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	02/25/2026

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility did not ensure that each resident has a safe, clean, comfortable and homelike environment for daily living for 3 of 61 Residents (R3, R21, and R34). R3's room was not clean.R21's room was not clean.R34's room was not clean.R21 and R34 share a bathroom. The shared bathroom was not clean.This is evidenced by:The facility's Cleaning Checklist for Elderly Home, undated, includes: Introduction Maintaining a clean and sanitary environment is essential in elderly care facilities to ensure the health and well-being of residents, staff, and visitors. This checklist provides guidance for cleaning areas where residents are present. Resident Rooms (Occupied) *Dust surfaces gently, avoiding disturbance to residents *Disinfect frequently touched surfaces: bed rails, tables, door handles, light switches *Sweep and mop floors, taking care around personal belongings *Clean bathroom area (if en-suite): toilet, sink, mirrors, grab bars.The facility utilizes a Daily Cleaning Checklist. There is a place for the housekeeper's signature and date. The Daily Cleaning Checklist includes a grid. The grid columns are labeled: Cleaning Task and each room number for the hallway across the top row. Under the Cleaning task column are the task to be completed, which includes: Empty trash, wipe surfaces, disinfect high touch points, sweep/vacuum floor, mop floor, check hand sanitizer, remove debris/clutter, clean & sanitize bathroom, restock paper produces, change curtain (if dirty), double check the room to make sure it's clean.On 2/22/26 at 4:19 PM, Surveyor interviewed R3. When surveyor asked R3 about the cleanliness of her room, R3 stated ugh, made a face of disgust, and gestured her hand around her room. R3 indicated that her room was not clean. Surveyor observed dark, dried spots of food on the floor. There were splatters of red/brown dried substances under R3's bedside table. There was thick string, approximately 6 inches long on the floor under the chair on the far side of the room. There was half of a wrapper for an alcohol prep pad on the floor near the sink.On 2/22/26 at 2:30 PM, Surveyor interviewed R21. R21 stated the facility is not kept clean. R21 stated her room is filthy. R21 stated her room is dusty and no one dusts it. R21 stated staff do not clean the sink counter. R21 stated no one moves the caddies on the counter to clean under them. R21 stated I don't live like this. It's disgusting. This isn't the way I want to live. I have to look at it every day. Surveyor observed R21's room. R21's room over bed light was dusty. There was a granola bar wrapper on the floor under the bed. There were dirty shoe prints on the floor near the bed. There was crushed, white powder on the floor in front of the nightstand near the head of the bed. The wall heater was pulling away from the wall approximately 1 inch, causing the paint to rip from the wall. The sink counter was full of clutter and not kept tidy.On 2/22/26 at 4:08 PM, Surveyor observed R34's room. R34's room had dirty shoe prints on the floor. R34's tube feeding pole had brown liquid splatters (tube feeding liquid) on the pole. R34's wall heater had fallen approximately 1.5 inches down the wall, causing the paint to rip from the wall. There was paper debris under the head of the bed.On 2/22/26 at 4:08 PM, Surveyor observed R21 and R34's shared bathroom. There was (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	feces in the toilet bowl. There were drips of brown liquid dried on the toilet seat. On the back of the toilet, there was a graduated cylinder (container used to empty urine from a foley catheter) sitting upside down on a disposable cloth, discolored and dried with urine. Sitting on the disposable cloth, there was also pair of tubigrip stockings (compression stockings).On 2/23/26 at 8:00 AM, Surveyor observed R3, R21, and R34's rooms. R3 and R34's rooms were the same and still not cleaned. R21's room was observed. R21's granola wrapper that was under the bed had been picked up, otherwise R21's room was the same. R21 and R34's shared bathroom was still not cleaned.On 2/23/26 at 2:33 PM, Surveyor interviewed CNA H (Certified Nursing Assistant) and CNA O. Both CNAs indicated resident rooms are not clean. CNA H indicated the residents have a lot of personal belongings, so it is hard for staff to clean around that. CNA O indicated the floors are dirty and should be mopped more often.On 2/24/26 at 8:31 AM, Surveyor observed a cleaning cart down the hallway where R3, R21, and R34 reside. Surveyor observed R3's room had been cleaned. R21 and R34's rooms and shared bathroom were still not cleaned.On 2/24/26 at 1:57 PM, Surveyor interviewed HS F (Housekeeping Supervisor) regarding resident room cleaning. HS F stated resident rooms should be cleaned daily. HS F stated housekeeping staff does not move resident belongings, so if residents have personal belongings on the sink counter, that area does not get cleaned by housekeeping. HS F stated there is a Daily Cleaning Checklist that gets completed daily and she keeps 3 months of logs in her binder.On 2/24/26, Surveyor requested the Daily Cleaning Checklist for the past 2 weeks for the hall R3, R21, and R34 reside on. The facility provided five days of Daily Cleaning Checklist, 2/10/26, 2/11/26, 2/12/26, 2/18/26, and 2/22/26.2/10/26 Daily Cleaning Checklist has blanks for the following: R3 did not receive sweep/vacuum floor or change curtain (if dirty). R21 did not receive any cleaning. R34 did not receive any cleaning.2/11/26 Daily Cleaning Checklist has blanks for the following: R3 did not have disinfect high touch points or change curtain (if dirty). R21 did not receive cleaning. R34 did not receive disinfect high touch points, clean & sanitize bathroom, and change curtain (if dirty).2/12/26 Daily Cleaning Checklist has blanks for the following: R3 did not receive cleaning. R21 did not receive sweep/vacuum floor, restock paper products, change curtain (if dirty). R34 did not receive sweep/vacuum floor, restock paper products, change curtain (if dirty).2/18/26 Daily Cleaning Checklist has blanks for the following: R3 did not receive mop floor and change curtain (if dirty). R21 did not receive sweep/vacuum floor, restock paper products, change curtain (if dirty). R34 did not receive sweep/vacuum floor, restock paper products, change curtain (if dirty).2/22/26 Daily Cleaning Checklist only has check hand sanitizer marked for R3, R21, and R34. The rest is blank. On 2/24/26 at 3:16 PM, Surveyor interviewed MT P (Maintenance) regarding the cleanliness of resident rooms. MT P indicated he oversees housekeeping, but HS F is the housekeeping supervisor. MT P indicated he was not aware resident rooms were not being cleaned. MT P indicated he was unaware the wall heater units in R21 and R34's room were falling off the walls. MT P indicated rooms are audited when a resident is discharged from the room. MT P indicated staff should put in a work order if there is maintenance required for a resident's room. MT P indicated staff should have reported the wall heater units were falling off the walls.

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F 0684 Level of Harm - 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 interview, and record review, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) for 1 of 3 sampled residents (R1). On 1/9/26, R1 voiced having increased abdomen and low back pain and was crying while voicing pain rated 10 out of 10. There is no documentation of a RN (Registered Nurse) assessment being completed. There is no documentation of nursing staff continuing to monitor R1's change in condition. R1 was sent to the emergency room on 1/10/26 and diagnosed with pneumonia, acute on chronic respiratory failure, sepsis (life-threatening condition due to the bodies response to an infection) with acute hypoxic respiratory failure (life-threatening condition characterized by severely low blood oxygen levels without an carbon dioxide level elevation, caused by lung injury or impaired oxygen exchange) and septic shock (most sever stage of sepsis occurring when an infection leads to low blood pressure and organ failure which require immediate medical intervention.). Evidenced by: According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process:(a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis.(b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis.(c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants.(d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. The facility's policy, Change of Condition, dated 8/1/15 with last revision date of 11/13/24, states, in part: Purpose: To ensure prompt notification of the resident, the attending physician. of changes in the resident's physical, psychosocial and/or mental condition and/or status. Procedure: . 2. Specific information that requires prompt notification include, but is not limited to: . c. Uncontrolled pain. o. A need to transfer the resident to a hospital/treatment center. 3. Nurse will complete assessment and document findings in resident record including but not limited to vital signs, pain.R1 was admitted to the facility on [DATE] with diagnoses that include, in part: bipolar disorder (mental health condition characterized by significant mood swings), other chronic pain, low back pain, fibromyalgia (long-term condition that causes widespread body pain and fatigue), schizoaffective disorder (mental health condition consisting of a mix of schizophrenia symptoms such as hallucinations and delusions), generalized anxiety disorder, psychophysiologic insomnia (chronic sleep disorder resulting in persistent difficulty falling asleep or staying asleep triggered by stress and anxiety), and adjustment disorder (excessive emotional or behavior response to stressors).R1's most recent MDS (Minimum Data Set) dated 2/2/26, indicates, in part: a BIMS (Brief Interview of Mental Status) score of 15 out of 15, indicating R1 is cognitively intact. R1's Comprehensive Care Plan states, in part: . Focus: The resident has altered respiratory status/difficulty breathing r/t (related to) chronic respiratory failure, RLD (Restrictive Lung Disease, a category of lung conditions that prevent lungs from fully expanding, leading to decreased lung volume), and OSA (Obstructive Sleep Apnea, a common and potentially serious sleep disorder where breathing repeatedly stops and starts during sleep). Requests/needs HOB (head of bead) elevated and on pillows (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	to prevent from becoming SOB (short of breath), pacing activities, and repositioning. Date initiated: 12/28/23. Revision on: 9/21/24.Interventions: CPAP settings per MD orders. Elevate head of bed. Monitor/document changes in orientation, increased restlessness, anxiety, and/or air hunger. Monitor for s/sx (signs and symptoms) of respiratory distress and reported to MD PRN (as needed): Increased respirations, decreased pulse oximetry, increased heart rate (tachycardia), restlessness, diaphoresis (sweating), headache, lethargy, confusion, hemoptysis, cough, pleuritic pain, accessory muscle usage. R1's Progress notes indicated: 1/9/26 at 1:47 PM: Resident was complaining of increased abdomen and low back pain. Resident was crying voiced pain 10/10. Writer called NP (Nurse Practitioner). NP gave order to send resident to hospital when writer informed resident. Resident became upset she could not get more meds resident declined to go. 1/10/26 at 2:20 PM: Writer called to resident's room by CNA (Certified Nursing Assistant) at approximately 0700 (7:00 AM). Resident unable to sit at edge of bed unassisted, rapid respirations, increased pain, altered mental status. Writer confirmed with resident that she wished to be transferred to ER, resident stated yes. 911 called, arrived approximately 0730 (7:30 AM), resident left facility via ambulance, nurse to nurse report given. DON (Director of Nursing) and NP [Name] updated. Resident admitted into [Hospital Name] ICU for sepsis and hypotension. Of note: There is no evidence in the medical record that R1 had been assessed by a nurse on 1/9/26, had adequate monitoring from 1/9/26 to 1/10/26, or had been assessed by a nurse prior to being sent to the ER on [DATE]. R1's hospital notes, dated 1/10/26, states, in part: . Chief Complaint: Breathing Problem (Patient states yesterday she felt like she was having difficulty breathing.History of Present Illness: [Resident Name] . presenting with dyspnea (shortness of breath) and respiratory distress. States that she is chronically dyspneic, has been getting worse for the past 24 hours or so.ED (Emergency Department) Course, Decision Making, and Medical Complexity: . [Resident Name] . presenting with respiratory distress. On initial assessment patient is noted to be in mild to moderate respiratory distress with increased work of breathing and speaking short sentences. She is noted to have low-grade fever and mild tachycardia (rapid heart rate). was also initially hemodynamically stable (normal stable vital signs)but progressively became more hypotensive (low blood pressure). received a sepsis fluid bolus (single dose given all at once). Ultimately she was stable but critically ill here in the emergency department. She will be admitted to the ICU for septic shock due to bacterial pneumonia with respiratory failure on BiPAP. Possible UTI as well.Procedure: . Critical Care Documentation. The patient has a critical illness or injury that acutely impairs one or more vital organs systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition. Critical Care Condition(s): . Hypercarbia (abnormally low carbon dioxide)/respiratory failure requiring non-invasive ventilation. Shock/Hypotension: Hypotension required blood pressure monitoring and IV fluids and IV pressors (potent medication given to treat life-threatening sepsis and shock in the ICU) and Severe sepsis requiring IV fluids and antibiotics. 1/15/26 at 3:42 PM, discharged from the hospital to return to the facility. On 2/25/26 at 3:41 PM, Surveyor interviewed R1 about her hospitalization. R1 stated that she had been telling them for a while that she wasn't feeling well. R1 stated, when I tell them I don't feel good, or something is wrong they don't listen. R1 indicated that she had told staff every day for about a week, multiple times, that she wasn't feeling well and thought that she had a urinary infection. R1 stated that by the time it was discovered it was really bad, and she had to be sent to the ER and was in the ICU for 5 days. Surveyor asked R1 if the staff had been monitoring or assessing her condition. R1 stated there no assessment or monitoring on 1/9/26 and then on 1/10/26 she was out of it and couldn't even sit up. R1 stated there was no assessment before she was sent to the ER, just that the nurse came and said she (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	didn't look good. R1 indicated that the nurse took her temperature, but no other vital signs were obtained. R1 stated that she was pissed off because no one listens to her concerns. On 2/25/26 at 7:49 AM, Surveyor interviewed RN S (Registered Nurse) about R1's change of condition. RN S stated she worked on 1/9/26 and R1 refused to be sent to the ER. RN S stated that she did not work on 1/10/26 but that she heard she was sent out to the ER on that day. Surveyor asked RN S if she completed any assessment on R1 on 1/9/26 when she worked. RN S stated that she thought she did an abdominal assessment, but she couldn't really remember. Surveyor asked RN S if she had documented the abdominal assessment in R1's electronic medical record. RN S stated that she really couldn't recall what she did back in January. On 2/25/26 at 9:15 AM, Surveyor interviewed DON B (Director of Nursing) if there were any assessments or monitoring of R1's condition on 1/9/26 and 1/10/26. DON B stated she would check in R1's medical record and report back to Surveyor. On 2/25/26 at 11:31 AM, DON B stated that no, she couldn't find anything in R1's medical record that she was further assessed or monitored. Surveyor asked DON B if R1 had a change of condition that would require monitoring and nurse assessments. DON B stated yes that she would have expected the nurse on duty to have taken vital signs and completed an assessment at least every shift, and to enter a progress note into the electronic medical record. Staff noted R1 was crying and endorsed 10/10 abdominal and lower back pain on 1/9/26. Despite R1's refusal to be sent to the ER on [DATE], staff completed no assessments and did no further monitoring of R1's change of condition. The following day, 1/10/26, R1 was confused, lethargic, and unable to sit up. R1 was transferred to the ER and spent 5 days in the ICU with a life-threatening condition.

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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** Number of residents sampled: 2Number of residents cited: 2Based on observation, interview, and record review, the facility did not ensure each resident received care, consistent with professional standards of practice, to prevent pressure injuries (PI) for 2 of 2 Residents (R8 and R34) reviewed for pressure injuries. R34 has a PI and was not repositioned per her care plan. R8 has a stage 4 pressure injury and was observed lying in bed without prevlon boots on. This is evidenced by: The facility's policy Pressure Injury Prevention and Wound Care Management, dated 8/25/25, includes: The purpose of the policy is to provide healthcare staff with the standards of care, and processes to be followed for all residents: *To identify factors that places the residents at risk for the development of pressure injuries and to implement appropriate interventions to prevent the development of clinically avoidable wounds. *To promote a systemic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown. *To promote healing of existing pressure injuries and wounds. It is the policy of this facility that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing, in accordance with eh comprehensive assessment and plan of care. The facility will ensure that a resident who is admitted without a pressure injury does not develop a pressure injury, unless clinically unavoidable. A resident who has a pressure injury will receive care and services to promote healing and to prevent additional ulcers. The skin care program will be utilized following the guidelines of the agency for Healthcare Research and Quality (AHRQ), the National Pressure Ulcer/Injuries Advisory Panel (NPIAP) and current standards of Clinical Practice. 2. Repositioning frequency is individualized based on skin/tissue tolerance, support surface, risk, and clinical condition. Example 1 R34 admitted to the facility on [DATE] with diagnoses of multiple sclerosis (autoimmune disease of the central nervous system, causing communication issues between the brain and bod), paraplegia (loss of motor and sensory function in the lower extremities), and pressure injury of sacral region stage 4 (a severe wound extending through the skin and subcutaneous fat to expose muscle, tendon, or bone). R34's Brief Interview for Mental Status, dated 12/9/25, has a score of 9, indicating R34 has moderately impaired cognition. R34's comprehensive care plan, last reviewed 12/4/25, includes: Focus: The resident has limited physical mobility.Interventions: bed mobility assist - two Focus: I am at risk for alteration in skin integrityInterventions: Updated 8/15----Turn and reposition me at least every 1-2 hours. On 2/23/26 at 8:00 AM, Surveyor observed R34 lying on her back in bed. R34's head of bed was elevated at approximately 45 degrees. Surveyor made observations of R34 in the same position at 9:33 AM, 10:29 AM, 11:32 AM, 12:53 PM, and 1:14 PM. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/23/26 at 1:55 PM, Surveyor interviewed CNA O (Certified Nursing Assistant) regarding cares for R34. CNA O indicated she was working with CNA H for the day shift. CNA O indicated she and CNA H had not yet provided cares for R34. CNA O indicated therapy had been in with R34 earlier. CNA O indicated R34 has a wound to her sacrum and should be repositioned at least every 2 hours. CNA O indicated she had not repositioned R34 this shift. On 2/23/26 at 1:56 PM, Surveyor interviewed OT Q (Occupational Therapy) about the care she provided to R34. OT Q indicated she provided oral care and washed R34's hands. On 2/23/26 at 2:33 PM, Surveyor interviewed CNA H regarding cares for R34. CNA H indicated she had just finished providing cares for R34. CNA H indicated R34 should be repositioned every 2 hours. CNA H indicated she did not reposition R34 today until she provided cares at 2:00 PM. On 2/23/26 at 3:51 PM, Surveyor interviewed LPN M (Licensed Practical Nurse) regarding residents with pressure injuries and repositioning. LPN M indicated staff should follow the resident's care plan for repositioning. LPN M indicated repositioning should be done every 1-2 hours if a resident has a pressure injury. On 2/23/26 at 3:58 PM, Surveyor interviewed ADON C (Assistant Director of Nursing) regarding residents with pressure injuries. ADON C indicated a resident with a pressure injury should be repositioned every 2 hours unless their care plan states differently. On 2/23/26 at 4:13 PM, Surveyor interviewed DON B (Director of Nursing) regarding residents with pressure injuries. DON B indicated a resident with a pressure injury should be repositioned every 1-2 hours. DON B indicated R34 should have been repositioned per her care plan. Example 2 R8 was admitted to the facility on `12/21/22 with diagnoses that include congestive heart failure (a condition where the heart muscles cannot pump blood efficiently enough to meet the body's needs, causing blood and fluids to back up into the lungs, legs, and abdomen), peripheral vascular disease (poor circulation to legs and feet), vascular dementia, and protein- calorie malnutrition. R8's most recent MDS (Minimum Data Set) dated 12/1/25 states that R8 has a BIMS (Brief Interview of Mental Status) of 15 out of 15, indicating that R8 is cognitively intact. R8's MDS states that they are dependent on staff for toilet hygiene, transfers, and dressing, and require substantial/ maximal assistance for personal hygiene and bed mobility. R8's care plan states in part: .Focus: I am at risk for alteration in skin integrity- decreased mobility, hemiplegia, GI (Gastrointestinal)/colitis.9/15/25 #7 stage 4- l great toe.Interventions: Foot cradle placed on bed. I use pressure reducing mattress/ air mattress.Manage my clinical conditions and contributing factors to reduce my risk of skin breakdown.Prevlon boots to feet while in bed. Provide my treatments as ordered by my physician or wound care team. Turn and reposition me every 2-3 hours. Wound Care physician's most recent note dated 2/19/26 states in part: .Stage 4 Pressure Wound of the left, first toe full thickness.Etiology: Pressure MDS 3.0 stage: 4.Approach: close monitoring, off- loading.wound size (L (length) x W (width) x D (depth): 0.21 x 0.23 x 0.1 cm (centimeters).granulation tissue: 100% . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/22/26 at 10:52 AM, Surveyor interviewed R8. Surveyor asked R8 where their pressure injury was located, R8 reported that it was on their foot and that staff has them wear boots during the day and off at night. Surveyor noted that R8 was laying in bed with an air mattress, foot cradle was on bed – keeping the blankets off of R8's feet, and the pressure relieving boots were on the floor. On 2/25/26 at 8:54 AM, Surveyor interviewed DON B. Surveyor asked DON B what the facility has determined the root cause to be for R8's pressure injury, DON B stated that it was due to the blankets causing pressure. Surveyor asked DON B what interventions were implemented, DON B stated they initiated a foot cradle to off- load the blankets. Surveyor shared the observation of R8 not wearing the pressure relieving boots and asked DON B if R8 should be wearing the boots when in bed, DON B stated yes.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure residents with limited range of motion, received appropriate treatment and services to increase range of motion/mobility and/or to prevent further decrease in range of motion/mobility for 1 of 2 residents (R21) reviewed for range of motion (ROM).R21 did not receive active assisted range of motion to her bilateral lower extremities (BLE) per R21's provider orders and comprehensive care plan.This is evidenced by:The facility's policy Activities of Daily Living (ADLs), dated 2/25/25, includes: Policy: Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. A resident will be given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. Based on the assessments, a personalized care plan is created. ADLs will be individualized. ADL cares will be provided based on the resident preferences. Resident ADL care needs will be communicated to staff via the care plan and Kardex (a care plan for the CNAs (Certified Nursing Assistants)).R21 admitted to the facility on [DATE] with diagnoses including quadriplegia C5-C7 incomplete (partial paralysis of limbs affecting cervical vertebrae 5 thru 7).R21's BIMS (Brief Interview for Mental Status), dated 2/4/26, has a score of 15, indicating R21 is cognitively intact.R21's physician order, dated 1/27/26, includes Physical Therapy Eval (Evaluation) and treat for ROM (Range of Motion) and pain/spasticity to BLE (Bilateral Lower Extremities).R21's Physical Therapy Treatment Encounter Note(s), dated 2/17/26, states: ROM to BLE targeting hip, knee and ankle. Pt (patient) (R21) tolerates well reporting improve comfort following. Pt (R21) d/c (discharged) this visit. Hung up ROM program in room. Staff given updated recommendation for ROM program. Pt (R21) d/c due to reaching max level of independence.R21's comprehensive care plan, last reviewed 2/12/26, includes: Focus: The resident has limited physical mobility.Interventions: Active Assisted Range of Motion Program daily to BLE (see signs hanging in room).R21's CNA (Certified Nursing Assistant) Kardex, printed 2/24/26, includes: Active Assisted Range of Motion Program daily to BLE (see signs hanging in room) and Active Assisted Range of motion to BLE (see signs hanging in room). R21's Passive Rage of Movement Exercise signs for the Leg and Foot include: Perform the exercises a minimum of 5 repetitions, once daily. Hip Bending Movement. Leg Movement In and Out. Hip Turning Movement. Hamstring Stretch. Bending Foot Down Movement. Bending Foot Up Stretch. Moving Foot In and Out. Toe Bending Movement.On 2/22/26 at 2:30 PM, Surveyor interviewed R21. R21 stated she does not receive the ROM exercises to her legs daily as she is supposed to. R21 indicated the ROM exercises decreases her edema and pain.On 2/23/26 at 1:55 PM, Surveyor interviewed CNA O (Certified Nursing Assistant) regarding R21's ROM program. CNA O indicated staff use the CNA Kardex to know what assistance a resident needs. CNA O stated R21 has a ROM program with exercises to be done while R21 is in bed. CNA O indicated she assisted CNA H with R21's cares today (2/23/26). CNA O stated they did not perform R21's ROM exercises.On 2/23/26 at 2:33 PM, Surveyor interviewed CNA H regarding R21's ROM program. CNA H indicated she and CNA O provided cares for R21. CNA H indicated the CNAs assist R21 with her ROM exercises. CNA H stated they did not assist R21 with her ROM exercises today (2/23/26). On 2/23/26 at 4:13 PM, Surveyor interviewed DON B (Director of Nursing) regarding care plans. DON B indicated staff should follow residents' care plans.

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	525418	A. Building B. Wing	02/25/2026

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

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 61Number of residents cited: 5Based on observation, interview and record review, the facility did not ensure that sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (R) for 5 of 61 residents reviewed (R1, R3, R19, R21, R34). R3 stated she has to wait up to 45 minutes for her call light to be answered and staff leave her room without meeting her needs. R21 states she does not get the care she is supposed to get per her care plan because the staff do not have enough time to complete the task because of lack of staffing. R21 states staff will turn off her call light and leave the room without meeting her needs. R34 did not get repositioned per her care plan because the CNAs stated they were too busy and do not have enough staff. Observation of long call light wait times. R1 does not receive care per her care plan. This is evidenced by: The facility's policy Sufficient Staffing, dated 10/19/23, includes: The facility will have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population. 3. Nursing direct care staffing ratios will be recalculated based on census and level of care needs. 2. Daily reviews of staffing patterns will be reviewed by the Scheduler, HR, administrator, and DON. Changes will be made to staffing hours with administrator approval, based on census and resident level of care. Example 1 On 2/22/2026 at 4:19 PM, Surveyor interviewed R3. R3 indicated there are not enough staff in the facility. R3 stated she gets frustrated with the call light wait times. R3 indicated it can take up to 45 minutes before staff answer her light. R3 indicated there are times when staff are too busy and will leave before meeting all her needs. R3 indicated staff will answer the call light, say they will come back, but it can be more than an hour before they do. Example 2 R21 admitted to the facility on [DATE] with diagnoses including quadriplegia C5-C7 incomplete (partial paralysis of limbs). R21's BIMS (Brief Interview for Mental Status), dated 2/4/26, has a score of 15, indicating R21 is (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitively intact. R21's physician order, dated 1/27/26, includes Physical Therapy Eval (Evaluation) and treat for ROM (Range of Motion) and pain/spasticity to BLE (Bilateral Lower Extremities). R21's comprehensive care plan, last reviewed 2/12/26, includes: Focus: The resident has limited physical mobility.Interventions: Active Assisted Range of Motion Program daily to BLE (see signs hanging in room). R21's CNA (Certified Nursing Assistant) Kardex, printed 2/24/26, includes: Active Assisted Range of Motion Program daily to BLE (see signs hanging in room) and Active Assisted Range of motion to BLE (see signs hanging in room). R21's Passive Rage of Movement Exercises for the Leg and Foot signs include: Perform the exercises a minimum of 5 repetitions, once daily. Hip Bending Movement. Leg Movement In and Out. Hip Turning Movement. Hamstring Stretch. Bending Foot Down Movement. Bending Foot Up Stretch. Moving Foot In and Out. Toe Bending Movement. On 2/22/26 at 2:30 PM, Surveyor interviewed R21. R21 stated the facility does not have enough CNAs. R21 stated she does not receive the ROM exercised to her legs daily as she is supposed to because the staff say they are too busy to complete the task. R21 states staff will come to turn off the call light and then will forget to come back. On 2/23/2026 at 10:46 AM, R21's call light came on. At 10:49 AM, facility staff entered R21's room. R21's call light turned off and staff exited the room. At 10:52 Surveyor entered R21's room and asked if R21's needs were met. R21 indicated she needed incontinent care and the staff member that came in turned off her light and informed R21 she would let a CNA know. At 11:13 AM, a CNA entered R21's room and provided cares for R21. On 2/23/26 at 1:55 PM, Surveyor interviewed CNA O (Certified Nursing Assistant) regarding R21's ROM exercises. CNA O indicated she did not perform R21's ROM exercises today because she was too busy. On 2/23/26 at 2:33 PM, Surveyor interviewed CNA H regarding R21's ROM program. CNA H indicated she and CNA H provided cares for R21. CNA H stated they did not assist R21 with her ROM exercises today because they were too busy. Example 3 R34 admitted to the facility on [DATE] with diagnoses of multiple sclerosis (autoimmune disease of the central nervous system, causing communication issues between the brain and bod), paraplegia (loss of motor and sensory function in the lower extremities), and pressure injury of sacral region stage 4 (a severe wound extending through the skin and subcutaneous fat to expose muscle, tendon, or bone). R34's Brief Interview for Mental Status, dated 12/9/25, has a score of 9, indicating R34 has moderately impaired cognition. R34's comprehensive care plan, last reviewed 12/4/25, includes: Focus: The resident has limited physical mobility.Interventions: bed mobility assist - two Focus: I am at risk for alteration in skin (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	integrityInterventions: Updated 8/15----Turn and reposition me at least every 1-2 hours. On 2/23/26 at 8:00 AM, Surveyor observed R34 lying on her back in bed. R34's head of bed was elevated to approximately 45 degrees. Surveyor made observations of R34 in the same position at 9:33 AM, 10:29 AM, 11:32 AM, 12:53 PM, and 1:14 PM. On 2/23/26 at 1:55 PM, Surveyor interviewed CNA O regarding cares for R34. CNA O indicated she was working with CNA H for the day shift. CNA O indicated she and CNA O had not yet provided cares for R34. CNA O indicated therapy had been in with R34 earlier. CNA O indicated R34 has a wound to her sacrum and should be repositioned at least every 2 hours. CNA O indicated she had not repositioned R34 this shift. On 2/23/26 at 1:56 PM, Surveyor interviewed OT Q (Occupational Therapy) about the care she provided to R34. OT Q indicated she provided oral care and washed R34's hands. On 2/23/26 at 2:33 PM, Surveyor interviewed CNA H regarding cares for R34. CNA H indicated she had just finished providing cares for R34. CNA H indicated that R34 should be repositioned every 2 hours. CNA H indicated she did not reposition R34 today until she provided cares at 2:00 PM. CNA H stated she tries to get to R34 to reposition her but does not always have time to get it done. Example 4 On 2/22/26 at 11:09 AM, Surveyor interviewed R19. R19 reported that the facility has 1 CNA for 20 residents, and they have had to wait up to 1.5 hours to go to the bathroom. Surveyor asked R19 if they had an accident, R19 stated yes and that it made them feel terrible, humiliated, and disrespected. Surveyor asked R19 if they could remember when this incident occurred, R19 stated no, but it was when they were first admitted . On 2/23/26 at 10:05 AM, Surveyor observed call lights. The facility has a call light system that tells how long the call light has been on for. This system is located at the desk in the center of the facility. At 10:05 AM, Surveyor noted that R19's call light had been on for 15 minutes, according to the system. No staff were observed on the hall. At 10:06 AM, NM K (Nurse Manager) went into the room next door to R19. NM K did not answer R19's call light. At 10:07 AM, R19 was noted sitting in the hallway. At 10:09 AM, R19's call light was answered. Total wait time was 19 minutes. At 10:10 AM, Surveyor noted that room [ROOM NUMBER]'s call light had been on for 8 minutes; the floor nurse and NM K were at the nurse's station talking. At 10:10 AM room [ROOM NUMBER]'s call light was turned off. Total wait time was 10 minutes. At 10:30 AM room [ROOM NUMBER]'s call light had been on for 11.5 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 10:45 AM room [ROOM NUMBER]'s call light was turned off. Total wait time was 26 minutes. At 10:38 AM room [ROOM NUMBER]'s call light had been on for 13 minutes. At 10:49 AM, room [ROOM NUMBER]'s call light was turned off. Total wait time was 32 minutes. Example 5: R1 was admitted to the facility on [DATE]. R1's most recent MDS (Minimum Data Set) dated 2/2/26, indicates, in part: a BIMS (Brief Interview of Mental Status) score of 15 out of 15, indicating R1 is cognitively intact. R1's Care Plan, dated 12/15/23, states, in part: Focus: The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) lymphedema, fibromyalgia, chronic pain and morbid obesity. Interventions: 2 staff in room for all cares for staff safety d/t (due to) allegations when able. bathing/shower assist – one. dressing assist – one. personal hygiene/oral care assist – one. toilet use: Hoyer to/from commode with mesh Hoyer sling with commode cut out. On 2/22/26 at 11:48 AM, Surveyor interviewed R1 in her room. Surveyor observed R1 sitting in her recliner with her feet up and the Hoyer sling under her in her chair. R1 stated that the facility does not have enough staff, especially on the PM and overnight shifts. R1 indicated that she had to wait up to an hour for staff to answer her call light or to assist her in getting off the commode. R1 stated that the staff have to use a Hoyer lift to assist her, which requires 2 staff members to get her in and out of bed and on and off the commode. R1 stated that when she has to wait that long on the commode, her right hip and leg go numb, and the back of her legs turn purple. R1 indicated that sitting on the Hoyer sling all day causes her to get indentations on her bottom which hurt like hell. R1 stated she had told staff that she shouldn't be sitting on the Hoyer sling all day, but the more she complains, the more sarcastic staff become, so she stopped saying anything. R1 stated that it makes her very angry and that her concerns are not being taken seriously by staff. On 2/23/26 at 1:55 PM, Surveyor interviewed CNA O regarding staffing. CNA O indicated there are not enough staff to complete everything the residents need. CNA O indicated things like repositioning, range of motion, and oral care does not get done because there is just too much to do. CNA O indicated she was unable to take lunch or break because she was too busy trying to meet the needs of the residents. On 2/23/26 at 2:33 PM, Surveyor interviewed CNA H regarding staffing. CNA H indicated things would be better and she would be able to complete her task if there was more help. CNA H stated she did not get a break today because there is too much to do. CNA H stated she is not able to get everything done. CNA H stated she has to tell residents that she does not have time to complete things or will tell the residents she will have to do things later, but it doesn't get done. CNA H stated she gets the residents clean, changed, and fed and doesn't have time to do much else.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 1 residents (R34) reviewed for medications.R34 had a medication error due to not receiving her medications timely. This is evidenced by:The facility's policy Administering Medications, dated 1/22/24, includes: Purpose: To ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. 4. Medications shall be administered per provider's (MD (Medical Doctor), NP (Nurse Practitioner), PA (Physician Assistant)) written/verbal orders upon verification of the right medication, dose, route, time and positive verification of the resident's identity when no contraindications are identified, and the medication is labeled according to accepted standards. 7. Medications should be administered within one (1) hour of the prescribed times. 10. The individual administering the medication shall sign the resident's Medication Administration Record (MAR) for the specific time and day the medication was administered.The facility's policy Medication Error and Drug Interactions, dated 2/12/24, includes: Definition: Medication Error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with: 1. The prescriber's order.R34 admitted to the facility on [DATE] with diagnoses including neuromuscular dysfunction of bladder (loss of normal bladder control due to nerve damage), central pain syndrome (chronic neurological condition leading to constant, moderate-to-severe pain), and calculus of kidney (hard mineral and salt deposits forming inside the kidneys, kidney stones).R34's physician orders for February 2026 include: Potassium Citrate-Citric Acid Oral Solution 1100-334 MG/5ML Give 5 ml via G-Tube (Gastrostomy tube, a medical device inserted through the abdomen into the stomach to deliver nutrition, fluids, and medications directly bypassing the mouth) four times a day for kidney stones. Oxybutynin Chloride Oral Solution 5 MG/5ML Give 5 ml via G-Tube three times a day for urinary leakage.Gabapentin Oral Solution 250 MG/5ML Give 2 ml via G-Tube three times a day for pain.R34's Medication Admin Audit Report includes:Potassium Citrate-Citric Acid Oral Solution 1100-334 MG/5ML Give 5 ml via G-Tube four times a day for kidney stones. Schedule Date 02/23/2026 8:00 AM. Administration Time 02/23/26 9:18 AM. Oxybutynin Chloride Oral Solution 5 MG/5ML Give 5 ml via G-Tube three times a day for urinary leakage. Schedule Date 02/23/2026 8:00 AM. Administration Time 02/23/26 9:18 AM. Gabapentin Oral Solution 250 MG/5ML Give 2 ml via G-Tube three times a day for pain. Schedule Date 02/23/2026 8:00 AM. Administration Time 02/23/26 9:18 AM.On 2/23/26 at 4:28 PM, Surveyor interviewed LPN N (Licensed Practical Nurse). LPN N indicated if a medication is scheduled at 8:00, the medication can be given between 7:00 AM and 9:00 AM. LPN N indicated if the medication is not given in that time frame, it would be a medication error.On 2/23/26 at 4:13 PM, Surveyor interviewed DON B (Director of Nursing. DON B indicated if a medication is scheduled at 8:00 AM, then the nurse can administer the medications between 7:00 AM and 9:00 AM. DON B indicated giving medications outside of the scheduled times would be considered a medication error.