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

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 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. This has the potential to affect all 61 residents. Kitchen staff were not testing the parts per million (PPM) of the chemical sanitizing solution in the low temperature dishwasher during a Norovirus (a contagious virus which causes nausea, vomiting and diarrhea) outbreak.In addition, on 2/4/26 DA I (Dietary Aide) was out with GI (gastrointestinal) illness symptoms. According to CDC (Center for Disease Control and Prevention) DA I should have been removed from work until 48 hours after DA I's last symptom/episode. DA I was allowed to return to work too early after the onset of GI symptoms and prepare food. Failure to ensure a system was in place to test ensure dishes were properly sanitized, and that staff with GI symptoms remained off of work for the appropriate amount of time created a finding of Immediate Jeopardy (IJ). The immediate jeopardy began on 2/6/26. Surveyor notified NHA A (Nursing Home Administrator) and RDO JJ (Regional Director of Operations) of the immediate jeopardy on 2/25/26 at 2:34 PM.The immediate jeopardy was removed on 2/26/26, however the deficient practice continues at a scope and severity of F (potential for harm/widespread) as the facility implements its action plan and due to the following examples:Surveyor observed packages of food on the floor and a dented can on the shelf in the dry storage room.Surveyor observed meat sitting on the kitchen counter to thaw.Surveyor observed food in circulation that was open and undated.Surveyor observed open staff food in a refrigerator and a freezer that contained resident food.Surveyor observed staff taking temperatures of food during lunch meal. Staff did not take temperatures of all foods and the foods were not placed in a steam table to hold temperature.Surveyor observed food brought in by visitors that was open, undated, and moldy.Surveyor observed mighty shake to be thawed and without a thaw or use by date. Findings include:1.) The facility uses the US Food Code as their kitchen's operational standards of practice.2017 Food and Drug Administration (FDA) Food Code states:4-302.14 Sanitizing Solutions, Testing Devices:A test kit or other device that accurately measures the concentration in MG/L of sanitizing solutions shall be provided.4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration:Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device.4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration:The effectiveness of chemical sanitizers is determined primarily by the concentration and pH (scale of acidity) of the sanitizer solution. Therefore, a test kit is necessary to accurately determine the concentration of the chemical sanitizer solution.4-701.10 Food-Contact Surfaces and Utensils:Utensils shall be sanitized.4-302.14 Sanitizing Solutions, Testing Devices:Testing devices to measure the concentration of sanitizing solutions are required for 2 reasons:1. The use of chemical sanitizers requires minimum concentrations of the sanitizer during the final rinse step to ensure sanitization; and2. Too much sanitizer in the final rinse water could be toxic. The facility's Dishwashing Temperature Log policy, undated, states, in part: Water temperature is critical to sanitization in warewashing operations. This is particularly true if the sanitizer being used is hot water. The effectiveness of cleaners and chemical sanitizers is also determined by the temperature (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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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	of the water used. A temperature measuring device is essential to monitor manual warewashing and ensure sanitization.The regular use of irreversible registering temperature indicators provides a simple method to verify that the hot water mechanical sanitizing operation is effective in achieving a utensil surface temperature of 71 degrees C (Celsius) (160 degrees Fahrenheit). (2017 FDA (United States Food and Drug Administration) Food Code). Scope: The policy is pertinent to all kitchen staff and has the potential to affect all residents. Purpose The purpose of this policy is to ensure that dish machine temperatures and concentration of sanitizer, if applicable, are documented for each meal and are within applicable guidelines and regulations to prevent the spread of food borne illness. For hot water sanitizing machines, plate surface temperature must also be documented on a regular basis. Procedure 1. Wash and rinse temperatures shall be documented for each meal on the Dish Machine Temperature Log specific to the type of dish machine in operation (e.g. hot water sanitizing or chemical sanitizing).4. The following guidelines shall be used: .b. Chemical sanitizing machine: i. 120 degree wash + 50-100 ppm hypochlorite (or according to manufacturer's specifications) on dish surface in final rinse. 5. Wash and rinse temperatures and/or sanitizer levels must reach target guidelines before any racks or dishes or utensils are run through the machine. 6. If dish machine temperatures are below guidelines, Dietary Manager and Maintenance Director shall be notified immediately and dishes/utensils shall be sanitized by chemical method.Definitions .Chemical Sanitizing dish machine: A dish machine that uses one of a number of approved sanitizers to sanitize wares.The Dish machines Owner's Manual Revision 1.01A, undated, states in part: .Follow the directions precisely that are on the litmus paper vial and test the water on the surface of the bottom of the glasses. Concentration should be 50 PPM minimum to 100 PPM maximum. If concentration is incorrect contact your chemical supplier.The facility's Dishmachine Temperature Log (high temp machine) dated February 2026, shows the facility documented the dishwasher wash and rinse temperatures three times per day; along with a surface temperature once daily. The log incorrectly identifies the dish machine as being high temperature, when it was actually low temperature. There is no space on the log for documentation of PPM despite facility policy. There is a hand written note at the bottom of the log which states: *wash-120+ * Rinse-140+ *PPM-50-100 * Surface Temp-160(of note: the facility has a low temperature dish machine, however they were utilizing a high-temp log.) The facility's GI Norovirus Outbreak summary indicates outbreak started on 2/9/26 and continued through 2/20/26. On 2/20/26 and 2/21/26, the Employee Call In log indicates that a staff member called in for nausea and vomiting on each date. Important to note: these staff members were not included in the outbreak summary.On 2/24/26 at 9:34 AM, Surveyor observed DA DD (Dining Assistant) and DA EE performing dishwashing of breakfast dishes. DA DD put dishes into the machine and DA EE removed dishes from the machine. Surveyor asked DA DD about the machine and checks that needed to be done to ensure sanitizing of dishes. DA DD indicated it is a high temp machine; we check the gauge for wash and rinse temperatures. The first cycle is the wash; we check the gauge. The second cycle is the rinse; we check the gauge. Surveyor asked if there are any further checks. DA DD stated no, we check the temperatures and mark them on the log. Surveyor reviewed the February 2026 log and asked about PPM and surface temperature. DA DD stated we check the surface temperature on a plate by the gun (thermometer gun). Surveyor asked if PPM is done. DA DD stated no. DA EE stated I checked the plate temperature; it came out right at 160.On 2/24/26 at 11:55 AM, Surveyor interviewed DM BB (Dietary Manager) and asked about dishwashing. DM BB stated it is a low temperature machine; they test the chemical with the test strip. Surveyor asked where the PPM is documented. DM BB reviewed the logs for January 2026 and February 2026 and stated they used the wrong form. This form is for a high temperature machine. They are putting the PPM in the surface temperature column. Surveyor asked DM BB to perform the check for PPM. DM BB took a test strip and dipped it into the well in the outer front of the machine, then held it to the control paper. DM BB stated it shows 100. Surveyor asked what readings the control paper can indicate. DM BB verified that the control paper had indicator for readings of 10, 25, 50, 100, and 200. Surveyor asked if there is (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Storage, and Food Procurement policy, dated 12/23/25, states, in part: .SCOPE This policy applies to all facilities to provide safe and sanitary storage, handling, and consumption of all food including food and fluids brought to residents by family and other visitors. This includes the storage, preparations, distribution, and serving food in accordance with professional standards of food service safety. PURPOSE The purpose of this policy is to ensure that the center: .2. Follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the center's food handling processes. Nursing home residents risk serious complications from foodborne illness as a result of their compromised health status. Unsafe food handling practices represent a potential source of pathogen exposure for residents. Sanitary conditions must be present in health care food service settings to promote safe food handling. CMS (Centers for Medicare and Medicaid Services) recognizes the U.S. Food and Drug Administration's (FDA) Food Code and the Center for Disease Control and Prevention's (CDC) food safety guidance as national standards to procure, store, prepare, distribute, and serve food in long term care facilities in a safe and sanitary manner. Effective food safety systems involve identifying hazards at specific points during food handling and preparation, and identifying how hazards can be prevented, reduced, or eliminated. It is important to focus attention on the risks that are associated with foodborne illness by identifying critical control points (CCPs) in the food preparation processes that, if not controlled, might result in food safety hazards are thawing, cooking, cooling, holding, and reheating foods, and employee hygienic practices. On 2/22/26 at 9:03 AM, during the initial kitchen tour with LC AA (Lead Cook,) Surveyor observed an open box of canisters of rolled oats and a box of fig bars sitting on the floor in the dry storage room. LC AA stated nothing should be on the floor. Surveyor observed a dented can of tuna sitting on the shelf. LC AA stated dented cans should not be in the storage room.On 2/24/26 at 2:53 PM, Surveyor interviewed DM BB (Dietary Manager) who stated there are to be no boxes on the floor and no dented cans in the dry storage area. 4.) On 2/22/26 at 9:16 AM, during the initial tour of the kitchen with LC AA (Lead Cook,) Surveyor observed 2 packages of sliced turkey breast sitting on the counter. LC AA stated, those are for supper tonight, they were taken out before serving breakfast this morning. Surveyor asked about process for thawing. LC AA stated they should be on the bottom shelf in the refrigerator.On 2/24/26 at 2:53 PM, Surveyor interviewed DM BB (Dietary Manager) who stated we have a prep schedule that I print, it lets them know when to take things out of the freezer and put them in the refrigerator. Everything should be thawed in refrigerator.5.) On 2/22/26 at approximately 9:20 AM, during the initial tour of the kitchen with LC AA (Lead Cook,) Surveyor observed the following items unlabeled in the Cook's refrigerator: a tray of potatoes, 5 bowls of pureed fruit, a container of chicken patties, and a jar of chicken stock base. LC AA stated that all of the items should be labeled.On 2/24/2026 at 2:53 PM, Surveyor interviewed DM BB (Dietary Manager) who stated all containers are to be labeled and dated.6.) On 2/22/26 at approximately 9:25 AM, during the initial tour of the kitchen with LC AA (Lead Cook,) Surveyor observed an unlabeled Culver's container of frozen custard, with a spoon in it, in the vegetable freezer and an unlabeled sandwich in the vegetable refrigerator. LC AA stated these were staff items and they were not allowed to be in the kitchen storage and should be in the staff refrigerator/freezer in the break room.On 2/24/2026 at 2:53 PM, Surveyor interviewed DM BB (Dietary Manager) who stated no personal items are allowed in the kitchen refrigerator/freezer.7.) The facility's Food Safety Requirements Use, Storage, and Food Procurement policy, dated 12/23/25, states, in part: . FACTORS IMPLICATED IN FOODBORNE ILLNESSES . *Inadequate Cooking and Improper Holding Temperatures-Poorly cooked food promotes the growth of pathogens that may cause foodborne illness. The PHF/TCS (Potentially Hazardous Food / Time/Temperature Control for Safety) foods require adequate cooking and proper holding temperatures to reduce the rapid and progressive growth of illness producing microorganisms, such as Salmonellae and Clostridium botulinum.On 2/22/26 at 12:05 PM, Surveyor observed LA CC (Laundry Aide) remove a tray of liver and onions from the oven and set it on a metal utility cart. LA (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	packages of cheese was open with slices of cheese sticking out. The edges of the cheese slices had a green/gray substance on them. Surveyor asked about the substance. LC AA stated it is mold. Surveyor asked about the label on the bag. LC AA stated it belongs to R17, but it should be labeled with a date on the bag and due to the mold, it needs to be thrown away. On 2/24/26 at 2:53 PM, Surveyor interviewed DM BB (Dietary Manager) who stated that when visitors bring in food, if it is going to be stored, rather than eaten right away, staff puts it into a container and labels with product, date, expiration date, and initials. The food in the resident refrigerator should be labeled with date. 9.) The facility's Med Pass Supplement policy, undated, states, in part: .5. Frozen supplements should be stored in freezer until use and pulled to thaw one day before using. Once pulled, supplement should be dated with an expiration date that is 14 days past the current date. Any product that is past expiration date must be discarded.On 2/24/26 at approximately 9:58 AM, Surveyor observed 1 thawed chocolate mighty shake with no use-by date in the resident refrigerator and asked LC AA (Lead Cook) how long a mighty shake is good once thawed. LC AA stated it is good for 2 days. Surveyor asked how long this shake had been thawed. LC AA stated that normally there would be a use-by date; in this case, with no label, did not know.On 2/24/26 at 2:53 PM, Surveyor interviewed DM BB (Dietary Manager) about thawed Mighty Shakes/Supplements. DM BB stated we only allow it for 7 days. In the kitchen we only date things for 3 days. It should be labeled with use by date once in refrigerator.

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe environment and to help prevent the development and transmission of communicable disease and infections. This has the potential to affect all 61 residents.The facility failed to follow infection control standards of practice and procedures.The facility failed to maintain accurate and up to date outbreak line listings for staff and residents. Staff were allowed to return to work early after the onset of GI (Gastrointestinal Illness) symptoms.The facility failed to ensure residents experiencing GI symptoms were put into precautions timely. Observations were made of staff inappropriately handling soiled linens.Observation were made of staff failing to wear PPE (Personal Protective Equipment) as required.These failures resulted in 17 residents and 13 staff either testing positive for norovirus or exhibiting symptoms of GI illness during a Norovirus outbreak. The facility failed to ensure adequate infection control processes were followed to ensure containment of norovirus during a facility outbreak. This failure created the potential for all residents, staff, and visitors of the facility to become infected with norovirus, potentially leading to serious illness, hospitalization, and or/death, and created a finding of immediate jeopardy (IJ) that began on 2/3/26. Surveyor notified NHA A (Nursing Home Administrator) and RDO JJ (Regional Director of Operations) of the immediate jeopardy on 2/25/26 at 2:31 PM. The immediate Jeopardy was removed on 2/26/26, however, the deficient practice continues at a scope and severity of F (potential for harm/widespread) as the facility implements its action plan. Findings include:The CDC (Center for Disease Control and Prevention) recommends:. When patients with norovirus gastroenteritis cannot be accommodated in single occupancy rooms, efforts should be made to separate them from asymptomatic patients. During outbreaks, place patients with norovirus gastroenteritis on Contact Precautions for a minimum of 48 hours after the resolution of symptoms to prevent further exposure of susceptible patients. Consider minimizing patient movements within a ward or unit during norovirus gastroenteritis outbreaks. Consider restricting symptomatic and recovering patients from leaving the patient-care area unless it is for essential care or treatment to reduce the likelihood of environmental contamination and transmission of norovirus in unaffected clinical areas. Consider suspending group activities (e.g., dining events) for the duration of a norovirus outbreak.Personnel who work with, prepare or distribute food must be excluded from duty if they develop symptoms of acute gastroenteritis. Personnel should not return to these activities until a minimum of 48 hours after the resolution of symptoms or longer as required by local health regulations.If norovirus infection is suspected, adherence to PPE use according to Contact and Standard Precautions is recommended for individuals entering the patient care area (i.e., gowns and gloves upon entry) to reduce the likelihood of exposure to infectious vomitus or fecal material. Use Standard Precautions for handling soiled patient-service items or linens, including the use of appropriate PPE. Handle soiled linens carefully, without agitating them, to avoid dispersal of virus. Use Standard Precautions, including the use of appropriate PPE (e.g., gloves and gowns), to minimize the likelihood of cross-contamination.Develop and adhere to sick leave policies for healthcare personnel who have symptoms consistent with norovirus infection. Exclude ill personnel from work for a minimum of 48 hours after the resolution of symptoms. Once personnel return to work, the importance of performing frequent hand hygiene should be reinforced, especially before and after each patient contact.Begin active case-finding when a cluster of acute gastroenteritis cases is detected in the healthcare facility. Use a specified case definition and implement line lists to track both exposed and symptomatic patients and staff. Collect relevant epidemiological, clinical, and demographic data as well as information on patient location and outcomes. The Wisconsin Department of Health Services (DHS), Recommendations for Prevention and Control of Acute Gastroenteritis Outbreaks in Wisconsin Long-Term Care Facilities, dated December 2017, was provided by the facility to the (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	survey team as the standard of practice they used to guide their GI outbreak. This Wisconsin DHS guidance indicates, in part: . A specific case definition for norovirus could be: Acute onset of vomiting and/or diarrhea (three or more loose stools in a 24-hour period) in a resident or staff member and whose symptoms have no other apparent cause. A log should be maintained to record ill staff symptoms, date when they became ill, date they became well, and date they returned to work. Laundry: Ensure laundry personnel are made aware of the potentially infected linen and are provided with appropriate PPE. Line List Instructions: A line list is a log of ill staff and residents with similar signs and symptoms. It should be used as a tool to track illnesses within a facility when an outbreak is suspected and while an outbreak is occurring in real time. A line list is a resource for those managing an outbreak and can help identify when restrictions can be lifted, when ill staff can return to work and when the outbreak is over. When completing the line lists it is important that: . The line list is maintained in real time so it can be used as a management tool. All fields be filled out completely so the outbreak can be fully assessed. Facility policy titled, Infection Control Program, dated 3/7/17, with last revision date of 5/8/24, states, in part: Purpose: The infection control program exists to assure a safe, sanitary, and comfortable environment for residents and personnel. It is designed to help prevent the development and transmission of disease and infection. The facility establishes a program under which it: Investigates, controls, and prevents infections in the facility; Decides what procedures such as isolation, should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. Preventing spread of infection: When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident; The facility must prohibit employees with a communicable disease. from direct contact with residents or their food. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This is accomplished by maintaining effective methods for investigating the incidence of infection, controlling transmission, and preventing infection. Intent: The intent of this policy is to assure, through the infection control program a system is in place to: Provide surveillance, investigation and monitoring to prevent, to the extent possible, the onset and the spread of infection; Prevent and control outbreaks and cross-contamination using transmission-based precautions in addition to standard precautions; Minimize chance of outbreaks by clustering or cohorting of residents to reduce spread of infection. Determine nursing home precautions (e.g. isolation) as a means of preventing cross-contamination. Demonstrate proper storage, handling, processing, and transport of linens to minimize contamination. Elements of the program include: Program oversight including planning, organizing, implementing, operating, monitoring, and maintaining all of the elements of the program and ensuring that the facility's interdisciplinary team is involved in infection prevention and control; Surveillance, including process and outcome surveillance, monitoring, data analysis, documentation. Surveillance based on systemic data collection to identify infections in residents; A system for detection, investigation, and control of outbreaks of infectious diseases; An isolation and precaution system to reduce the risk of transmission of infectious agents; Infection Control policies, procedures, and practices which promote consistent adherence to evidence-based infection control practices; Process to evaluate and enforce proper environmental controls; Process to evaluate and enforce proper infection control practices by personnel; An employee health program. Facility policy titled, Infection Control - Employee Health, dated 1/10/19, with last revision date of 5/8/24, states, in part: Purpose: To ensure and maintain a health standard required of all employees to perform their duties. Policy: . 1a. No employee with a communicable disease shall be allowed to work in the facility until the period of communicability has been determined to have terminated. Procedure: 2. CDC guidance and recommendations will be followed to determine when an employee may return to work after a possibly infectious illness such as Influenza, COVID, GI Flu, etc. Facility policy titled, Personal Protective Equipment, dated 8/1/15, with last revision date of 6/14/24, states, in part: Policy: To provide guidance for the use and selection of appropriate personal protective equipment (PPE) based on risk of exposure to blood or (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	body fluids, in accordance with state and federal regulations. Procedure: 1. Personal protective equipment (PPE) includes gloves, masks, protective gowns, eyewear, and face shields. 2. PPE will be utilized when an employee is at risk to exposure to blood or body fluids through absorption, inhalation, and/or physical contact. 4. PPE is required for entry into isolation rooms and removal is required prior to leaving isolation rooms. Gloves: 1. Gloves are readily available and should be worn when coming into contact with blood, body fluids, secretions, excretions, mucous membranes and/or intact skin. a. Providing direct resident care involving contact with blood or body fluids. c. When handling soiled linen or items that may be contaminated. f. When entering isolation areas. Gowns: 1. Gowns should be worn when performing tasks that will likely soil the employee's clothing with blood or body fluids. 2. Gowns will be applied prior to entering treatment area. Facility OutbreakDocuments provided by the facility stated that they were in GI/Norovirus Outbreak from 2/9/26 - 2/20/26. A review of the facility's February 2026 Monthly Infection Surveillance log, GI Outbreak Summary, and Employee Call-In Log, provided by the facility, indicated the following: On 2/4/26:DA I (Dietary Aide) listed on the Employee Call-In log as having diarrhea. No well date or return-to-work date listed. DA I's employee timecard log indicates that DA I returned to work on 2/6/26.On 2/25/26 at 11:44 AM, Surveyor interviewed DA I, who stated he had Chinese food for dinner on 2/4/26 and then started experiencing diarrhea in the night, about 5 hours after consuming the Chinese food. DA I indicated he had diarrhea a couple of times in the night, then started to feel better the next day, after about 24 to 35 hours. DA I confirmed that he returned to work on 2/6/26 for the PM shift. DA I stated his kitchen duties include washing dishes, setting up food trays, putting trays on the food cart, helping with drinks, assembling the trays and taking the food cart down to the halls. DA I stated that after the meal, he cleans the dining room, breaks down the food carts, puts the condiments and drinks away and washes the meal dishes.On 2/25/26 at 12:42 PM, Surveyor interviewed ADON/IP C (Assistant Director of Nursing/Infection Preventionist) about DA I's symptoms and return-to-work date. ADON/IP C stated that DA I called in with an episode of diarrhea on 2/3/26 and then came back on the 2/6/26. ADON/IP C stated that DA I called in at 5:00 AM on 2/4/26 saying he wasn't going to be in and that he had diarrhea the day before. ADON/IP C stated that DA I called again at noon on 2/4/26 stating that he was feeling better hadn't had another episode of diarrhea since that morning.The facility surveillance list did not include DA I, the employee call-in log indicated DA I called in on 2/4/26, the log did not include a well date or time for DA I. The facility had no way to verify that DA I was excluded from work for 48 hours after symptoms resolved. On 2/6/26:R10 on 400 hall with nausea, vomiting, and diarrhea. Date of onset 2/6/26. Notes: . [Resident Name] reported nausea, vomiting and diarrhea this morning. feeling better this afternoon and up walking in his room and was down to sunroom for activity. Date resolved: 2/9/26.The facility did not restrict the movement of R10 through the facility for 48 hours after symptoms resolved in order to limit the exposure to well residents. On 2/7/26:R70 on 300 hall with nausea, vomiting and diarrhea. Date of onset 2/7/26. Notes: . Resident reported having diarrhea for two days. Writer got report on the 7th that issue was resolved. At 2230 (10:30 PM) it was reported that resident has been having bouts of watery stools throughout the day. Writer was called into resident's room for vomiting. Upon entering room emesis was puddled by head in bed. Resident also presented more watery stools. On-call [Dr. Name] notified. stated give PRN medication if tolerated. If resident can't tolerate (medication) send to ER. Resident was given medication 0045 (12:45 AM). Writer monitoring for effectiveness. 2/9/26: positive for norovirus. hospitalized . Returning 2/17/26. Last watery stool on 2/14/26. No isolation/monitoring needed upon return. Date resolved: 2/17/26.Of note: The facility stated the GI/Norovirus outbreak began on 2/9/26, despite a staff member with diarrhea on 2/4/26 and two residents reporting nausea, vomiting, and diarrhea on 2/6/26 and 2/7/26. On 2/23/26 at 4:25 PM, Surveyor interviewed ADON/IP C and asked what the criteria is for a norovirus outbreak. ADON/IP C stated that the requirements for a GI outbreak are when a staff or resident had 3 or more episodes of signs and symptoms. On 2/9/26:R49 on 300 hall exposure to nausea and vomiting. Date of onset 2/9/26. Notes: 2/10/26: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident is being monitored for exposure to roommate with norovirus. Contact precautions in place. 2/11/26: Resident in dining room this AM for breakfast. noted to previously be on isolation for exposure to norovirus. Writer met with resident to assess. [Resident] remains without S&S (signs and symptoms) for > (greater than) 24 hours and reports feeling fine. 2/12/26: Per nursing note on 2/11/26 emesis x2 (times two) on PM shift. Isolation reinstated. Date resolved: 2/15/26. R54 on 200 hall with watery stool, nausea, vomiting. Date of onset: 2/9/26. Notes: 2/9/26: Watery stools noted, 1 watery stool documented. 2/11/26: Resident feeling ill. reports vomiting x3 in the bathroom this AM. Continued with loose stool. Resident placed on Contact precautions. 2/12/26: positive for norovirus. Date resolved: 2/15/26. R33 on 300 hall with multiple loose/watery stools, emesis x1. Date of onset 2/9/26. Notes: 2/10/26: is being monitored for loose/watery stools. Contact isolation. watery stools noted 2/9/26 x1 and 2/10/26 x2. 2/12/26: Emesis x1 on last PM shift. Date resolved: 2/15/26.The facility provided GI/Norovirus Outbreak summary states, in part: S&S (signs and symptoms) started with resident [Resident Initials], (R70), on 2/7/26 per her report of starting with diarrhea ?2 days ago'. Reports of more residents displaying GI S&S throughout the day Monday (2/9/26). Those displaying GI S&S were immediately placed on system monitoring and contact/enteral precautions.Of note: Nothing in the facility GI/Norovirus Outbreak summary is mentioned about R10's nausea, vomiting and diarrhea 2 days ago. R70 was admitted to the facility on [DATE] , a review of R70's nursing progress notes, provided by the facility, include the following:--2/2/26: Watery stools noted. No loose stools on this shift.--2/3/26: an episode of watery stools twice on the shift.--2/5/26: Watery stools noted; intermittent stools noted.--2/9/26: Resident reported having diarrhea for two days. Writer got report on the 7th that issue was resolved. At 2230 (10:30 PM) it was reported that resident has been having bouts of watery stools throughout the day. Writer was called into resident's room for vomiting. Upon entering room emesis was puddled by head in bed. Resident also presented more watery stools.--2/9/26: CNA (certified nursing assistant) notified this writer resident had another incontinent loose BM (bowel movement) and would like writer to assess. Writer in to see resident. Resident states she couldn't make it to the commode in time and BM (bowel movement) keeps coming out.--2/9/26: Resident alert and up in chair with no change to baseline mentation. Resident reports ongoing diarrhea. Resident continues to have diarrhea at this time. Writer awaiting results of C-diff testing.On 2/9/26, R70 was seen by the facility APNP (Advanced Practice Nurse Practitioner), whose nursing note states . seen today for chief complaint of abdominal pain, diarrhea, nausea and vomiting. reports she had emesis X2 so far today, last time was after her clear liquid breakfast tray. Symptoms of n/v/d (nausea, vomiting, diarrhea) started yesterday, and she feels they are worsening as the day has progressed. she is having almost constant loose stools. negative c-diff and enteric panel is pending. concern about her abdominal pain as well as ongoing n/v/d. [Resident Name] agreeable to transfer to ER.A 2/9/26 ER note indicates the following, in part: . presented from nursing home with complaint of diarrhea, loose stool > 4-5 BM (bowel movement) a day for 2 days. her stool test today is positive for norovirus. patient is very sick. admit as inpatient. IV hydration given.R70 was admitted to the hospital from [DATE] to 2/17/26. Hospital discharge summary indicates the following, in part: principal diagnosis of acute kidney injury due to diarrhea and norovirus. strongly encouraged patient to vastly improve her oral fluid intake.Of note: R70's care plan was updated on 2/9/26 to include, Resident is being monitored for GI S&S. vomiting and loose/watery stool. Contact/droplet precautions in place. Interventions include, in part: monitoring pain and vital signs, assisting resident with hand washing, provide increased rest periods, notify MD/NP (Medical Director/Nurse Practitioner) of any change in condition.However, there is no intervention to monitor for dehydration or increase fluids with the resident experiencing multiple bouts of watery stools and vomiting. On 2/25/26 at 12:02 PM, Surveyor interviewed ADON/IP C about R70 having several watery stools prior to being placed on isolation precautions. ADON/IP C stated that R70 had one watery stool on 2/1/26 and another on 2/4/26, then nothing until 2/9/26 with two more watery stools. ADON/IP C stated she got that date of 2/7/26 from nursing notes that stated R70 reported to staff having loose stools for 2 days. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	ADON/IP C stated that R70 probably didn't get put on isolation precautions until the morning of 2/9/26 when she followed up with the NP and got the orders. ADON/IP stated that the norovirus outbreak wasn't confirmed yet because R70 hadn't had 3 loose stools in 24 hours.Of note: A review of R70's nursing notes indicates that R70 had one watery stool on 2/2/26 and two more watery stools on 2/3/26, which would have met the criteria of 3 watery stools within 24 hours. On 2/11/26:R38 on 300 hall with nausea, decreased appetite, decreased PO (by mouth) intake. Date of onset: 2/11/26. Notes: 2/11/26: Resident is being monitored for GI S&S, nausea, decreased appetite, decreased PO intake. Contact precautions in place. Date resolved: 2/14/26.R21 on 300 hall with nausea, vomiting, decreased appetite, decreased PO intake. Date of onset: 2/11/26. Notes: 2/11/26:. Resident experienced sudden onset of nausea and vomiting.2/12/26: one emesis at 0600 (6:00 AM) this AM shift. Date resolved: 2/15/26.R31 on 300 hall with nausea, frequent loose stools, decreased appetite, decreased PO intake. Date of onset: 2/11/26. Notes 2/11/26: Resident woke not feeling well. Reports GI S&S (frequent loose stools, nausea and wants to vomit, reports spitting up. Placed on Contact precautions. 2/12/26: continues with watery stools. positive for norovirus. Date resolved: 2/17/26.HK G (Housekeeper) called off today for continuous diarrhea. is aware she can return 48 hours after last episode. Well date: 2/15/26. No return-to-work date.CNA H sent home for dizziness, nausea, fatigue. worked the 300 hall during the start of GI outbreak. She worked the AM shift and started to develop S&S at the start of PM shift. Sent home due to feeling ill. Returned to work 2/16/26 free of GI S&S.On 2/12/26:R27 on 100 hall with mild nausea. Date of onset 2/12/26. Notes: 2/12/26: . resident having mild nausea this AM. resolved after breakfast. participating in therapy. No isolation required at this time. Date resolved: 2/15/26.R18 on 300 hall with nausea and body aches. Date of onset 2/12/26. Notes: . Resident states not feeling good, upset stomach and body aches. Already in contact precautions due to roommate with GI S&S. Date resolved: 2/15/26.(of note: R18 sits at the same dining table as R70 who first had watery stools on 2/2/26)R30 on 200 hall with body aches and nausea. Date of onset: 2/12/26. Notes: 2/12/26 Resident refused medications. stated does not feel good, body aches and upset stomach. Date resolved: 2/15/26.R44 on 200 hall with diarrhea, abdominal pain and confusion. Date of onset: 2/12/26. Notes: 2/12/26 Resident had two episodes of diarrhea. resident complaints of abdominal pain. Sent to ER for increased confusion. GI panel was positive for norovirus. resident admitted to hospital. 2/16/26 returned from hospitalization S&S free. Date resolved: 2/16/26.R62 on 100 hall with weakness, decreased appetite, loose stools, congestion, cough, fatigue. Notes: Resident admitted . positive for Influenza A. Droplet/contact precautions upon admit. has had 1-2 episodes of loose stools for the past few days. Date resolved: 2/14/26.(Of note: the 300, 200, and 100 hallway have residents experiencing GI symptoms and a second resident was sent to the hospital.)On 2/13/26:R6 on 200 hall with emesis, loose watery stools. Date of onset: 2/13/26. Notes: Resident reports not feeling well on 2/13/26. monitoring for emesis and loose stools. noted meal intake is decreased. two watery stools noted on 2/13/26 . continues with loose/mushy stool today. 2/16/26 continues with watery stool this past NOC (overnight) shift. remain on isolation at this time. Date resolved: 2/19/26.R43 on 100 hall with nausea, chills, and body aches. Date of onset: 2/13/26. Notes: Reported feeling ill on 2/13/26, nausea, chills, body aches, placed on contact precautions due to GI outbreak. 2/15/26: per nurse took off isolation due to no S&S since Thursday. Date resolved: 2/15/26.On 2/15/26:LPN R (Licensed Practical Nurse) Started with GI S&S this AM: Vomiting, diarrhea. Next scheduled shift 2/19/26, returned with no further GI S&S. Onset date: 2/15/26. Well date: 2/19/26.RN S (Registered Nurse) Started with GI S&S today: emesis x2. Next scheduled shift 2/19/26, returned with no further GI S&S. Onset date: 2/15/26. Well date: 2/19/26.On 2/16/26:R39 on 100 hall with nausea, vomiting, loose stools, poor appetite and fatigue. Date of onset: 2/16/26. Notes: 2/16/26 resident had vomited in the dining area, large emesis noted while eating breakfast. states he was nauseous this AM, however, did not report to staff. 2nd emesis after lunch. 2/17/26: . not eating breakfast, reports poor appetite and fatigue. Date resolved: 2/18/26.Of note: the noted resolved date is only 2 days after the resident experienced 2 episodes of nausea and (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	vomiting.CNA E Started with GI S&S today: Loose stools x2, nausea, sweats. Left shift early. Next assigned shift 2/18/26. No further GI S&S. Onset date: 2/16/26. Well date: 2/18/26.R44 was admitted to the hospital on [DATE] with acute onset of nausea, vomiting, diarrhea, altered mental status, and a witnessed seizure-like episode in the emergency department. she had several days of nausea, vomiting, and diarrhea with stool studies positive for norovirus and negative for c-difficile/parasites.A review of R44's physician orders indicate that R44 had fluid monitoring in place with a start date of 11/5/25.Of note: R44's care plan was updated on 2/12/26 to include, Resident is being monitored for GI S&S. vomiting and loose/watery stool. Contact/droplet precautions in place. Interventions include, in part: monitoring pain and vital signs, assisting resident with hand washing, provide increased rest periods, notify MD/NP (Medical Director/Nurse Practitioner) of any change in condition., etc. However, there are no person-centered interventions regarding R44's symptoms or infection. On 2/17/26:R62 with nausea and loose stools. Date of onset: 2/17/26. Notes 2/17/26. reports nausea. states has been having loose stools in her briefs last night and today. Contact precautions initiated due to S&S consistent with GI outbreak. 2/18/26 reports nausea. Date resolved: 2/20/26.R27 with GI S&S. Date of onset: 2/17/26. Notes: 2/17/26 reports new onset of GI S&S. Placed on contact precautions due to GI outbreak. 2/18/26 resident has been without nausea/spitting up for >24 hours. isolation and monitoring for GI S&S discontinued. Date resolved: 2/18/26.(of note: R27 was removed from precautions too early. Symptoms resolved on 2/18/26, which would indicate R27 should have remained on precautions until 2/20/26R39 with recent nausea, vomiting, and cough. Notes: . recent nausea/vomiting episodes. no isolation needed as treating as aspiration pneumonia vs. infectious. Date resolved: 2/24/26.On 2/18/26:DA T Called in today for GI S&S: diarrhea. Onset date: 2/18/26. Well date: 2/22/26.On 2/19/26:R66 with loose stools. Notes: . resident starting with loose stools today. BM (bowel movement) meds held. Continue to monitor. No further stools. Not added to outbreak. Date resolved: 2/19/26.On 2/20/26:CNA U called in with nausea and vomiting. Onset date: 2/20/26. Well date: 2/22/26. Of note: facility declares end of GI Outbreak in their documentation, despite several staff still reporting norovirus symptoms of nausea, vomiting, diarrhea, and low-grade fever as follows: On 2/21/26:CNA V called in with nausea and vomiting. Onset date: 2/21/26. Well date: 2/24/26.CNA W called in with a fever of 100 degrees. Onset date: 2/21/26. Well date: 2/22/26.On 2/23/26:CNA X reported vomiting. Onset date: 2/23/26. Well date: 2/24/26.(of note, CNA X's well date is less than 48 hours from onset)On 2/24/26:MT Y (Maintenance) reported diarrhea. Date onset: 2/24/26. Well date: 2/24/26.On 2/25/26:AD Z (Activities Director) report vomiting. Onset date: 2/25/26. Well date: not listed. 2.) Not wearing PPEOn 2/22/26 at 11:26 AM, Surveyor observed LPN D (Licensed Practical Nurse) and CNA E (Certified Nursing Assistant) enter the room of R1 without wearing PPE. Surveyor observed that R1 had signage on the door that indicated R1 was on contact precautions.On 2/22/26 at 11:28 AM, Surveyor observed LPN D come out of R1's room and asked her about the nature of R1's precautions. LPN D stated that she thought R1 was on precautions for the GI (gastrointestinal) outbreak that the facility had. Surveyor asked LPN D what types of PPE should be worn for someone on contact precautions. LPN D indicated that contact precautions include wearing a gown, gloves, and masks. Surveyor asked LPN D if she had worn PPE while in R1's room. LPN D stated that she had not, because she was only assisting with the Hoyer transfer and not providing cares.On 2/22/26 at 11:31 AM, LPN D approached Surveyor in the hallway and stated that she wanted to clarify that R1 was not on precautions for GI but for pink eye, and that because she was not around R1's eye area she was not required to wear PPE in her room.On 2/22/26 at 11:35 AM, Surveyor observed CNA E come out of R1's room and asked her if R1 was on contact precautions. CNA E stated, not that I know of. Surveyor asked CNA E if she had worn PPE in R1's room. CNA E stated that she had worn gloves to help get R1 ready for the day. 3.) Laundry TourOn 2/23/26 at 7:30 AM, Surveyor completed the facility laundry tour with HS F (Housekeeping Supervisor). Surveyor observed HK G (housekeeper) in the sorting room without wearing PPE. HK G stated that she wears a gown and gloves to sort the laundry, but that she had just taken it off prior to Surveyor entering the (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	room. Surveyor observed HK G donning gown and gloves in the sorting room and begin to sort the soiled laundry. HS F stated that HK G would take off the soiled gown but keep her gloves on when taking soiled linens from the sorting room to the washing machine. HS F stated that HK G would not wear a gown when putting the soiled linens into the washing machine, because the washing room was considered a clean area and there may be risk of rubbing the soiled gown on the laundry cart or clean clothes. 4.) Handling soiled linensOn 2/24/26 at 11:33 AM, Surveyor observed CNA H wheeling an open, overflowing laundry cart down the hallway without wearing any PPE. While Surveyor was observing, CNA H stopped and donned gloves, then continued down the hall, tied up the laundry bag, and placed it in the soiled linen closet. CNA H then returned the empty linen cart back to the clean linen closet and added a new bag to the cart without changing gloves or performing hand hygiene.On 2/24/26 at 1:38 PM, Surveyor interviewed CNA H about the observation with the soiled linens. CNA H stated that when handling soiled linens, they usually wear a gown and gloves. Surveyor asked CNA H if she had worn a gown or gloves when she transferred the soiled linens before lunch. CNA H stated no, that she had forgotten to wear the appropriate PPE. On 2/24/26 at 3:05 PM, Surveyor interviewed ADON/IP C about the facility's infection control program and the recent GI outbreak. ADON/IP C stated that with the GI outbreak she learned that the staff need more supervision and education. ADON/IP C indicated that she would like to do hand washing audits with staff, but that she hadn't had time to start them yet. Surveyor asked if any audits had been completed, such as the use of appropriate PPE. ADON/IP C stated that she did not believe any audits had been done yet.ADON/IP C indicated that as soon as the leadership team found out about residents with GI signs and symptoms, she met with HS F (housekeeping supervisor) to ensure that bleach was used for cleaning to control the spread of infection. ADON/IP C stated she also educated staff on handwashing, and she notified public health about the outbreak. Surveyor asked ADON/IP C about the staff education, and ADON/IP C clarified that the education was verbal only in regards to hand washing.ADON/IP C stated that residents that were in double rooms were left with their roommates as they didn't want to move residents around. ADON/IP C stated affected residents with signs and symptoms stayed in their rooms for the duration of their symptoms until they were clear of symptoms. ADON/IP C stated she believed the dietary manager used disposable tableware for those residents, and they could come out of their rooms for therapy, but that therapy staff were instructed to bleach whatever area they were at. ADON/IP C indicated that individual activities were provided for the residents isolated to their rooms. Surveyor asked ADON/IP C to provide a facility map of the GI outbreak. ADON/IP C stated that she had not completed an outbreak map

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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 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 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview, the facility did not ensure that garbage and refuse were properly disposed of in outside garbage storage receptacles. This practice has the potential to affect all 61 residents. Surveyor observed the facility's outside garbage receptacle to be full to the top and the lid wide open. Evidenced by:On 2/22/26 at approximately 9:30 AM, during the initial kitchen tour with LC AA (Lead Cook), Surveyor observed the outside garbage storage receptables. One of the receptacles had the cover wide open and there were garbage bags up to and over the top of the sides. Surveyor asked LC AA about the lid. LC AA stated, that shouldn't be open, it could cause problems.On 2/24/26 at 2:53 PM, Surveyor interviewed DM BB (Dietary Manager) who stated the lid should be closed for pest control.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. :Based on interview and record review, the facility's Quality Assessment and Assurance committee failed to develop and implement appropriate plans of action to correct deficient practices related to food safety requirements and infection control. This has the potential to affect all 61 residents.The facility failed to follow infection control standards of practice and proper sanitation of dishware during a Gastrointestinal illness outbreak. Evidenced by: The facility's Quality Assurance/Assessment and Performance Improvement (QAPI) Plan policy, dated 9/4/24, states, in part: Purpose: The QAPI Program is to utilize an on-going, data driven, pro-active approach to advance to the quality of life and quality of care for all residents at the facility. QAPI principles will drive our facilities decision making to promote excellence in all resident and staff related areas. All facility staff, families, and residents will be encouraged to be involved in identifying opportunities for improvement. Feedback, Data Systems, and Monitoring: The facility will monitor multiple data sources and performance indicators in determining areas of concern, gaps and opportunities and also to determine effectiveness of system modifications and other interventions. Performance Improvement Projects (PIPs) The facility will review the designated sources of data; identify areas where gaps in performance may negatively affect resident or staff outcomes. Where opportunities for improvement are detected, the QAPI Committee with input from the Leadership team will prioritize focus areas for PIP development. Documents provided to Surveyors by the facility, during the recertification survey from 2/22/26-2/25/26, stated that they were in GI/Norovirus Outbreak from 2/9/26 - 2/20/26. The facility did not ensure a resident with norovirus symptoms (R70) was immediately placed on isolation precautions, failed to monitor residents for hydration status resulting in a resident's hospitalization (R70), failed handle soiled linens appropriately or ensure that staff wore personal protective equipment. The facility did not maintain an accurate outbreak line list and facility staff failed to understand return-to-work criteria. These findings created a situation of Immediate Jeopardy. Cross reference F880. Observation, record review and interview during the recertification survey from 2/22/26-2/25/26, showed that the facility was not checking the PPM (parts per million) for the chemical dishwasher and therefore not ensuring that dishes were properly sanitized during the GI/Norovirus outbreak. Cross reference F812. On 2/25/26 at 3:21 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and DON B (Director of Nursing) regarding QAPI. NHA A and DON B indicated that concerns for QAPI are identified through quality measures, audits, falls, wounds, trends noted. Sometimes we start working on things prior to the meeting and then we review at the meeting. Surveyor asked if there is discussion of infection control at QAPI. NHA A and DON B stated that it is discussed every month and includes outbreaks. Surveyor asked if concerns regarding the gastrointestinal illness outbreak had been discussed with QAPI; timing of placement of residents on isolation, accuracy of outbreak line list, timing of staff return to work. Surveyor asked if sanitation in the kitchen, proper chemical testing, was discussed with QAPI. NHA A stated uncertainty if the specific items had been reviewed; would review notes and update. On 2/25/26 at 4:09 PM, NHA A stated, no, we did not identify the concerns and discuss with QAPI prior to this survey.When adverse resident events are identified, the facility must analyze the cause of the error/event, implement corrective actions to prevent future events, and conduct monitoring to ensure desired outcomes are achieved and sustained, this was not initiated or completed by the facility for infection control despite having a gastrointestinal illness outbreak affecting 17 residents and 13 staff.

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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 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 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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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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 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 4Number of residents cited: 2Based on interview and record review, the facility did not make prompt efforts to document, investigate, and resolve grievances a resident may have for 2 of 4 residents reviewed for grievances (R2 and R40). R2 voiced a grievance to the facility. Staff did not write their concerns up as a grievance, complete an investigation, or follow-up with the complainant. R40's APOA (Activated Power of Attorney) voiced a grievance to the facility. Staff did not write their concerns up as a grievance, complete an investigation, or follow-up with the complainant. Evidenced by: The facility's policy titled Grievance/Concerns last revised on 10/29/24 states in part .Procedure: 1. Facility will make prompt efforts to resolve all grievances.4. Residents have the right to file grievances orally or in writing; and they have the right to file grievances anonymously. 5. At any time, comments, suggestions, or complaints by the residents and/or their representatives are encouraged to direct their concerns to; The Administrator, Social Services Director, Director of Nursing or designee, or any appropriate manager.9. The grievance form includes the date the grievance was received, a summary statement of the resident's grievance, the steps being taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the residents' concerns, whether the grievance was confirmed or not confirmed, corrective action taken, or to be taken, and the date the written decision was issued. Resolution of the grievance and reporters [sic] satisfaction with the resolution. Example 1 R40 was admitted to the facility on [DATE] with diagnoses that include heart disease, chronic pain, type 2 diabetes mellitus, and other symptoms and signs involving cognitive functions and awareness (memory loss, confusion, concentration, language difficulties, and poor judgement). R40's most recent MDS (Minimum Data Set) dated 12/5/25 states that R40 has a BIMS (Brief Interview of Mental Status) of 6 out of 15, indicating that R40 has severe cognitive impairment. R40's MDS section GG states that R40 requires partial/moderate assistance for bathing, personal hygiene, and upper body dressing, and is dependent on staff for lower body dressing. R40 has an APOA. R40's care plan initiated on 9/6/24 states in part .FOCUS: The resident has an ADL (Activities of Daily Living) self- care performance deficit r/t (related to) weakness, and deconditioning. Resident frequently refuses assistance with ADLs.Interventions: Assist to change brief and get into pajamas every bedtime (date initiated 2/18/26). Bathing/Showering Assist- One.Dressing Assist- One. Personal Hygiene/Oral Care Assist- One. R40's CNA (Certified Nursing Assistant) task interventions history states: (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/4/25 Assist res (resident) nightly w (with)/ pajamas. Resident to have poise pad in underwear. 11/14/25 Assist res nightly w/ pajamas 2/23/26 Assist res nightly w/ pajamas On 2/22/26 at 12:18 PM, Surveyor interviewed APOA J. APOA J stated that R40 was wearing the same clothes that they had on the day before and that staff don't always change them into their pajamas at night. APOA J stated that they lay R40's pajamas on the bed for the night and that they were still there today. Surveyor asked APOA J if they have spoken to facility staff regarding this concern, APOA J stated that they have spoken to NM K (Nurse Manager). On 2/23/26 at 3:27 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if APOA J's concerns regarding R40 not being changed into their pajamas was written up as a grievance, DON B stated that they would have to check. Surveyor asked DON B if they would expect R40 to be changed into their pajamas at night, DON B stated yes. On 2/23/26 at 3:37 PM, Surveyor interviewed NM K. Surveyor asked NM K if they had any conversations with APOA J regarding R40 being changed into their pajamas at night, NM K stated that they have had several conversations and that they updated R40's care plan and talked to the staff and provided education. Surveyor asked NM K if they wrote APOA J's concerns up as a grievance, NM K stated no, and they just handled it. Surveyor asked NM K if they audited R40's cares to ensure that the task was being completed and that the education was effective, NM K stated no. On 2/25/26 at 9:40 AM, NHA A (Nursing Home Administrator) provided Surveyor with a copy of a grievance for R40 and APOA J. The Grievance Form states: Date/ Time of Report: 2/22/26 Origin of Report: Voiced by Individual/Family Resident: [R40 Name] .Reported by: [APOA J name] . Grievance (include Approximate Date/Time): [APOA J name] complained that she felt the caregivers are not changing her mother's brief and putting her in pajamas before bed each night. I lay out a brief, her pajamas, and clothes and she's wearing the same clothes she had on yesterday She stated I'm mostly concerned about getting the brief changed, for obvious reasons citing [sic] odor and skin irritation if left in a wet brief. It is important to note that the Grievance Form does not include and investigation notes or resolution documentation. Surveyor asked NHA A when the grievance was filed, NHA A stated that they had NM K write is yesterday. Surveyor asked NHA A if they would expect grievances to be written up on the day that they occur or when staff is made aware of a concern, NHA A reported that they discuss concerns in the morning meeting. Surveyor asked NHA A if NM K brought APOA J's concerns to the morning meeting, NHA A stated that NM K was not at the morning meeting on Monday. Example 2 R2 voiced a grievance to the facility. Staff did not write up the concern as a grievance or complete an investigation. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/22/26 at 3:00 PM, Surveyor interviewed RR FF (Resident Representative) during initial screening of residents. RR FF stated that R2 had a concern regarding a staff member who didn't speak English and R2 wasn't able to properly communicate with the staff member. RR FF stated that the facility was aware as R2 had spoken with NP GG (Nurse Practitioner) about the concern not wanting the staff member to return to care for R2. Surveyor reviewed the facility's February Grievance log. There was no documentation for R2. On 2/23/26 at 2:02 PM, Surveyor interviewed NP GG who stated that R2 had called and left a message about the concern. NP GG stated the information was forwarded to DON B (Director of Nursing) and ADON C (Assistant Director of Nursing) in an email on 2/16/26. On 2/23/26 at 2:12 PM, Surveyor interviewed DON B and asked about R2's concern. DON B reviewed email from 2/16/26 and stated I have a voicemail attachment that I guess I didn't listen to; the email is marked unread. On 2/23/26 at 4:30 PM, DON B stated NS HH (Nursing Scheduler) had been aware of the concern and took care of it. On 2/24/26 at 7:14 AM, a Grievance form and an updated grievance log was provided. The updated log included a line that stated, in part: Date received 2.16.26 Resident Identifier R2 complaint type 'other' Person filing report: DON Date of grievance 2/26 The Grievance form, dated 2/23/26, states, in part; Date/Time of Report: 2/16/26.Date Investigation Completed: 2/23/26. On 2/24/26 at 11:09 AM, Surveyor interviewed NS HH who stated I was told R2 didn't want CNA II (Certified Nursing Assistant) working with R2 due to a language barrier. I talked with CNA II and the float CNA and made arrangements for the float to work with R2. Surveyor asked if administration was made aware of the resident concern. NS HH stated it was someone from administration who told me; I don't recall who, but it was one of them. On 2/25/2026 at 9:59 AM, Surveyor interviewed DON B about the new Grievance log and the Grievance Form. DON B stated my email was marked as unread, I filled out the grievance form and discussed with NS HH on 2/23/26. The situation was handled by NS HH at time of concern. Surveyor asked when the Grievance Form was completed. DON B stated after the discussion with Surveyor on 2/23/26. Surveyor asked if the facility is able to track and trend concerns if grievances are not written up and entered on the log. DON B stated no, I would expect it to be written up, added to log, the process followed through. On 2/25/2026 at 10:24 AM, Surveyor interviewed NHA A, who stated I would expect that all grievances would be reviewed and logged for tracking/trending and ensured follow through.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility did not ensure to develop and implement written policies and procedures that: S483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 3 of 8 staff reviewed for background checks. RN LL (Registered Nurse) did not have a background check completed every 4 years.LPN MM (Licensed Practical Nurse) did not have a background check completed every 4 years.CNA X (Certified Nursing Assistant) did not have a universal background check completed despite indicating that she lived out of state last year. This is evidenced by:The facility policy, Policy and Procedure Vulnerable Adult Abuse and Neglect Prevention, dated 11/17/17 with last revision date of 2/25/25, states, in part: Purpose: To provide residents a safe environment that is free from harm. Resident Protection Program Policy and Procedure: The seven elements of the prevention and investigation include: Screening. 1. Screening and Training of New Employees and Volunteers: a. Employees: i. Screen potential employees for a history of abuse, neglect, exploitation, or mistreatment. This includes. checking with the appropriate licensing boards and registries. iv. A criminal background check will be conducted on all prospective employees as provided by the facility's policy on criminal background checks, using the state-specified criminal background system. RN LL (Registered Nurse) was hired by the facility on 10/15/19. RN LL's last completed background check was completed on 10/17/19. RN LL should have had a background check completed by 10/17/23.LPN MM (Licensed Practical Nurse) was hired by the facility on 11/2/20. LPN MM's last background check was completed on 11/2/20. LPN MM should have had a background check completed by 11/2/24.CNA X (Certified Nursing Assistant) was hired by the facility on 2/6/26. CNA X's Background Information Disclosure Form (BID) indicated that she lived in Mississippi from 2/1/18 to 2/19/25. CNA X should have had a background check completed for Mississippi or a universal background check completed. On 2/23/26 at 1:47 PM, Surveyor interviewed HR KK (HR Director) and asked how often background checks should be completed for employees. HR KK stated that background checks are supposed to be completed every 4 years or sooner if they feel like they need to run another one. Surveyor asked about RN LL and LPN MM's background checks. HR KK stated that they were ran yesterday, but that they hadn't been run on time within the last 4 years. Surveyor asked HR KK what they do if an employee indicates that they have lived outside of the state. HR KK stated that they run universal background checks if the employee has lived out of state within the last 5 years. Surveyor asked if a universal or background check had been run on CNA X. HR KK stated that she apparently had overlooked running a universal background check for CNA X. HR KK indicated that she didn't know why it didn't get done, and it should have. HR KK stated that she started her role in November and had an audit in place, but it hadn't been completed yet. On 2/23/26 at 3:24 PM, Surveyor interviewed NHA A (Nursing Home Administrator) about RN LL, LPN MM, and CNA X's background checks. NHA A stated that HR KK started her role in either November or December and that her predecessor had gotten behind on completing the background checks, so corporate had suggested they complete an audit. Surveyor asked NHA A how often she expected the employee background checks to be completed. NHA A indicated that employee background checks should be completed every 4 years. Surveyor asked NHA A what kind of background check should be completed if an employee had lived outside of the state. NHA A stated that employees who have lived outside of the state within the last 7 years should have a national background check completed. Surveyor asked NHA A if it was her expectation that all employee background checks be completed every 4 years and that employees that had lived outside of the state have a universal/national background check completed prior to the start of working in the facility. NHA A stated yes, she would expect those things to be done to keep the residents safe.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure that a resident who is unable to carry out activities of daily living (ADLs) receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene for 1 of 3 sampled Residents (R40).R40's APOA (Activated Power of Attorney) reported that R40 was not being changed into their pajamas at night,Evidenced by:The facility's policy titled Activities of Daily Living with a revision date of 2/25/25 states in part 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 demonstrates that such diminution was unavoidable.R40 was admitted to the facility on [DATE] with diagnoses that include heart disease, chronic pain, type 2 diabetes mellitus, and other symptoms and signs involving cognitive functions and awareness (memory loss, confusion, concentration, language difficulties, and poor judgement). R40's most recent MDS (Minimum Data Set) dated 12/5/25 states that R40 has a BIMS (Brief Interview of Mental Status) of 6 out of 15, indicating that R40 has severe cognitive impairment. R40's MDS section GG states that R40 requires partial/moderate assistance for bathing, personal hygiene, and upper body dressing, and is dependent on staff for lower body dressing. R40 has an APOA. R40's care plan initiated on 9/6/24 states in part .FOCUS: The resident has an ADL (Activities of Daily Living) self- care performance deficit r/t (related to) weakness, and deconditioning. Resident frequently refuses assistance with ADLs.Interventions: Assist to change brief and get into pajamas every bedtime (date initiated 2/18/26). Bathing/Showering Assist-One.Dressing Assist- One. Personal Hygiene/Oral Care Assist- One. R40's CNA (Certified Nursing Assistant) task interventions history states:6/4/25 Assist res (resident) nightly w (with)/ pajamas. Resident to have poise pad in underwear.11/14/25 Assist res nightly w/ pajamas2/23/26 Assist res nightly w/ pajamas The task documentation screen states: Question 1: Dressing- Level of Staff Support Provided- CNAs primarily mark 1-person physical help. Question 2: *Activity Did Not Occur-CNAs primarily marked Not Applicable. On 2/22/26 at 12:18 PM, Surveyor interviewed APOA J. APOA J stated that R40 was wearing the same clothes that they had on the day before and that staff don't always change them into their pajamas at night. APOA J stated that they lay R40's pajamas on the bed for the night and that they were still there today. Surveyor asked APOA J if they have spoken to facility staff regarding this concern, APOA J stated that they have spoken to NM K (Nurse Manager). On 2/23/26 at 3:21 PM, Surveyor interviewed CNA L. Surveyor asked CNA L to explain the assistance that R40 requires for getting ready for bed, CNA L stated that R40 needs physical help and reminders, otherwise they will sleep in their clothes. CNA L reported that they know that it has been a problem with R40 not getting into their pajamas and that some staff don't help R40 get changed into their pajamas. On 2/23/26 at 3:27 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if they would expect R40 to be changed into their pajamas nightly, DON B stated yes. Surveyor reviewed R40's CNA task documentation with DON B. Surveyor asked DON B what their interpretation of the task was, DON B stated that R40 requires assistance. Surveyor asked DON B by looking at the documentation, does it appear that R40 has been assisted with getting into their pajamas nightly, DON B stated no. Surveyor asked DON B who is responsible for monitoring CNA documentation, DON B stated that nursing management should be monitoring the task documentation. Surveyor asked DON B if the task stating Activity did not occur would make sense in this instance and if staff should be reporting tasks that don't make sense, DON B stated yes, staff should be reporting a task that doesn't make sense. On 2/23/26 at 3:37 PM, Surveyor interviewed NM K. Surveyor asked NM K if they had any conversations with APOA J regarding R40 being changed into their pajamas at night, NM K stated that they have had several conversations and that they updated R40's care plan and talked to the staff and provided verbal education, but could not remember to who the education was provided to. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked NM K if they feel that the education was effective, NM K stated no, because the caregivers are not getting R40 into their pajamas. Surveyor asked NM K if they monitor or audit whether or not tasks are being completed, NM K stated no. Surveyor reviewed R40's task documentation with NM K. Surveyor asked NM K, based on the documentation, does it appear that R40 is never being changed into their pajamas, NM K stated that's what it looks like.

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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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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.

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

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 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** Based on interview and record review, the facility did not ensure that a resident's drug regimen was free from unnecessary medications for 1 of 5 residents reviewed for unnecessary medications (R1). R1 takes a medication used for anxiety PRN (as needed). The facility failed to recognize that all PRN psychotropic medications or medications used off-label as psychotropic medications should be limited to 14 days unless deemed appropriate by the provider. Evidenced by:The facility policy, Psychotropic Medication, dated 8/1/15 with a last revision date of 5/1/25, states, in part: . Procedure: . 11. PRN orders for psychotropic drugs are limited to 14 days. Except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. 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 orders state, in part.hydroxyzine HCL (hydrochloride) oral tablet 25 mg (milligrams). Give 1 tablet by mouth at bedtime for anxiety AND Give 0.5 tablet by mouth in the morning for anxiety AND Give 1 tablet by mouth as needed for anxiety once daily. Start date 1/15/26. End date: Indefinite.No evidence was provided to Surveyor that R1's PRN Hydroxyzine was renewed after 14 days. On 2/25/26 at 3:37 PM, Surveyor interviewed DON B (Director of Nursing) who indicated that if a resident has a PRN psychotropic medication or a medication used off-label as a psychotropic medication PRN, the resident should have a new order from the physician every 14 days. DON B stated she did not have a more recent order for R1's hydroxyzine.