Metoprolol Succinate ER Oral Tablet Extended Release 24-hour 25 mg- Give 1 tablet by mouth one time a day for HTN hold for systolic less than 110. Order Date: 12/30/24 . D/C (discontinue) Date: 5/01/25 . Note: The MARs show the medication was administered but does not indicate a blood pressure was checked prior to administration to know systolic pressure was above 110. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's blood pressures in R3's electronic health record (EHR) shows R3 did not have a blood pressure check daily. Blood Pressure readings recorded on 4/29, 4/22, 4/15, 4/08, 4/01, 3/31, 3/18, 3/11, 3/04, 2/25, 2/22, 2/18, 2/11, 2/04, 1/26, 1/25, 1/24, 1/23, 1/21, 1/19, 1/13, 1/12, 1/11, 1/10, 1/07, 1/02, 12/31/24, 12/30/24, 12/29/24, 12/28/24, 12/26/24, 12/25/24, 12/24/24 and 12/20/24. On 5/13/25 at 12:09 PM, Surveyor interviewed DON B (Director of Nursing) and asked, looking at R3's order for Metoprolol Succinate ER 25 mg- 1 tablet by mouth daily for hypertension- hold for systolic less than 110 would you expect blood pressure to be checked before administering the Metoprolol and DON B indicated yes. Surveyor showed DON B R3's MAR and asked if blood pressure was being checked prior administration and DON B indicated no. DON B indicated blood pressure should have been checked daily prior administration. Surveyor reviewed R3's blood pressures recorded in EHR with DON B and DON B verified R3 was not getting his blood pressures checked daily as ordered.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on observation, interview, and record review, the facility did not ensure residents received food that is palatable and at a safe and appetizing temperature for 1 of 1 test tray on the 100 hallway affecting 9 out of 10 residents and 1 of 4 residents (R16) interviewed on food. R16 voiced concerns regarding cold food. Surveyor received a test tray, and the food was cool and not palatable. Evidenced by: The facility policy, entitled Food Temperature Record, dated 6/28/22, states, in part: .Policy: To ensure that foods and beverages are held and served at temperatures which comply with State and Federal Regulations. F804: Each resident receives, and the facility provides food that is palatable and at the proper temperature . Procedure: . 2. TCF (Time/Temperature Control for Safety Food) foods such as meat, poultry, fish and eggs should be cooked to the minimum internal temperature specified below: Pork, Beef, or Veal (Steaks or Chops)- 145* F for 15 seconds (Roasts)- 145* F for 4 minutes Poultry- 165* F for 15 seconds Fish- 145* F for 15 seconds Ground meats (except poultry)- 160* F for 15 seconds Ground chicken or turkey- 165* F for 15 seconds Casseroles- 165* F for 15 seconds Egg dishes- 160* F for 15 seconds 3. Foods not listed above must be cooked to a minimum of 135* F and transferred to holding equipment. 4. Hot foods must be held at a minimum of 135* F . (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 1: R16's Minimum Data Set (MDS) dated [DATE] indicates R16 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating R16 is cognitively intact. On 5/13/25 at 4:10 PM, Surveyor interviewed R16. R16 reported her only concern was about cold food. R16 stated that the food would be good if it wasn't always cold. Surveyor asked R16 how often she gets cold food. R16 replied it is pretty much always cold. Example 2: On 5/13/25 at 8:15 AM, Surveyor received a test tray and recorded the following temperatures: Scrambled eggs- 88.3* F Bacon- 77.5 * F Toast with butter not melted- 74.8* F Oatmeal- 124* F Milk- 34.5 * F Surveyor found the scrambled eggs were cold and tasteless, the bacon was cold and chewy, the toast was cold, and the butter was not melted, and the oatmeal was lukewarm. On 5/13/25 at 8:19 AM, Surveyor interviewed RN C (Registered Nurse) and asked if it is the expectation the residents are served hot, palatable food and RN C indicated yes. RN C looked at the toast on the test tray with unmelted butter and indicated that does not look good. On 5/13/25 at 12:23 PM, Surveyor interviewed DM D (Dietary Manager) and asked what his expectation is for food temperatures for hot food being served. DM D indicated meats should be 165* F, vegetables- 149* F, and eggs -150*-160* F. Surveyor informed DM D of the test tray temperatures. DM D indicated the foods are not at the temperature they should be. DM D indicated there are no warmers in the carts and the food is served on heated plates with insulated bottoms and tops. DM D indicated he is aware of the issue with cold food. DM D indicated the facility got new carts in December that are insulated. DM D indicated he feels the problem is the nursing staff need to pass the trays out faster. DM D indicated it is expected residents receive hot food and has offered to the residents who have voiced concerns with cold food that they can eat in dining room so the meals reach them faster or they can send the trays back to the kitchen for a new tray.