STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525422	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindengrove Waukesha	425 N University Dr Waukesha, WI 53188

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not ensure each resident received adequate supervision and assistance devices to prevent accidents for 4 (R13, R2, R8, and R19) of 6 residents reviewed for falls. * R13 experienced 2 falls on 7/18/25 and was sent to the emergency room. R13 was diagnosed with blunt head trauma, forehead laceration requiring sutures, and traumatic intracranial hemorrhage (bleeding on the brain). When R13 returned to the facility, R13 fell an additional 8 times between 7/18/25 through 9/7/25. Two of these falls resulted in R13 hitting his head again and required steri-strips to close the wounds. The 10 falls that R13 experienced at the facility were not thoroughly investigated and did not determine a root cause for R13's falls. A resident-specific care plan intervention was not always put in place after a fall, and previous interventions were not always documented if they were in place at the time of the fall. R13's fall care plan interventions were observed to not be in place during the survey process. The facility's failure to provide adequate supervision to R13, failure to thoroughly investigate R13's falls to determine an accurate root cause, and failure to implement resident-centered care plan interventions to prevent future falls and ensure safety for R13 created a finding of immediate jeopardy that began on 7/18/25. Surveyor notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the finding of immediate jeopardy on 09/15/2025 at 1:49 PM. The immediate jeopardy was removed on 9/26/25. Deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as evidenced by the following examples: *R2 has a history of falls. R2 experienced falls with no injury on 1/31/25, 2/2/25, 2/3/25, and 2/4/25 that were not thoroughly investigated to determine an accurate root cause, and a resident-centered care plan was not always initiated after each fall. On 5/16/25, R2 experienced a fall while unsupervised in the dining room and suffered a closed head injury. The fall on 5/16/25 was not thoroughly investigated to determine an accurate root cause. R2 had 2 additional falls with no injury on 7/1/25 and 7/15/25 that were not thoroughly investigated to determine an accurate root cause. *On 6/26/25, at 7:15 AM, R8 sustained an unwitnessed fall and was found by facility staff lying on the floor in R8's room. The facility did not complete a thorough fall investigation, determine a thorough root cause, place interventions on R8's care plan after R8's fall, and care plan interventions were observed to not be in place during the survey process. *R19's fall interventions were not observed to be in place. R19 experienced a fall on 8/12/25 that (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was not thoroughly investigated. Findings include: The facility staff policy with a last review date of 5/8/25, titled Falls, documents, in part: Prevention measures are put in place to reduce the occurrence of falls and risk of injury from falls. A licensed nurse will determine the individuals' risk for falls and individualized care needs. If the individual is at risk for falls, then create a falls care plan. Procedure of fall event and implementation of intervention: Licensed nurse completes electronic documentation of the Fall Incident Report. The care plan will be updated with an identified intervention. Registered Nurse reviews and completes the fall assessment and interventions. The Interdisciplinary Team (IDT) will review Fall incident report and utilize root cause analysis to make further recommendations. Director of Nursing (or designee) and Executive Director to review and sign Fall Incident Report. The undated facility protocol titled, Standard Falls Protocol documents in part: Problem: Individual is at risk for falling. Goal: Risk of injuries related to falling will be minimized. Nursing. Teach safety measures as needed (i.e. proper hand placement when transferring, keep assistance device close to self with mobility) . Keep bed in lowest position. Encourage use of proper, well-maintained footwear. Respond to call lights and assist as able. Provide clutter free environment. Reorient to environment. Call light within reach. Keep personal and frequent items within reach. Report safety concerns to nursing. Offer diversional activities. Involve individual and/or responsible party in care plan process. 1.) R13 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease with late onset, Dementia with agitation, Depression, Muscle weakness, and Unsteadiness on feet. R13's admission Minimum Data Set (MDS) assessment dated [DATE] documents that R13 is severely cognitively impaired. The MDS documents: R13 displays verbal behaviors directed towards others 4-6 days a week; R13 is dependent for toileting and hygiene; R13 requires partial/moderate assist for transfers; R13 is always incontinent of urine and frequently incontinent of bowel; R13 has a history of falls; R13 has had falls since admission, one fall with no injury and one fall with major injury; R13 takes an antipsychotic medication and an antidepressant medication. R13's Fall Care Area Assessment (CAA) dated 7/22/25 documents: [R13] has a history of falls prior to admission and has had three falls since admission . [R13] is at risk for fall related injury. Resident is receiving physician ordered antidepressant increasing his fall risk. No referrals at this time, will proceed to care plan with goal to have no fall related injuries. R13's Behavior CAA dated 7/22/25 documents: [R13] triggered behavior CAA for having episodes of yelling out/screaming. [R13] is in a new environment which can lead to increased behaviors and confusion. [R13] has a diagnosis of dementia and Alzheimer's which can lead to increased behaviors. [Plan of Care] in place for [R13] to have an improvement in behaviors. R13's Psychotropic drug use CAA dated 7/22/25 documents: CAA triggered for psychotropic drug due to [R13] receiving physician ordered anti-depressant and anti-psychotic medication to manage diagnosis of depression and antipsychotic . Resident is at risk for adverse reactions to these medications including falls . MD is updated with medication refusals. Resident has had three falls since admission. No referrals at this time. Will proceed to care plan with goal to have no drug related side effects. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed R13's Comprehensive Care plan and noted R13 does not have an active care plan for R13's behaviors and does not have an active care plan for psychotropic drug use. R13's Fall care plan initiated on 7/15/25 documents in part: The resident is at risk for falls [related to] unsteady gait. Interventions include: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Ensure that the resident is wearing appropriate footwear when ambulating, transferring or mobilizing in [wheelchair]. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. R13's Activities of daily living care plan initiated on 7/15/25 documents the following intervention: Transfer: the resident is able to [complete by] assist of 1, gait belt and with or without [wheeled walker].R13's Fall risk evaluation dated 7/15/25 documents a score of 13, indicating R13 is at high risk for falls.R13's MD orders with a start date of 7/15/25 documents:-Duloxetine (an antidepressant medication) 20 milligrams (mg) 2 times a day.-Seroquel (an antipsychotic medication) 25 mg 3 times a day.-Mirtazapine (an antidepressant medication) 7.5 mg at bedtime.Surveyor reviewed all R13's MD orders and noted that R13 is not on a blood thinning medication. R13's progress note dated 7/18/25 at 6:16 PM documents: [R13] was in [R13's] wheelchair at the nurse's station and attempted to stand up without help. [R13] fell down onto [R13's] buttocks and did not hit [R13's] head. [R13] denies pain, range of motion within normal limits. Vital signs stable. Will continue to monitor. R13's facility fall investigation dated 7/18/25 documents in part: Fall occurred at 4:30 PM. Was this incident witnessed: Yes. [R13] was wearing gripper socks at the time of the fall. Immediate action taken: . Resident brought closer to the desk to try and watch [R13]. No injuries observed at time of incident. MD, [Power of Attorney], [Director of Nursing] updated. Root cause: IDT team met. Resident restless and wants to walk. [R13] attempted to stand up without assistance Resident fell on [R13's] bottom. Fall was witnessed by nurse. Intervention: Resident will have tray table in front of [R13] at nurses' station with activity to keep busy. Surveyor reviewed R13's fall care plan and noted the intervention for R13's 7/18/25, 4:30 PM fall was not present on R13's fall care plan. Surveyor noted the facility did not document an accurate root cause as to why R13 was trying to get up. Surveyor noted the facility did not document when R13 was last toileted or checked. Surveyor noted that, aside from the nurse who documented on the fall, staff statements were not collected by facility staff. On 9/11/25 at 7:02 AM, Surveyor interviewed Registered Nurse (RN)-M, who witnessed and documented R13's fall on 7/18/25. RN-M stated R13 had been at the facility 3 days and RN-M noticed that R13 had a cognitive deficit, was confused and impulsive. Because of these reasons, RN-M decided to keep R13 in the common area by the nurse's station. RN-M stated RN-M was at the nurse's station and saw R13 starting to stand up. RN-M stated RN-M got to R13 as fast as RN-M could but R13 fell on R13's buttocks. On 9/10/25 at 11:52 AM, Surveyor interviewed Director of Nursing (DON)-B regarding R13's fall on 7/18/25 at 4:30 PM. Surveyor asked what the real root cause was for this fall and if there was (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	documentation of when R13 was last toileted. DON-B stated R13 was previously toileted before R13 was brought to the nurse's station. DON-B stated R13 was not incontinent at the time of the fall. DON-B stated R13's Power of Attorney (POA)-Q made staff aware that R13 had a history of getting restless and trying to stand without assistance. Surveyor noted the facility did not provide documentation on the last time R13 was toileted. Surveyor noted DON-B did not provide clarification on the root cause of this fall. R13's Progress note dated 7/18/25 at 8:14 PM documents in part: [R13] was seated in [R13's] wheelchair in the dining room. [R13] fell out of [R13's] chair and fell onto the floor, striking the left side of [R13's] face. There was a small hematoma noted and some bleeding on [R13's] face and on the floor. Staff placed a blanket under [R13's] head and this writer called 911 immediately. EMS arrived and transported [R13] to the hospital for further evaluation of head trauma. Director of nursing updated. Writer also called and updated resident's [POA], [POA-Q] stated that [POA-Q] would be going to the hospital to check on R13. Provider updated . This writer received a phone call from the [Emergency Room] with an update that they are performing a head CT at this time. R13's facility fall investigation dated 7/18/25 documents in part: Fall occurred at 6:30 PM. Was this incident witnessed: No. Root cause: Was in the dining room without supervision after dinner and tried to ambulate without assistance. Intervention: Resident will be brought back to the nurse's station after dinner with [R13's] tray table and activity until bedtime for supervision. Surveyor reviewed R13's fall care plan and noted an intervention with an initiation date of 7/21/25: Resident will be brought back to the nurse's station after dinner with [R13's] tray table and activity until bedtime for supervision. Surveyor noted the fall intervention was placed in R13's care plan 3 days after the fall on 7/18/25. Surveyor noted the fall investigation documents the fall was unwitnessed. Surveyor noted the facility did not document an accurate root cause as to why R13 was up and trying to ambulate in the dining room. Surveyor noted facility staff did not document when R13 was last toileted or checked. Surveyor noted the fall investigation did not include what R13 was wearing on R13's feet. Surveyor noted that, aside from the nurse who documented on the fall, staff statements were not collected by facility staff. On 9/11/25 at 7:02 AM, Surveyor interviewed Registered Nurse (RN)-M, who assessed R13 after the fall and documented R13's fall. RN-M stated R13 was in the dining room after dinner. RN-M stated R13 had some sort of activity in front of R13 at the table. RN-M stated RN-M went to take care of another resident. RN-M stated RN-M heard a holler and went to the dining room right away to see what happened. RN-M stated RN-M thinks a Certified Nursing Assistant (CNA) was in the dining room at the time that R13 fell. RN-M stated as soon as RN-M got to the Dining room, RN-M assessed R13 and called 911. RN-M stated it was obvious that R13 needed intervention at a higher level of care. RN-M stated R13 still had the same gripper socks on that R13 was wearing during the previous fall. RN-M stated R13 returned from the hospital the same evening. RN-M continued neurological checks per facility policy and monitored R13 more closely. R13's Hospital emergency room Visit note dated 7/18/25 documents, in part: . Computed tomography scan (CT) head and cervical spine were obtained. There was no cervical fracture but there was evidence of post traumatic intracranial bleed. I discussed the CT findings with [POA-Q]. Hospitalization was considered. [R13] has had a brain bleed in the past. [POA-Q] understands this (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	documented on the fall, staff statements were not collected by facility staff. On 9/10 25 at 11:52 AM, Surveyor interviewed DON-B about R13's fall on 7/27/25. DON-B stated this fall was the same common theme for most of R13's falls. Surveyor asked if there is documentation of when R13 was last toileted or checked. DON-B stated R13 was incontinent at the time of this fall. DON-B stated staff were just about to do rounds to check on resident. Surveyor asked when R13 was last seen. DON-B stated the CNAs pass water and do their afternoon rounds at 2:30, so R13 would have been seen then. Surveyor asked for documentation. DON-B indicated there is not documentation confirming that. Surveyor asked what R13 was wearing on R13's feet. DON-B stated DON-B did not have that information. Surveyor shared concern that there is no actual root cause. DON-B stated, right. R13's hospice nurse's note dated 7/29/25 documents, in part: . [R13] has not tried to leave [R13's] unit but has had multiple falls when trying to get up alone. Last fall was 2 days ago.Staff has made changes to patient environment with bed low to the ground, padding/pillows on floor next to bed, moving [R13] to the nurse's station during wake times for more visibility. Surveyor reviewed R13's comprehensive care plan and noted that the interventions listed in the above hospice note are not documented in the facility's fall care plan for R13.R13's hospice nurse's note dated 7/31/25 documents in part: Broda chair ordered .A Broda chair is a specialized wheelchair designed to provide superior comfort, stability and therapeutic support for individuals with mobility challenges. On 9/15/25 at 11:15 AM, DON-B informed Surveyor that R13's Broda chair was delivered to the facility and implemented on 8/1/25. On 9/11/25 at 1:24 PM, Surveyor interviewed Hospice Case Manager (HCM)-O. Surveyor asked why a Broda chair was ordered and delivered for R13. HCM-O stated the original reason that a Broda chair was ordered is because the facility was worried that R13 would continue to fall in a regular wheelchair. HCM-O stated the facility staff wanted a Broda chair to get R13's feet off the ground to prevent R13 from standing up without assistance. On 9/15 at 8:37 AM, DON-B informed Surveyor that on 8/1/25, the facility IDT team met. DON-B stated DON-B had talked to nursing staff and noted that R13's most active time is between 4 and 630 PM. A new intervention was added to R13's care plan on 8/1/25 and documents: Resident is the most active between [4 and 630 PM] and needs regular supervision at nurse's station and [to follow] the nurse while on the med cart when CNA needs to complete cares in a room. R13's progress note dated 8/4/25 documents: Writer walked into [R13's] room and noticed [R13] on the floor, [R13] didn't know how [R13] got down there, [R13] was assessed and placed into Broda chair. Vitals signs [within normal limits], no [complaints of] pain [or] injuries. Denies hitting head, neuro checks in place, [Assistant Director of Nursing], [POA-Q] and [Nurse Practitioner] all notified of fall. On 9/10 25 at 11:52 AM, DON-B informed Surveyor that the above progress note was a late entry for a fall that R13 had on 8/2/25. DON-B provided the fall investigation to Surveyor. R13's facility fall investigation dated 8/2/25 documents in part: Fall occurred at 11 AM. Was this incident witnessed. No. No injuries observed at time of incident. Root cause: [R13] was in [R13's] (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	room in the morning and kept trying to get out of bed unassisted and was found on the floor. Intervention: Resident will be a morning wake up and after breakfast resident will be placed at the nurse's station with an activity. Surveyor reviewed R13's fall care plan and noted the following intervention initiated on 8/5/25: Resident will be a morning wake up and after breakfast resident will be placed at the nurse's station with an activity. Surveyor noted the fall intervention was placed in R13's care plan 3 days after the fall. Surveyor noted facility staff did not document if past interventions were in place at the time of the fall. Surveyor noted the facility did not document an accurate root cause as to why R13 was getting out of bed. Surveyor noted the facility did not document when R13 was last toileted or checked. Surveyor noted the fall investigation did not include what R13 was wearing on R13's feet. Surveyor noted there is no documentation as to if R13's call light was on or if R13's call light was within reach. Surveyor noted that, aside from the nurse who documented on the fall, staff statements were not collected by facility staff. Surveyor noted facility staff did not document that hospice was made aware of the fall on 8/2/25. On 9/11/25 at 1:24 PM, Surveyor interviewed HCM-O. HCM-O confirmed that hospice was not made aware that R13 fell on 8/2/25. On 9/10/25 at 11:22 AM, Surveyor attempted to reach the nurse who documented R13's fall on 8/2/25 by telephone. The nurse did not answer Surveyor's phone call. On 9/10 25 at 11:52 AM, Surveyor interviewed DON-B about R13's fall on 8/2/25. Surveyor asked what the phrase in the facility fall investigation, Kept trying to get out of bed meant. DON-B stated facility staff were trying to see if laying R13 down in between breakfast and lunch would help with R13's restlessness. DON-B stated it did not work. DON-B stated the intervention for this fall is effective and works well now. Surveyor asked when resident was last toileted or seen. DON-B stated 10 AM. Surveyor asked where that information is documented. DON-B stated it is standard for CNAs to do rounds at 10 AM. DON-B stated during that time, DON-B and other leadership do purposeful rounding with staff at that time and DON-B can see that CNAs are rounding. Surveyor asked why interventions are put in days later after a fall has happened. DON-B stated DON-B does not like to put interventions in right away. DON-B likes to make sure that the intervention makes sense and is effective before documenting it on the care plan. DON-B stated it is not effective to just put an intervention in the care plan right away. R13's MD orders with a start date of 8/7/25 documents: -Targeted Behavior: Hallucinations observed this shift. -Targeted Behavior: Yelling out observed this shift. Surveyor reviewed R13's Medication Administration Record and noted that R13 was receiving Seroquel as ordered since admission on [DATE] and Behavior Monitoring started 8/7/25. R13's progress note dated 8/9/25 at 8:30 PM documents: At about [8PM] writer was informed by one [of] the CNAs that [R13] was on the floor. Upon arrival, [R13] was laying on [R13's] buttock, alert, no bruise, bleeding noted, denied pain. Assessed pain, obtained vital signs and neuro check. Notified case manager [name of a hospice company], [provider], [POA-Q] [and] [NHA-A]. [R13] was assisted back to bed, bed on lower level, call light within reach and precaution mat placed on the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	floor. Continue check on R13. Surveyor noted that the wrong hospice company was notified of R13's fall on 8/9/25. On 9/11/25 at 1:24 PM, Surveyor interviewed HCM-O. HCM-O confirmed that R13's hospice was not made aware that R13 fell on 8/9/25. R13's facility fall investigation dated 8/9/25 documents, in part: Fall occurred at 8 PM. Was this incident witnessed. No . No injuries observed at time of incident. Root cause: Resident with Alzheimer's and also becomes restless. Fall prevention intervention: staff to round/check on resident every 2 hours, even [if] resident placed at nurse's station. Surveyor reviewed R13's fall care plan and noted the following intervention initiated on 8/11/25: Staff to round on resident every 2 hours, even if resident is stationed by the nurse's station. Surveyor noted the fall intervention was placed in R13's care plan 2 days after the fall. Surveyor noted facility staff did not document if past interventions were in place at the time of the fall. Surveyor noted the facility did not document an accurate root cause as to why R13 was found on the floor. Surveyor noted the facility did not document when R13 was last toileted or checked. Surveyor noted the fall investigation did not include what R13 was wearing on R13's feet. Surveyor noted there is no documentation as to if R13's call light was on at the time of R13's fall. Surveyor noted there is no documentation if R13 had an activity to keep R13's attention. Surveyor noted that, aside from the nurse who documented on the fall, staff statements were not collected by facility staff, even though a staff CNA found the resident and alerted the nurse to come to R13's room. On 9/10/2025 at 10:52 AM, Surveyor interviewed RN-P, who was the nurse who responded to R13's room after R13's fall on 8/9/25. RN-P stated that a CNA notified RN-P that R13 was on the floor. RN-P stated RN-P assessed R13, and completed the notifications to hospice, POA, and provider. Surveyor asked what RN-P thinks caused R13 to fall. RN-P stated RN-P was told by other staff members that R13 is a jumper. RN-P stated R13 was just restless and always wants to get up. RN-P stated R13 likes music and that has worked in the past to keep R13 calm. Surveyor asked when R13 was last seen or last toileted. RN-P stated that RN-P was not sure. RN-P stated that it could be that [R13] wanted to go to the bathroom, but RN-P was not 100% sure. RN-P stated R13 was not wearing shoes but thinks that R13 had socks on. Surveyor asked if the call light was on. RN-P stated that RN-P is not sure that R13 knows how to use it. RN-P stated that the call light was in reach though. On 9/10/25 at 11:52 AM, Surveyor interviewed DON-B about R13's fall on 8/9/25. DON-B stated DON-B believed that the interventions in place on R13's fall care plan were ef

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 6 (R3, R4, R1, R8, R19, and R47) of 6 residents reviewed for hospitalizations received the proper notice of transfer, reason for transfer, location of transfer, appeal rights, and name and address (including mail and email) with the telephone number of the Office of the State Long-Term Care Ombudsman, were notified of the reason for transfer/discharge & bed hold policy in writing to the resident & their representative and the rate to reserve the residents bed. *R3 was transferred to the hospital on 4/3/25 and 5/20/25. A transfer notice and bed hold rate was not provided in writing to R3 and/or R3's representative. *R4 was transferred to the hospital on 7/16/25 and 8/11/25. A transfer notice and bed hold rate was not provided in writing to R4 and/ or R4's representative. *R1 was transferred to the hospital on 3/15/25. A transfer notice and bed hold rate was not provided in writing to R1 and/ or R1's representative. *R8 was transferred to the hospital on 4/30/25 and 6/26/25. A transfer notice and bed hold rate was not provided in writing to R8 and/ or R8's representative. *R19 was transferred to the hospital on 5/9/25. A transfer notice and bed hold rate was not provided in writing to R19 and/ or R19's representative. *R47 was transferred to the hospital on 9/2/25. A transfer notice and bed hold rate was not provided in writing to R47 and/ or R47's representative. Findings include: The facility policy titled Individual Bed Hold dated 5/2/25 documents: Upon transfer to the hospital: individual will be informed and receive a copy of the bed hold procedure and letter. The facility policy titled Individual Transfer and discharge date d 5/2/25 documents: The individual and/or individual representative will receive a written notice including the resident's reason for transfer. The notice shall contain the name, address and telephone number of the board on aging and long-term care. On 09/10/2025 at 2:28 PM, Director of Nurses (DON)-B was interviewed and indicated there were no bed hold or transfer notices completed for R3, R4, R1, R8, R19 or R47's transfers to the hospital. 1.) R3 was admitted to the facility on [DATE]. On 9/9/25 R3's medical record was reviewed and indicated he has transferred to the hospital on 4/3/25 and 5/20/25. No bed hold or transfer notice could be located in R3's medical record. The above findings were shared with Nursing Home Administrator (NHA)-A and DON-B on 9/10/25 at 3:00PM. Additional information was requested as to why R3 did not receive bed hold and transfer (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notices for his 4/3/25 and 5/20/25 hospitalizations. None was provided. 2.) R4 was admitted to the facility on [DATE]. On 9/9/25 R4's medical record was reviewed and indicated he has transferred to the hospital on 7/16/25 and 8/11/25. No bed hold or transfer notice could be located in R4's medical record. The above findings were shared with Nursing Home Administrator (NHA)-A and DON-B on 9/10/25 at 3:00PM. Additional information was requested as to why R4 did not receive bed hold and transfer notices for his 7/16/25 and 8/11/25 hospitalizations. None was provided. 3.) R1 was admitted to the facility on [DATE], with diagnoses including bipolar disorder (a chronic mental health condition characterized by extreme mood swings between periods of mania (elevated mood) and depression), dementia (a decline in cognitive abilities such as memory, thinking, reasoning, and judgment), and paraplegia (a condition characterized by the loss of movement and sensation in both legs). R1's Electronic Medical Record (EMR) documents R1 was transferred to the hospital on 3/15/25 for a change in condition. There is no documentation that R1 was provided a written copy of transfer notice or bed hold rate for R1's hospitalization on 3/15/25. DON-B was notified of these findings and additional information was provided. None was provided. 4.) R8 was admitted to the facility on [DATE], with diagnoses that include right femur fracture (a break in the right thighbone), difficulty walking, and weakness. R8's EMR documents R8 was transferred to the hospital on 4/30/25 and 6/26/25 for a change in condition. There is no documentation that R8 was provided a written copy of transfer notice or bed hold rate for R8's hospitalization on 4/30/25 and 6/26/25. On 9/9/25, at 1:42 PM, Surveyor interviewed Social Worker (SW)-C about bed hold notice and transfer notice when a resident is transferred to the hospital. SW-C stated she is under the impression nursing staff completes the bed hold and transfer forms. On 9/9/25, at 2:36 PM, at the daily exit meeting with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, Surveyor requested bed hold notices and transfer notices for R1 dated 3/15/25 and R8 dated 4/30/24 and 6/26/25. NHA-A informed Surveyor they would review and let Surveyor know. On 9/10/25, at 9:00 AM, Consultant-H notified Surveyor the facility did not have bed hold notices and transfer notices for R1 and R8. Consultant-H indicated she was previously completing bed hold and transfer notices. Surveyor asked who at the facility is responsible for completing the bed hold and transfer notices. Consultant-H states she is unsure who completes the bed hold notices and transfer notices since she has not been onsite at the facility for two months. Consultant-H then stated she is not surprised the survey team has not received the requested bed hold and transfer notices. Surveyor notified Consultant-H of concerns with R1 not receiving the bed hold and transfer for 3/15/25 and R8 not receiving the bed hold and transfer notice for 4/30/25 and 6/26/25. On 9/10/25, at 3:16 PM, Surveyor notified Director of Nursing (DON)-B, Assistant Director of Nursing (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(ADON)-D, and Consultant-H of concerns that the facility did not provide R1 and R8 bed hold notices and transfers for R1 and R8. DON-B, ADON-D, and Consultant-H acknowledged these concerns. Surveyor requested additional information if available. None was provided. 5.) R19 was admitted to the facility on [DATE] . On 9/9/25 R19's medical record was reviewed and indicated he has transferred to the hospital on 5/9/25. No bed hold or transfer notice could be located in R19's medical record. The above findings were shared with Nursing Home Administrator (NHA)-A and DON-B on 9/10/25 at 3:00PM. Additional information was requested as to why R19 did not receive bed hold and transfer notice for the 5/9/25 hospitalization. None was provided. 6.) R47 admitted to the facility on [DATE] and has diagnoses that include Hepatic Encephalopathy, Metabolic Encephalopathy, infection and inflammatory reaction due to indwelling urethral catheter, severe protein-calorie malnutrition, alcohol dependence with alcohol-induced persisting dementia, retention of urine, second degree Atrioventricular Block (AV) and anemia. R47 was hospitalized on [DATE] for a change in condition. The hospital discharge summary documented diagnoses of acute cystitis without hematuria, second degree AV block, Mobitz type I, bradycardia, chronic cognitive impairment presumably due to heavy ETOH (alcohol). There is no evidence R47 was provided a written copy of transfer notice or bed hold rate for this hospitalization. On 9/9/25 at 1:35 PM, Surveyor asked Nursing Home Administrator (NHA)-A who is responsible for hospital transfer/discharge and bed hold notices. NHA-A reported the Social Worker (SW) is responsible. Surveyor asked for the above information regarding R47's hospitalization on 9/2/25. On 9/9/25 at 1:43 PM, SW-C advised Surveyor she does not have any of the requested information. SW-C reported she was under the impression the nurses did it, but there is confusion as to who was supposed to do it, and NHA-A is looking into it. No additional information was provided.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on interview and record review, the facility did not ensure that all facility staff received required effective communication program training for 1 of 5 sampled Certified Nursing Assistants (CNAs).This deficient practice has the potential to affect residents who reside at the facility on the wing where CNA-W is working and have the potential to receive care from CNA-W. Findings Include:On 09/25/24, at 11:00 AM, Surveyor reviewed CNA-W's completed trainings for the past year and noted there was no documentation that CNA-W received training on the facility's effective communication program which outlined and informed staff of the elements and goals of the facility's effective communication program. On 9/25/24, at 12:01 PM, Surveyor requested missing documentation from NHA (Nursing Home Administrator)-A for CNA-W's training of the facility's effective communication program which outlined and informed staff of the elements and goals of the facility's effective communication program. Surveyor was informed by NHA-A to call Learning Facilitator (LF)-X. NHA-A informed Surveyor that LF-X tracks and records the education for all the facility's staff.On 9/25/24, at 12:24 PM, Surveyor conducted a phone interviewed with LF-X about CNA-W's training of the facility's QAPI program. LF-X informed Surveyor that CNA-W had not yet completed the required training of the facility's effective communication program.On 09/25/25, at 12:45 PM, Nursing Home Administrator (NHA)-A confirmed the facility has not provided CNA-W with the mandatory QAPI training. NHA-A informed Surveyor the facility was working on providing effective communication training to CNA-W.No additional information was provided as to why the facility did not ensure that CNA-W received the required effective communication program training.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interview and record review, the facility did not ensure that all facility staff received required Quality Assessment and Performance Improvement (QAPI) program training for 1 of 5 sampled Certified Nursing Assistants (CNAs).This deficient practice has the potential to affect residents who reside at the facility on the wing where CNA-W is working and have the potential to receive care from CNA-W. Findings Include:On 09/25/24, at 11:00 AM, Surveyor reviewed CNA-W's completed trainings for the past year and noted there was no documentation that CNA-W received training on the facility's QAPI program which outlined and informed staff of the elements and goals of the facility's QAPI program. On 9/25/24, at 12:01 PM, Surveyor requested missing documentation from NHA (Nursing Home Administrator)-A for CNA-W's training of the facility's QAPI program which outlined and informed staff of the elements and goals of the facility's QAPI program. Surveyor was informed by NHA-A to call Learning Facilitator (LF)-X. NHA-A informed Surveyor that LF-X tracks and records the education for all the facility's staff.On 9/25/24, at 12:24 PM, Surveyor conducted a phone interviewed with LF-X about CNA-W's training of the facility's QAPI program. LF-X informed Surveyor that CNA-W had not yet completed the required training of the facility's QAPI program.On 09/25/25, at 12:45 PM, Nursing Home Administrator (NHA)-A confirmed the facility has not provided CNA-W with the mandatory QAPI training. NHA-A informed Surveyor the facility was working on providing QAPI training to CNA-W.No additional information was provided as to why the facility did not ensure that CNA-W received the required Quality Assessment and Performance Improvement program training.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. Based on interview and record review, the facility did not ensure that all facility staff received required compliance and ethics program training for 1 of 5 sampled Certified Nursing Assistants (CNAs).This deficient practice has the potential to affect residents who reside at the facility on the wing where CNA-W is working and have the potential to receive care from CNA-W. Findings Include:On 09/25/24, at 11:00 AM, Surveyor reviewed CNA-W's completed trainings for the past year and noted there was no documentation that CNA-W received training of the facility's compliance and ethics program.On 9/25/24, at 12:01 PM, Surveyor requested missing documentation from NHA (Nursing Home Administrator)-A for CNA-W's training of the facility's compliance and ethics program. Surveyor was informed by NHA-A to call Learning Facilitator (LF)-X. NHA-A informed Surveyor that LF-X tracks and records the education for all the facility's staff.On 9/25/24, at 12:24 PM, Surveyor conducted a phone interviewed with LF-X about CNA-W's training of the facility's compliance and ethics program. LF-X informed Surveyor that CNA-W had not yet completed the required training of the facility's compliance and ethics program.On 09/25/25, at 12:45 PM, Nursing Home Administrator (NHA)-A confirmed the facility has not provided CNA-W with the mandatory compliance and ethics program training. NHA-A informed Surveyor the facility was working on providing compliance and ethics program training to CNA-W. No additional information was provided as to why the facility did not ensure that CNA-W received the required compliance and ethics program training.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and family interviews, the facility did not inform the resident or the resident's guardian of a psychoactive medication that required informed consent for administration for 1(R43) of 5 sampled residents reviewed for unnecessary medications.R43 received the antipsychotic medication Seroquel and the antidepressant medication Zoloft without receiving consent from R43's guardian.Findings include:R43 was admitted to the facility on [DATE] with diagnosis that included Dementia and Major Depressive Disorder.R43 has an activated Power of Attorney/Guardian.R43's quarterly MDS, dated [DATE], documents that R43 received antipsychotic and antidepressant medications daily during the assessment reference period.A review of the current physician orders for R43 document the following:Quetiapine Fumarate (Seroquel) 25 MG (milligram), give 0.5 tablet by mouth at bedtime. This order was active starting 6/5/25.Sertraline 50 MG, give by mouth in the morning related to Major Depressive Disorder. The order was active starting 5/30/25.A review of R43's medical record showed that signed consent was given by the Guardian on 7/16/25 for the Quetiapine 50-100 mg (anticipated dosage range) and Sertraline 50- 100 mg (anticipated dosage range) and after R43 was already administered the medications. On 9/11/25 at 11:33 AM, Surveyor interviewed DON (Director of Nursing)- B regarding the need for consent prior to the administration of psychoactive medication. DON- B stated that yes, consent is needed from either the resident or their Guardian before the resident is administered the medication. DON- B stated she does not know why the facility did not obtain consent on 5/30/25 for the Sertraline or on 6/5/25 for the Quetiapine for R43 prior to both medications being administered to R43. No additional information was provided as to why the facility did not obtain consent from R43's guardian prior to administering the above psychoactive medications.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that 2 (R8 and R30) of 2 residents with allegations of abuse was reported to the State Survey Agency within the required reporting timeframe. *On 7/3/25, R8's Activated Power of Attorney (APOA) notified Director of Nursing (DON)-B that R8's wallet was missing. The facility started an investigated on 7/3/25 and submitted an initial report to the State Agency on 7/3/25, at 3:57 PM. The facility did not submit a 5-day report to the State Agency as required. *R30 informed Surveyor that a facility staff member, Certified Nursing Assistant (CNA)-F, yelled at R30 and made R30 scared. R30 had informed Certified Nursing Assistant (CNA)-E of the interaction between R30 and CNA-F. R30 stated that CNA-E informed R30 that CNA-E would file a complaint. CNA-E did not file a complaint and did not inform Assistant Director of Nursing (ADON)-D, Director of Nursing (DON)-B or Nursing Home Administrator (NHA)-A of R30's concern. On 9/8/25, Surveyor informed NHA-A that R30 reported to Surveyor that a facility staff member yelled at R30 and made R30 scared. NHA-A did not report this to the State Agency as an allegation of potential abuse. Findings include: The facility's policy titled “Comprehensive Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Program”, dated 8/28/17, last reviewed 11/8/23, documents: Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by a resident, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse, including abuse facilitated or enabled through the use of technology. Abuse Policy Requirements: Immediately upon receiving a report on alleged abuse, the Executive Director, and or designee will coordinate delivery of appropriate medical and/or psychological care and attention. Ensuring safety and well-being for the vulnerable residents are of utmost priority. Safety, security and support of the resident, their roommate, if applicable and other residents with and potential to be affected will be provided. Reporting and Response: It is the policy of this facility that abuse allegations are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	caused the allegation do not involve abuse and do not result in serious bodily injury, to the Executive Director of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against the resident in the facility. External Reporting: Each covered resident shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located, any reasonable suspicion of a crime against any resident who is a resident of or is receiving care from, the facility, and each covered resident shall report immediately, but not more than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. Initial reporting of allegations: If an incident or allegation is considered reportable the Executive Director or designee will make an initial (Immediate or within 24 hours) report to the State Agency. A follow up investigation will be submitted to the State Agency within five (5) working days. When making a report, Misconduct Incident Reporting (MIR) system will be used. Report the results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State law, including immediate or 24 hour reporting to the State Survey Agency, law enforcement and the follow up report to the State Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Law Enforcement: All reports of suspected crime and/or alleged sexual abuse must be immediately reported to local law enforcement to be investigated. Facility staff will fully cooperate with the local law enforcement designee. 1.) R8 is a [AGE] year-old resident who was admitted to the facility on [DATE] with diagnoses that include dementia, anxiety, osteoporosis, macular degeneration, glaucoma, history of falls, weakness, difficulty walking, and Peripheral Vascular Disease (PVD). R8's Significant Change Minimum Data Set (MDS) completed 7/8/25 documents that R8 has a history of one fall with a fracture in the last month. R8 requires substantial/maximal assistance with showering, chair to bed transfers, and rolling left to right. R8 is dependent for toileting hygiene, and shower transfers. R8 was documented as having a Brief Interview for Mental Status (BIMS) score of 3, indicating that R8 is severe cognitively impaired. On 9/9/25, Surveyor reviewed the facility self-report for allegations of misappropriation for R8, which documents the following: Initial report submitted to the State Agency on 7/3/25, at 3:57 PM. On 7/3/25, R8's APOA reported to DON-B, R8's wallet was missing out of R8's purse. Social Worker (SW)-C immediately performed the facility investigation on 7/3/25. (continued on next page)

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	525422	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindengrove Waukesha	425 N University Dr Waukesha, WI 53188

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SW-C interviewed R8 who agreed to have SW-C search R8's room and laundry. SW-C was unable to locate R8's wallet after searching R8's room and laundry. Facility staff contacted local law enforcement on 7/3/25. Self-report Summary was signed and dated 7/8/25, by Nursing Home Administrator (NHA)-A. SW-C performed interviews and statements with R8, R8's APOA, 22 residents, and 5 staff members. Surveyor noted there is was 5-day report submitted to the State Agency as required. On 9/10/25, at 1:19 PM, Surveyor interviewed SW-C who indicated that she was notified on 7/3/25, by DON-B of allegations of misappropriation with R8's missing wallet. SW-C stated she started an investigation immediately on 7/3/25. SW-C states she contacted local law enforcement, and a case number was provided. SW-C states NHA-A submits self-reports to the State Agency. On 9/11/25, at 8:41 AM, Surveyor interviewed NHA-A who indicated he is responsible for submitting facility self-reports to the State Agency. NHA-A states he was notified of allegations of misappropriation with R8's wallet missing on 7/3/25. NHA-A states SW-C started an investigation immediately on 7/3/25. NHA-A states he submitted the initial self-report of the allegations of misappropriation of R8's wallet going missing on 7/3/25. Surveyor asked NHA-A for documentation of the 5-day self-report being submitted to the State Agency. NHA-A stated he did not submit the 5-day self-report as required. Surveyor asked why the 5-day self-report wasn't submitted to the State Agency. NHA-A replied he was submitting facility self-reports by email to the State Agency for a while but had recently switched email accounts and is now unable to locate an email confirming the 5-day report was submitted to the State Agency for the allegations of misappropriation of R8's missing wallet. NHA-A then stated his emails delete after 30 days. Surveyor notified NHA-A of concerns with the 5-day self-report not being submitted to the State Agency as required and requested additional information if available. NHA-A acknowledged these concerns. No additional information was provided. 2.) R30 was admitted to the facility on [DATE]. R30's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents R30 is cognitively intact. On 9/8/25 at 10:44 AM, R30 informed Surveyor that about 4 to 6 weeks ago, R30 put R30's call light on. R30 stated that R30 has an electric wheelchair and wanted to know if it was plugged in or not so that R30 could use it later in the day. R30 stated that a CNA-F came in to answer the call light and started yelling at R30. R30 indicated that the CNA-F screamed that CNA-F did not have time for questions like that. R30 stated that CNA-F scared R30. R30 stated that R30 and R30's family member informed CNA-E that same day of the interaction. R30 stated that CNA-E told R30 that CNA-E would file a complaint. R30 stated that CNA-F returned to R30's room and confronted R30 and CNA-F asked R30 if R30 had put a complaint in about CNA-F. R30 stated that R30 was scared but told CNA-F that R30 did complain about CNA-F and how CNA-F screamed at R30. R30 stated that no one else from the facility talked to R30 about the interaction. R30 stated that after CNA-F screamed and scared R30, R30 never saw CNA-F again. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the facility reported incident files for the last 3 months and a report about this interaction between R30 and CNA-F and none was located. Surveyor reviewed the facility grievance log for the last 3 months and no grievance for this interaction between R30 and CNA-F and none was located. On 9/8/25 at 2:43 PM, Surveyor interviewed CNA-E. Surveyor asked if CNA-E recalled a time that R30 reported to CNA-E an incident of R30 being yelled at and scared of a facility employee. CNA-E stated that over a month ago, R30 and R30's family member informed CNA-E that a different staff member yelled at R30 and that R30 and did not like the way R30 was talked to. CNA-E stated that at the time R30 could not remember the name of the CNA who yelled at R30. Surveyor asked if CNA-E reported the incident to anyone. CNA-E stated No. CNA-E stated that CNA-E told R30 to tell the nurse and told R30 that CNA-E could not do anything if R30 did not know the name of who it was that yelled at R30. Surveyor asked what CNA-E should do if a resident reports a different staff member yelling and making them scared. CNA-E stated that if there was a situation of abuse, CNA-E would take that seriously. CNA-E would first go to the coworker to see what happened and then go the nurse. CNA-E indicated that sometimes staff can be cranky in the morning and can short with other staff and residents. CNA-E stated that R30's interaction was not an abuse situation and CNA-E would have done something if CNA-E believed that it was abusive. On 9/8/25 at 2:56 PM, Surveyor informed Nursing Home Administrator (NHA)-A that R30 reported to Surveyor that about 4 to 6 weeks ago, a CNA yelled at R30 and made R30 scared. R30 reported this to CNA-E who told R30 that CNA-E would file a complaint. CNA-E did not file a complaint or grievance. R30 told Surveyor that the CNA who yelled at R30 returned to R30's room and confronted R30. R30 stated again that during that interaction R30 was scared. Surveyor asked NHA-A what NHA-A would expect staff to do if they were told by a resident that they were yelled or scared of a different facility staff. NHA-A stated that they should let the nurse, supervisor and NHA-A know and NHA-A would take it from there. NHA-A stated that the facility will go speak to R30 and follow up with CNA-E about the incident. On 9/9/25 at 11:01 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-D. Surveyor asked if ADON-D had been informed weeks ago that R30 reported that a staff member yelled at R30. ADON-D stated that ADON-D had not heard anything about that. Surveyor asked what a staff member should do if a resident reports to a staff that a different staff member yelled at them. ADON-D stated that staff should come to one of us (management). From there, they would submit a grievance and discuss the incident with management team to see if anything further should be done. On 9/9/25 at 1:18 PM, Surveyor interviewed Social Worker (SW)-C. SW-C stated that SW-C spoke to R30 yesterday. SW-C stated that the CNA who yelled at R30 is no longer working for the facility. SW-C stated that SW-C did fill out a grievance for R30 regarding the incident from weeks ago. SW-C stated that NHA-A spoke to CNA-E about the incident. SW-C provided R30's grievance to Surveyor. R30's grievance dated 9/8/25 documents, in part: … Resident expressed concern to Surveyor regarding a verbal interaction she had with a CNA 4-6 weeks ago… Facility spoke with resident and CNA resident reported concerns to at time of incident… CNA Resident had interaction with no longer works at the facility speaking with resident. [R30] has had no further concerns regarding verbal interactions with staff. CNA that received concern educated on grievance process… On 9/9/25 at 1:22 PM, Surveyor spoke to NHA-A. NHA-A stated that facility staff spoke to R30 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	yesterday. NHA-A stated that everything is good, and this was one isolated incident. NHA-A stated that CNA-E knew who R30 was talking about (CNA-F). NHA-A stated that CNA-F no longer works for the facility. NHA-A stated that the situation should have been brought to the nurse's attention, and a staff should have followed the grievance process. NHA-A indicated that a grievance had now been filed. Surveyor reviewed CNA-F's employee file and noted CNA-F's last day of employment at the facility was 8/5/25. On 9/9/25 at 2:37 PM, Surveyor shared concern with NHA-A that Surveyor was told by R30 that a facility staff member screamed at R30 and scared R30. Surveyor shared this with NHA-A on 9/8/25 at 2:56 PM and this was not reported to the State Agency as an allegation of abuse. NHA-A stated that R30 did not report this to facility staff when they went to go speak to R30 yesterday. Surveyor informed NHA-A that R30 made the allegation of abuse to Surveyor and after Surveyor informed NHA-A, the allegation should have been reported to the State Agency. No additional information was provided.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview the facility did not develop and implement a comprehensive person-centered care plan to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment for 2 (R2 and R13) of 15 residents reviewed R2 and R13 did not have comprehensive behavior care plans based on their comprehensive assessments for behavior management including targeted behaviors and non-pharmalogical approaches for behavior management. Findings include: 1.) R2 was admitted to the facility on [DATE] with diagnoses that included Anxiety and Dementia with Behavioral Disturbance. R2's quarterly Minimum Data Set (MDS) dated [DATE] documented R2 exhibited rejection of care 1-3 days over the last week of the reference period. On 9/10/25, R2's current physicians orders were reviewed and documented: Seroquel 25 milligrams (mg) twice a day with a start date of 2/6/25 for dementia with behavioral disturbance. Seroquel is an anti-psychotic medication. On 9/10/25 R2's care plan was reviewed and included monitoring for side effects of psychotropic medication but does not include any non-pharmalogical approaches for R2's behaviors of pacing and, violence and aggression toward staff and others. In addition, R2's care plan does not address the rejection of care documented on her 7/21/25 Quarterly MDS. On 9/10/25 at 1:30 PM Director of Nurses (DON)-B was interviewed and indicated R2's care plan should include non-pharmalogical interventions and all the behaviors she is exhibiting should be addressed. On 9/10/25, the above findings were shared with Nursing Home Administrator (NHA)-A and Director of Nurses-B. Additional information was requested if available as to why R2 did not have her pharmacy recommendations addressed. None was provided. 2.) R13 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease with late onset, Dementia with agitation, and Depression. R13's admission Minimum Data Set (MDS) assessment dated [DATE] documents R13 is severely cognitively impaired. R13 displays verbal behaviors directed towards others 4-6 days a week. R13 takes an antipsychotic medication. R13's Behavior Care Area Assessment (CAA) dated 7/22/25 documents, in part: . [R13] triggered behavior CAA for having episodes of yelling out/screaming. [R13] is in a new environment which can lead to increased behaviors and confusion. [R13] has a diagnosis of dementia and Alzheimer's which can lead to increased behaviors. [Plan of Care] in place for [R13] to have an improvement in behaviors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's Psychotropic drug use CAA dated 7/22/25 documents: CAA triggered for psychotropic drug due to [R13] receiving physician ordered anti-depressant and anti-psychotic medication to manage diagnosis of depression and antipsychotic . Resident is at risk for adverse reactions to these medications including falls . MD is updated with medication refusals. Resident has had three falls since admission. No referrals at this time. Will proceed to care plan with goal to have no drug related side effects. R13's MD order with a start date of 7/15/25 documents: Seroquel (an antipsychotic medication) 25 mg 3 times a day. Surveyor reviewed R13's Comprehensive Care plan and noted R13 does not have an active care plan for R13's behaviors and does not have an active care plan for psychotropic drug use despite R13's CAAs documenting that R13 has plan of care. On 9/15/25 at 7:36 AM, Surveyor interviewed Registered Nurse (RN)-U Surveyor asked if a resident who is on an antipsychotic medication should have a care plan. RN-U stated yes. They would have an antipsychotic care plan. The care plan would include things that help specific resident's behaviors, and it would have side effect monitoring. On 9/15/25 at 8:37 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked if a resident on an antipsychotic medication should have a care plan. Surveyor informed DON-B that R13 has been on Seroquel from the start of R13's admission and does not have a psychotropic and/or behavior care plan. DON-B stated that the MDS nurse is typically the one who puts the care plan in. DON-B stated that DON-B would look into that. On 9/15/25 at 2:56 PM, Surveyor informed Nursing Home Administrator (NHA)-A and DON-B of the concern that R13 was taking an antipsychotic medication since admission and R13 does not have a psychotropic drug use care plan in place to address non-pharmalogical interventions and any behaviors that R13 is exhibiting. No additional information was provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not complete neurological checks in accordance with facility protocol and standards of practice for 2 (R2 and R13) of 4 residents reviewed for unwitnessed falls.*R2 sustained unwitnessed falls on 1/31/25, 2/2/25, 2/3/25, 5/16/25 and 7/1/25. Facility staff did not document neurological checks as completed per the facility protocol and standards of practice.*R13 sustained unwitnessed falls on 9/2/25 and 9/7/25. Facility staff did not document that neurological checks were completed per the facility protocol and standards of practice.Findings include:On 9/15/25 at 8:59 AM, Consultant-G informed Surveyor that the facility does not have a neurological check policy.The American Association of Post-Acute Care Nursing document dated August of 2021 and titled, Post Fall Assessments documents, in part: . An assessment of neurological status, often called a neuro check, should be done when a resident hits his or her head or if it is unknown if they hit their head (unwitnessed fall). A subdural hematoma may not show symptoms until several days after the fall.The undated facility document titled, Neurological Flow Sheet documents, in part: Vital signs and Neuro Checks: At the time of event. [Every] 30 [minutes] x 2. [Every] 1-hour x 4. [Every] shift x 3. Progress along this time schedule only if signs are stable.1.) R2 was admitted to the facility on [DATE] with diagnoses that include Dementia with other behavioral disturbance, Generalized anxiety disorder, and Depression.R2's Significant change Minimum Data Set (MDS) assessment dated [DATE] documents, R2 is severely cognitively impaired. R2 uses a wheelchair for mobility. R2 is dependent for toileting. R2 is dependent for bed mobility and transfers. R2 had recent surgery requiring care.R2's Fall Risk Evaluation dated 1/17/25 documents a score of 13, indicating R2 is at high risk for falls.R2's progress note dated 1/31/2025 at 3:37 AM, documents, in part: [Certified Nursing Assistant (CNA)] notified writer that [R2] was on the floor. writer entered the room, and [R2] was laying alongside [R2's] bed on [R2's] stomach. vitals were taken and were [within normal limits]. Assessment was complete, [R2] complained of all over pain, no new bruises noted. [POA] notified. [R2] was sent out via stretcher with. ambulance.Surveyor reviewed the facility fall investigation for R2's fall on 1/31/25. Surveyor noted R2's fall was unwitnessed. Surveyor reviewed R2's paper documentation and electronic medical record for documentation of completed neurological (neuro) checks after R2's fall. Surveyor did not locate completed neuro checks.On 9/11/25 at 9:12 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-R, who was the nurse who first assessed R2 and documented the fall on 1/31/25. Surveyor asked if neurological checks were completed. LPN-R stated not sure. R2's progress note dated 2/2/2025 at 11:11 AM, documents in part: Writer/nurse was notified that [R2] had a unwitnessed fall at [755 AM], nurse/writer went into resident room right away and observed [R2] lying face down on [R2] bedroom floor with [R2] head under [R2] bed with the right leg bent. Writer/nurse called 911 at [8:01 AM] to send [R2] to [Hospital] for further observation. While [R2] was being treated at hospital, nurse/writer spoke with the doctor caring for [R2] and they notified nurse that [R2] sustained no injuries and . will be returning back to facility today with no new orders.Surveyor reviewed the facility fall investigation for R2's fall on 2/2/25. Surveyor noted R2's fall was unwitnessed. Surveyor reviewed R2's paper documentation and electronic medical record for documentation of completed neuro checks after R2's fall. Surveyor did not locate completed neuro checks.On 9/11/25 at 9:28 AM, Surveyor attempted to reach the nurse who cared for and documented R2's fall on 2/2/25 over the telephone. The nurse did not answer Surveyors attempts for interview.R2's progress note dated 2/3/25 at 11:26 AM documents, in part: [R2] was found down with [R2's] legs on the floor, chest and head against the bed . EMS (emergency medical services) called. [R2] to hospital at [7:25 AM] for evaluation. POA. Manager notified. [Nurse Practitioner] notified. [R2] returned at [11:15 AM] via EMS. Vitals assessed upon return. [R2] resting comfortably in bed.Surveyor reviewed the facility fall investigation for R2's fall on 2/3/25. Surveyor noted R2's fall was unwitnessed. Surveyor reviewed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's paper documentation and electronic medical record for documentation of completed neuro checks after R2's fall. Surveyor did not locate completed neuro checksSurveyor attempted to reach the nurse who assessed and documented R2's fall but was unable to interview the nurse.R2's progress note dated 5/16/25 at 9:06 PM documents, in part: [R2] found on floor of dining room. [R2] alert and talking to staff. Able to tell staff that [R2] was reaching for something and got caught. Mentation is at baseline. [R2] does report hitting [R2's] head when [R2] fell. [R2] complaining of pain in [R2's] head. [R2] does have a lump developing in the back of [R2's] head. Called an ambulance and sent [R2] to [hospital] for further evaluation. Notified family and all other pertinent parties per protocol.Surveyor attempted to reach the nurse who assessed and documented R2's fall on 5/16/25 but was unable to interview the nurse.R2's Hospital After Visit Summary dated 5/16/25 documents, in part: . Reason for visit-Ground level fall. Diagnoses-Fall from wheelchair. Closed head injury. [R2] presents to the emergency department for evaluation after fall from wheelchair. [R2] does have a small posterior scalp. [R2] remained stable and will plan for discharge back to facility.Surveyor reviewed the facility fall investigation for R2's fall on 5/16/25. Surveyor noted R2's fall was unwitnessed and R2 was diagnosed with a closed head injury. Surveyor reviewed R2's paper documentation and electronic medical record for documentation of completed neuro checks after R2's fall. Surveyor did not locate completed neuro checks.Surveyor was provided a fall investigation for a fall that R2 had on 7/1/25. Surveyor reviewed R2's progress notes and noted facility staff caring for R2 on 7/1/25 did not document a progress note about the fall.R2's facility fall investigation dated 7/1/25 documents, in part: Time occurred 3:10 PM. Alerted by staff, found resident sitting on floor in bathroom (nearest nursing station). Resident sitting on floor in front of toilet and holding self-upright. [R2] alerted staff by calling out for help. Denies head bump and/or injury. Resident description: Unable to articulate events.Surveyor noted R2's fall was unwitnessed. Surveyor reviewed R2's paper documentation and electronic medical record for documentation of completed neuro checks after R2's fall. Surveyor did not locate completed neuro checksOn 9/10/25 at 10:25 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-J. Surveyor asked when neuro checks should be completed. LPN-J stated that they are completed after every fall where a resident hits their head or if the fall is unwitnessed. LPN-J stated that LPN-J typically completes them after every fall.On 9/11/25 at 7:02 AM, Surveyor interviewed Registered Nurse (RN)-M. Surveyor asked when neuro checks are completed. RN-M stated that RN-M follows the policy and does them for an unwitnessed fall and a fall that the resident hit their head.On 9/9/25 at 2:37 PM, Director of Nursing (DON)-B informed Surveyor that neuro checks are completed after an unwitnessed fall and after a fall with head injury. DON-B stated that the neuro checks are completed on a paper form. Once all neuro checks are completed, they are scanned into the electronic medical record.On 9/11/25 at 9:28 AM, Surveyor interviewed DON-B. Surveyor reviewed R2's falls. Surveyor asked if neuro check should have been done for R2 after the falls on 1/31, 2/2, 2/3, 5/16 and 7/1/25. DON-B indicated yes. Surveyor shared the concern that the facility did not provide documentation of completed neuro checks for the 5 falls. DON-B indicated that DON-B understood.On 9/11/25 at 9:58 AM, Surveyor informed Nursing Home Administrator (NHA)-A of the concern that R2 sustained multiple unwitnessed falls and neuro checks were not completed per facility protocol. NHA-A stated ok.2.) R13 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease with late onset, Dementia with agitation, Depression, Muscle weakness, and Unsteadiness on feet.R13's admission Minimum Data Set (MDS) assessment dated [DATE] documents: R13 is severely cognitively impaired. R13 has a history of falls. R13 has had falls since admission, one fall with no injury and one fall with major injury.R13's Fall Care Area Assessment (CAA) dated 7/22/25 documents, in part: . [R13] has a history of falls prior to admission and has had three falls since admission. [R13] is at risk for fall related injury.R13's Fall risk evaluation dated 7/15/25 documents a score of 13, indicating R13 is at high risk for falls.R13's progress note dated 9/2/25 at 12:32 PM documents: [R13] found on the floor sitting in front of a chair with [R13's] feet in front of [R13] directly next to [R13's] Broda chair. Vitals stable. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No new injuries. Safely transferred [R13] into Broda chair. Neuro checks negative. Denies any pain. Alert and baseline behavior noted. Presently up eating lunch with [POA-Q].Surveyor noted R13's progress note documents neuro checks negative. Surveyor asked DON-B for R13's fall investigation and neuro check documentation for R13's fall on 9/2/25. Surveyor was provided documentation of a fall investigation for this fall.Surveyor reviewed the facility fall investigation for R13's fall on 9/2/25. Surveyor noted R13's fall was unwitnessed. Surveyor reviewed R13's paper documentation and electronic medical record for documentation of completed neuro checks after R13's fall. Surveyor did not locate completed neuro checks.On 9/10/25 at 11:24 AM, Surveyor attempted to reach by telephone, the nurse who documented R13's fall on 9/2/25. The nurse did not answer Surveyor's phone call.R13's progress note dated 9/7/25 at 3:42 PM documents: [R13] had a fall, writer was called after taking a break for a couple minutes that [R13] was on the floor screaming. Writer came and seen that [R13] was on the floor with blood coming from [R13's] head. Writer then called hospice and made them aware of the situation and writer was told to send [R13] out. R13's Hospital Emergency Department Provider Note dated 9/7/25 documents, in part: . [R13] presents to the emergency department with a head injury. The patient had an unwitnessed fall resulting in a bleeding hematoma on the left forehead. There are multiple abrasions oozing with the hematoma, but there is no lacerations that need suture repair. The wound was cleaned, and I used 2 Steri-strips to tack avulsions skin back in place. [POA-Q] . [stated] that [POA-Q] would not like any imaging performed. [POA-Q] declined any imaging for the patient. Surveyor noted R13's fall was unwitnessed and in R13's emergency department documentation, R13 had a head injury. Surveyor asked DON-B for the fall investigation and neuro checks for R13's fall on 9/7/25. Surveyor was not given a fall investigation or neuro check documentation regarding R13's fall on 9/7/25.On 9/10/25 at 11:09 AM, Surveyor interviewed Nurse extern (NE)-K, who was the nurse who assessed and documented R13's fall on 9/7/25. NE-K indicated that R13's head was bleeding quite a bit so after alerting all the necessary people, R13 was sent to the hospital. NE-K stated that R13 returned to the facility the same day around 7 PM. Surveyor asked when neuro checks should be completed. NE-K stated they should be completed with unwitnessed falls. Surveyor asked if they were completed after R13's fall on 9/7. NE-K could not remember.On 9/10/25 at 10:25 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-J. Surveyor asked when neuro checks should be completed. LPN-J stated that they are completed after every fall where a resident hits their head or if the fall is unwitnessed. LPN-J stated that LPN-J typically completes them after every fall.On 9/11/25 at 7:02 AM, Surveyor interviewed Registered Nurse (RN)-M. Surveyor asked when neuro checks are completed. RN-M stated that RN-M follows the policy and does them for an unwitnessed fall and a fall that the resident hit their head.On 9/9/25 at 2:37 PM, Director of Nursing (DON)-B informed Surveyor that neuro checks are completed after an unwitnessed fall and after a fall with head injury. DON-B stated that the neuro checks are completed on a paper form. Once all neuro checks are completed, they are scanned into the electronic medical record.On 9/11/2025 9:53 AM Surveyor interviewed DON-B. Surveyor shared the concern that neuro checks were not completed when R13 sustained an unwitnessed fall on 9/2/25 and 9/7/25. DON-B stated that's fair. DON-B then stated that R13 was sent to the hospital after the fall on 9/7 and DON-B believed that is why there is not documentation of neuro checks being completed. DON-B stated that DON-B would look into that and get back to Surveyor.Surveyor reviewed R13's electronic medical record and noted R13 returned to the facility the same day on 9/7/25.On 9/11/25 at 9:58 AM, Surveyor informed Nursing Home Administrator (NHA)-A of the concern that R13 sustained 2 unwitnessed falls and neuro checks were not completed per facility protocol. NHA-A stated ok.No additional information was provided.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the comprehensive assessment of a resident, the facility must ensure that residents receive care, consistent with professional standards of practice, to prevent pressure injuries and does not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure injuries receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new injuries from developing for 1 of 6 (R50) residents reviewed for pressure injuries.R50's pressure injury was not comprehensively assessed upon admission. The pressure injury was assessed by the wound physician 6 days later and documented as an unstageable DTI (Deep Tissue Injury) with moderate serosanguinous exudate. Findings include:The facility policy and procedure titled Pressure Injury Prevention and Managing Skin Integrity reviewed 5/8/25, documents (in part) . Prevention measures are put in place to reduce the occurrence of pressure injuries.a. Upon identification of abnormal skin findings, a licensed nurse will complete a skin assessment. Individual with abnormal skin concern(s) will be added to weekly wound rounds.b. Registered Nurse (RN) or designee will: Conduct weekly skin evaluation. Update the PCP (Primary Care Provider) with any decline in wound appearance, or as necessary. Update the care plan with any new interventions as applicable. Update individual representative as indicated. R50 admitted to the facility on [DATE] and has diagnoses that include acute and chronic respiratory failure with hypoxia, encephalopathy, fluid overload, Diabetes Mellitus type 1, kidney transplant status, hypertensive heart and chronic kidney disease, anxiety disorder, chronic Atrial Fibrillation, dysphagia, Hypothyroidism, Hyperlipidemia and Atherosclerotic Heart Disease.On 9/8/25 at 1:32 PM, during the initial interview, R50 reported she has a pressure injury on her heel that was present before she admitted to the facility. She reported she wears Prevalon boots whenever she is in bed and they are working hard to get it to heal, but I'm diabetic too, so that don't help. R50's Braden dated 8/21/25 documents a score of 16, indicating R50 is at risk for the development of pressure injuries.R50's care plan documents: The resident has actual DTI (Deep Tissue Injury) to the R (right) heel upon admission - initiated 8/21/25. Apply pressure relieving boots while in bed or chair. R50's Admit/Readmit Screener dated 8/21/25, Section C -Skin Integrity documents:Site: Right heel. Type: Pressure. Length/Width/Depth/Stage - No documentation. Surveyor noted that there was no evidence of a comprehensive assessment to include a description, measurements or staging of the pressure injury.R50's Medication Administration Record (MAR) documented: DTI R (right) lateral heel. Cover with Mepilex every Day shift for wound care - start 8/22/25, discontinued 8/27/25.Surveyor located no other documentation regarding the pressure injury except for a progress noted dated 8/23/25 at 8:27 PM, which documented: Resident has right heel scabbed area, area cleansed and rebandaged for protection.The facility Skin & Wound Evaluation dated 8/27/25 documents: Deep Tissue Injury (Persistent non-blanchable deep red, maroon or purple discoloration) right heel present on admission. Staged by wound care clinic. Exudate Moderate Serosanguinous. There were no measurements or wound bed description.The [NAME] Wound Physician Initial Wound Evaluation & Management Summary dated 8/27/25, documents: Focused Wound Exam - Unstageable DTI of the right heel. Wound Size (L x W x D): 1 x 0.6 x 0.1 cm (centimeters). MDS 3.0 stage: Unstageable DTI within and around wound. Exudate: Moderate serosanguinous.Dressing treatment plan: Primary dressing - Leptospermum honey apply three times per week and as needed. Secondary dressing - Foam with border apply three times per week and as needed if saturated, soiled, or dislodged.R50's August TAR documented: DTI Right lateral heel - Cleanse with wound cleanser, Dry. Apply border foam dressing in the morning every Mon, Wed, Fri for wound care - start date 8/29/25. Surveyor noted this was not the treatment ordered by the wound physician on 8/27/25. Although treatment was not implemented as ordered, the wound did not decline.The [NAME] Wound Physician Wound Evaluation & Management Summary dated 9/3/25 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documents: Focused Wound Exam - Unstageable DTI of the right heel. Wound Size 0.9 x 0.4 x 0.1 cm. MDS 3.0 stage: Unstageable DTI within and around wound. Exudate: Moderate serosanguinous. Wound progress: Improved evidenced by decreased surface area.Surveyor noted R50's September TAR documented treatment implemented as ordered. On 9/10/25 at 10:59 AM, Surveyor was unable to observe wound care as scheduled because R50 was sent out and admitted to the hospital the prior evening. On 9/10/25 at 1:01 PM, Surveyor asked Director of Nursing (DON)-B what the expectation for a resident that admits with or if staff identifies a pressure injury. DON-B reported the nurse should document on the admit/readmit screener, call for a treatment order and the wound care nurse (WCN) would assess it the next day. Surveyor advised DON-B the admission assessment documents only pressure right heel, there is not a comprehensive assessment to include a description of the wound or measurements. There is no evidence the pressure injury was assessed by the WCN the next day (Friday). There is no evidence of a comprehensive assessment until a week later, on 8/27/25 when R50 was seen by the wound physician, who then documents the pressure injury as an unstageable DTI of the right heel - unstageable DTI within and around wound with moderate serosanguinous exudate. Surveyor advised the physician ordered treatment on 8/27/25 of Leptospermum honey did not get implemented until after she was seen by [NAME] on 9/3/25. DON-B reported it was 6 days later, not a week - when R50 was seen by the wound physician, stating I believe we have a week to do the assessment. Surveyor advised DON-B that I was not sure what she meant by we have a week to do the assessment. DON-B stated, Upon admission we do the skin check and document any areas and then add the resident to weekly wound rounds. Surveyor advised DON-B a wound can change within a week and there is no evidence the facility completed a comprehensive assessment of the wound upon admission (to include a description of the wound and measurements) until she was seen by the wound physician, when he then documents the pressure injury as unstageable.On 9/10/25 2:36 PM, DON-B provided Surveyor the hospital After Visit Summary (AVS) to show R50's pressure injury was present prior to admission (PTA). Surveyor advised DON-B there is no dispute R50 admitted with a pressure injury. The concern is the facility did not comprehensively assess the pressure injury to include a description/characteristic of the wound, measurements or staging of the pressure injury upon admission. R50's pressure injury wasn't comprehensively assessed until she was seen by the wound physician 6 days later, when it was documented as unstageable DTI within and around the wound with moderate serosanguinous exudate.Surveyor reviewed the hospital AVS most recent documentation on 8/19/25 which documented: DTPI (Deep Tissue Pressure Injury). Dressing clean, dry, intact, reinforced. Wound exudate: None. Wound bed/tissue type: Maroon, purple, red, boggy. Wound edge poorly defined. Last measurements on 8/19/25 - 2 x 1.3 x 0 cm. Based on these measurements, there is no evidence the wound was open or had drainage on that date. On 9/11/25 at 9:38 AM, Consultant-H was advised of the above concerns and reported she understood the concern. On 9/11/25 at 1:52 PM, Surveyor spoke with Medical Doctor (MD)-L and asked if he can explain the documentation of R50's wound on 8/27/25. MD-L stated, It's just like it sounds, there is a DTI component to it, within, surrounded by an open wound. Normally for a DTI, I would order skin prep or betadine, but it was open around the edges, so I ordered the honey to promote healing. If it gets entered as DTI, the system shuts down and will not allow me to type in the characteristics because a DTI is not open, but hers was open with the DTI component within the wound. R50 readmitted to the facility on [DATE].Facility progress notes entered by Licensed Practical Nurse (LPN)-J document:9/12/25 at 3:41 PM, Skin assessment completed, buttocks has o/a (open area) stage 1 on buttocks, zinc applied, her left heel is scabbed. No drainage noted.9/13/25 at 9:18 PM, her bilateral buttock and coccyx area is excoriated, areas measured this shift and noted, no drainage. She denies pain or discomfort, zinc applied TID (three times daily) and as needed after changing.9/14/25 at 6:02 PM, her buttocks is excoriated, zinc applied TID and after changing. Will continue to monitor, bandage placed on left heel for protection. Denies pain or discomfort.R50's Admit/Readmit Screener dated 9/12/25 documents: Site - Left buttock. Type -other (specify) - red, OA, skin shear. Left heel (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure. Comments: Random bruising from hospital pokes, g-tube site draining serosanguinous fluids, red and inflamed. Surveyor was unable to locate any measurements of the excoriated shear areas on her buttocks or the scabbed area on her heel.On 9/15/25 at 9:10 AM, Surveyor asked Registered Nurse (RN)-I to observe R50's skin and treatments. RN-I informed Surveyor R50 doesn't really have any treatments, she only has some excoriated areas on her buttocks and gets zinc applied with cares. Surveyor observation of R50's skin: Left heel skin intact, no redness or skin breakdown. Right heel small, dried pale patchy scabbed area on lateral heel, no redness. Buttocks - several dry excoriated areas on coccyx that do not appear to be open. 2 small open excoriated areas on left buttock. Surveyor observed evidence of white zinc oxide cream covering buttocks, resident had not been washed up yet.On 9/15/25 during the exit meeting, the facility was advised of the above concerns. No additional information was provided at that time.On 9/15/25, while Surveyor was exiting the facility, Consultant-G asked to speak with Surveyor. Consultant-G asked for clarification of why the pressure injury concern would be a harm level citation, because R50 admitted with the pressure injury, it improved and is now healed. Surveyor explained the facility admission assessment only documented pressure there was no description of the pressure injury, measurements or staging. A comprehensive assessment was not completed until she was seen by the wound physician 6 days later, where the pressure injury was then documented as unstageable and open with exudate. Consultant-G reported the facility had additional information that the pressure injury was present in the hospital and did not decline while in the facility. Surveyor advised Consultant-G that I would be happy to review any additional information and provided card with email information.On 9/16/25, Surveyor received additional information via email from Consultant-G.The facility typed review and timeline on resident heel wound:- Heel wound measured in hospital on 8/19/25 shows 2 x 1.3 x 0 cm. Treatment during inpatient stay - foam with borders. Heel assessment notes 8/18/18 indicate necrotic tissue with eschar wound bed.- admission assessment completed by staff nurse - skin assessed, and pressure noted to right heel; as no order was on hospital DC summary, treatment obtained and entered 8/21. (Surveyor concern: Facility reports admission assessment completed; however, the assessment only listed pressure - there was no description, measurements or staging).- Wound was being viewed daily as evidenced by treatment order completion records. (Surveyor noted there was no documentation of what the wound looked like).- [NAME] wound MD (physician) evaluation on 8/27, wound decreased in size from hospital measurements on 8/19, no sign of infection. (Surveyor noted measurements did improve, except for the depth. Hospital measurements documented 0 mm - indicating the wound was not open. [NAME] documented 0.1 cm indicating an open wound).- [NAME] wound MD evaluation on 9/3 documents continued improvement and decrease in size of wound. (Surveyor does not dispute. Pressure injury did improve and was all but healed at the end of survey.)No additional information was provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist, and that irregularities identified by the pharmacist were reviewed, and action was taken to address them, for 3 (R1, R2, R43) of 5 residents reviewed. *R1 had pharmacist reviews dated 7/3/25, 8/7/25, and 9/3/25 with recommendations for a tardive dyskinesia assessment to be completed as R1 is on antipsychotic medication. The pharmacy recommendations were not followed up on. *R2's pharmacy reviews for 6/25, 7/25, 8/25, and 9/25 indicated that a screening for tardive dyskinesia assessment was needed to be completed due to Seroquel administration. The pharmacy recommendations were not followed up on. *The Pharmacist monthly review for R43 recommended the facility conduct an AIMS Assessment. The facility did not act upon this recommendation although R43 continued to take Antipsychotic medication. On 8/7/25, the Pharmacy Review again questioned why the AIMS assessment had not been completed for R43. Findings include: The facility's policy titled Consultant Pharmacist Reports, dated 05/2018, documents the following: Recommendations are acted upon and documented by the facility staff and/or the prescriber. Prescriber accepts and acts upon suggestion or rejects and provides an explanation for disagreeing. If there is potential for serious harm and the attending physician or prescriber does not concur, or refuses to document an explanation for disagreeing, the director of nursing and the consultant pharmacist will contact the medical director. The director of nursing or designated licensed nurse address and document recommendations that do not require a physician intervention, for example monitor blood pressure. 1.) R1 was admitted to the facility on [DATE], with diagnoses including bipolar disorder (a chronic mental health condition characterized by extreme mood swings between periods of mania (elevated mood) and depression), dementia (a decline in cognitive abilities such as memory, thinking, reasoning, and judgment), and paraplegia (a condition characterized by the loss of movement and sensation in both legs). On 9/9/25, Surveyor reviewed R1's Pharmacist's Medication Regimen Reviews dated 7/3/25, 8/7/25, and 9/3/25, which documents recommendations for tardive dyskinesia AIMS (Abnormal Involuntary Movement Scale) assessments to be completed for R1. R1's Electronic Medical Record (EMR) including current physician orders, Medication Administration Record (MAR), and Treatment Administration Record (TAR), documents that R1 is prescribed (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Aripiprazole 15 mg by mouth in the evening for bipolar disorder and Lamotrigine 200 mg by mouth one time a day for bipolar disorder. R1's EMR documents an AIMS completed on 10/5/24 and 4/10/24. Surveyor notes R1's EMR documents monthly pharmacy reviews dated 7/3/25, 8/7/25, and 9/3/25, with recommendations to complete an AIMS. On 9/9/25, Surveyor requested all AIMS assessments for R1, and documentation of follow up from R1's Pharmacist's Medication Regimen Reviews dated 7/3/25, 8/7/25, and 9/3/25, from the facility. On 9/10/25, at 10:41 AM, Surveyor interviewed Director of Nursing (DON)-B who indicates the facility meets with the pharmacist monthly to review monthly pharmacy recommendations. Surveyor asked DON-B about R1's pharmacy recommendations dated 7/3/25, 8/7/25, and 9/3/25, which recommend the facility complete an AIMS for R1. DON-B stated R1 did not have an AIMS completed as recommended by the pharmacist on 7/3/25, 8/7/25, and 9/3/25. DON-B then stated we need to improve our Pharmacist Medication Regimen Review process and takes full responsibility for not following up on recommendations from 7/3/25, 8/7/25, and 9/3/25. DON-B stated it's an important process and she will be making changes. Surveyor notified DON-B of concerns with R1 not having an AIMS completed as recommended by the pharmacist on 7/3/25, 8/7/25, and 9/3/25, and per facility policy. DON-B acknowledged these concerns. No additional information was provided. 2.) R2 was admitted to the facility on [DATE] with diagnoses that included Anxiety and Dementia with Behavioral Disturbance. On 9/10/25, R2's current physicians orders were reviewed and read: Seroquel 25 milligrams (mg) twice a day with a start date of 2/6/25 for dementia with behavioral disturbance. Seroquel is an anti-psychotic medication. On 9/10/25 R2's pharmacy reviews were reviewed and documented under recommendations for 6/5/25, 7/3/25, 8/7/25, and 9/4/25 was for the facility to complete an Abnormal Involuntary Movement Scale (AIMS) for R2. On 9/20/25 R2's medical record was reviewed, and no AIMS assessment was found. On 9/10/25 at 1:30 PM Director of Nurses (DON)-B was interviewed and indicated that R2 did not have her pharmacy recommendations for AIMS completed and it should have been. The above findings were shared with Nursing Home Administrator (NHA)-A and Director of Nurses-B on 9/10/25 .Additional information was requested if available as to why R2 did not have her pharmacy recommendations addressed. None was provided. 3.) R43 was admitted to the facility on [DATE] with diagnosis that included dementia and major depressive disorder. R43's quarterly MDS (Minimum Data Set), dated 8/21/25, documents that R43 receives antipsychotic medications on a routine basis. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor conducted a review of R43's medications and noted a physician order for Quetiapine Fumarate (Seroquel) tablet 25 mg, give 0.5 tablet by mouth at bedtime related to Dementia with mood disturbance. On 7/3/25, the consulting pharmacist made a recommendation that R43 needed to have a AIMS (Abnormal Involuntary Movement Scale) completed. The consulting pharmacist again recommended the AIMS be completed on 8/7/25. R42's monthly pharmacy review recommended the facility conduct a AIMS Assessment. The facility did not act upon this recommendation although R43 continued to take an antipsychotic medication. On 8/7/25, the pharmacy review again questioned why the AIMS assessment had not been completed for R43. Surveyor conducted further review of R43's medical record and noted that the facility had only completed an AIMS assessment on 8/22/24. No further assessments had been completed, per policy, until 8/7/25 after the second recommendation from the pharmacist. On 9/11/25 at 1:10 PM, Surveyor interviewed DON (Director of Nursing)- B regarding R43 not having an AIMS assessment completed per policy. DON- B stated that an assessment was completed as a result of the pharmacist recommendation on 8/7/25. No additional information was provided as to why R43 did not have an AIMS assessment per the pharmacist recommendations on 7/3/25 and not until 8/7/25.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review the facility did not ensure its medication error rate is not 5 percent or greater. The medication error rate was 11.54%.Findings include:The facility policy titled Medication Administration General Guidelines dated May 2018 documents (in part):Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions.7). Tablet crushing/capsule opening: Crushing tablets may require a physician's order, per facility policy. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines:c. Orders to crush medications should not be applied to medications which, if crushed, present a risk to the resident. For example:1. Long-acting or enteric-coated dosage forms should not be crushed; an alternative should be sought.On 9/10/25 at 7:45 AM, Surveyor observed Nurse Extern-K prepare R24's medications. The following medications were prepared and placed in a plastic medication cup:Divalproex capsule 125 mg (milligrams) DR (Delayed Release) 2 capsules, Multivitamin with minerals 1 tablet, Miralax Polyethylene Glycol 17 grams, Finasteride 5 mg 1 tablet, Metoprolol Tartrate 25 mg 1 tablet, Trazodone 50 mg 1/2 tablet, Pregabalin 50 mg 1 capsule.Nurse Extern-K stated aloud, I don't have this med (medication) so I can't give it. Surveyor asked which medication she was referring to. Nurse Extern-K stated, Apixaban 5 mg. I'll have to let pharmacy know. Surveyor verified the number of tablets. Nurse Extern-K removed the Divalproex and Pregabalin capsules, placed them in a separate medication cup, then crushed the remaining tablets and added them to applesauce. Nurse Extern-K opened the Pregabalin capsule and Divalproex Delayed Release capsules and emptied the contents of the capsules into the applesauce containing the crushed medications. The medications were administered to R24 followed by water. On 9/10/25 at 9:20 AM Surveyor reconciled R24's medications. R24's Medication Administration Record (MAR) documented an order for Apixaban Oral Tablet 5 mg give 1 tablet by mouth two times a day related to mixed hyperlipidemia. Times: Morning and HS (hour of sleep) 7 PM. Surveyor noted Nurse Extern-K signed/entered 5 (hold/see progress notes) for the AM dose on 9/9/25 and today (9/10/25).After reconciling R24's medications, Surveyor asked Nurse Extern-K if she gave R24's Apixaban this morning. Nurse Extern-K stated, No, it wasn't available, I still have to call pharmacy to let them know we don't have it. Surveyor advised the MAR documents she entered 5 for the 9/9/25 AM dose of Apixaban as well. Nurse Extern-K stated, Yes, I didn't have it yesterday either. Surveyor advised Nurse Extern-K that PM shift documents the medication signed out as administered the past 2 days and asked if they have a separate card for Apixaban. Nurse Extern-K stated, Yes, there are cards for AM and PM shift.Surveyor asked Nurse Extern-K if the facility has a medication contingency supply, Nurse Extern-K replied Yes. Surveyor asked if Apixaban is available in contingency. Nurse Extern-K replied, Sometimes it is, sometimes it isn't. Surveyor asked if she checked contingency to see if Apixaban is available to be given this morning. Nurse Extern-K stated, No, I was just going to call pharmacy.On 9/10/25 at 9:25 AM, while Surveyor was still on the unit, Nurse Extern-K informed Surveyor that Apixaban is available in contingency, and asked Do you want me to give it? Surveyor advised Nurse Extern-K to do what she would normally do; as Surveyor was not telling her what to do. Surveyor reviewed the list of medications available in the Omnicell contingency supply. Surveyor verified Apixaban 2.5 mg tablet is available in the facility contingency.On 9/10/25 at 11:34 AM, Surveyor verified R24's MAR still documented Apixaban entered as 5 indicating the medication was not given. There was no documentation in progress notes regarding holding of the medication or Physician notification.On 9/11/25 at 8:57 AM, Surveyor verified R24's MAR still documented Apixaban entered as 5 indicating the AM dose was not given on 9/10/25. There was no documentation in progress notes regarding holding of the medication or Physician notification.On 9/10/25 a 8:00AM Surveyor observed Licensed (continued on next page)

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	525422	A. Building B. Wing	09/25/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practical Nurse (LPN)-J prepare R47's medications. The following medications were prepared and placed in plastic medication cups:Ferrous Sulfate EC (Enteric Coated) 325 mg 1 tablet, Folic Acid 1 mg 1 tablet, Lactulose 10g (grams)/15 ml (milliliters) 15 ml, Magnesium Oxide 400 mg 1 tablet, Multivitamin with minerals 1 tablet, Pantoprazole 40 mg 1 tablet, Vitamin B1 100 mg 2 tablets, Vitamin D3 50 mcg (micrograms) 1 tablet.Surveyor verified the number of tablets. LPN-J then crushed all the tablets together, mixed them with vanilla pudding and the resident swallowed the medications followed by water.Surveyor reconciled R47s medications. R47's MAR documented an order for Ferrous Sulfate Oral Tablet Delayed Release 325 MG Give 1 tablet by mouth in the morning for supplement with breakfast. On 9/10/25 at 1:01 PM, Director of Nursing (DON)-B was advised of concerns that Delayed Release medication was opened/administered and Enteric Coated medication was crushed/administered. In addition, Apixaban was not administered, even though the medication was available in contingency. No additional information was provided.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure hospice collaboration and communication was established to ensure continuity of care between hospice provider and the facility for 1 (R13) of 2 residents reviewed for hospice services. *R13 started receiving hospice care and treatment on 7/29/25. R13's hospice plan of care initiated on 7/29/25, included Lorazepam (an anti-anxiety medication) and Hydromorphone (a narcotic pain medication) to be ordered and implemented by facility staff. Facility staff did not enter the physician order for Lorazepam until 9/6/25 and Hydromorphone until 9/15/25. R13 sustained falls on 8/2/25, 8/9/25, 8/18/25 and 9/2/25. Facility staff did not inform hospice staff of these falls on the day the falls happened. According to hospice and facility staff, R13 is to have a hospice binder at the nurse's station to aid in communication between the facility and the hospice provider. R13 was observed to not have a hospice binder.Findings include:The facility hospice contract dated 6/1/2028 titled, Hospice-Nursing facility Services Agreement documents, in part: Coordination of care: General: Hospice and Facility shall communicate with one another regularly and as needed for each particular Hospice Patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day. Design of hospice plan of care: Hospice retains primary responsibility for determining each Hospice Patient's appropriate Hospice Plan of Care. Facility shall ensure that Facility's care plan for each Hospice Patient reflects both the most recent Hospice Plan of Care. Modifications to Hospice Plan of Care: Facility will not make any modifications to the Hospice Plan of Care without first consulting with Hospice. Hospice retains the sole authority for determining the appropriate course of hospice care provided. Notification of Change in Condition: Facility shall immediately inform Hospice of any change in the condition of a hospice patient.R13 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease with late onset, Dementia with agitation, Depression, Muscle weakness, and Unsteadiness on feet.R13's admission Minimum Data Set (MDS) assessment dated [DATE] documents R13 is severely cognitively impaired. R13 displays verbal behaviors directed towards others 4-6 days a week. R13 is dependent for toileting and hygiene. R13 has a history of falls. R13 has had falls since admission, one fall with no injury and one fall with major injury.R13's physician order entered on 7/28/29 documents: Hospice [evaluation] and treat.R13 started receiving hospice services on 7/29/25. The admitting diagnosis for hospice services is Alzheimer's disease with late onset.R13's hospice care plan initiated 7/31/25 documents the following pertinent interventions: Assess resident coping strategies and respect resident wishes. Keep the environment quiet and calm. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Work with nursing staff to provide maximum comfort for the resident.HOSPICE MEDICATIONSR13's Hospice plan of care effective on 7/29/25 included the following hospice medication orders, in part:-Hydromorphone (narcotic pain medication) 2 mg every hour as needed for moderate pain or shortness of breath. Take 4 mg every hour as needed for severe pain or shortness of breath.-Lorazepam (antianxiety medication) 1 mg by mouth every hour as needed for moderate anxiety. Take 2 mg by mouth every hour as needed for severe anxiety.Surveyor reviewed R13's physician medication orders and noted Hydromorphone and Lorazepam were not entered as active orders when R13 was started on hospice on 7/29/25. R13's hospice nurse's visit note dated 8/30/25 documents: . [Facility nurse] said they know to give Lorazepam if staff not able to calm [R13] down with distraction or laying [R13] down in bed. [Facility nurse] states [R13] usually calms down when lay [R13] down in bed.Surveyor noted that the hospice nurse and facility nurse talked about using Lorazepam as needed.Surveyor noted that despite hospice ordering Lorazepam on 7/29/25, as of 8/30/25, the facility had still not entered the order into R13's medical record and facility staff are not (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	utilizing the anti-anxiety medication.R13's hospice nurse's visit note dated 9/5/25 documents, in part: . Per facility nurse, no lorazepam required this shift so far, states [R13] has been pretty sleepy.Surveyor noted that the hospice nurse and facility nurse talked about using Lorazepam. Surveyor noted that despite hospice ordering Lorazepam on 7/29/25, as of 9/5/25, the facility had still not entered the order into R13's medical record and facility staff are not utilizing the anti-anxiety medication.R13's physician order dated 9/6/25 documents: Lorazepam 1 mg every 1 hour as needed for Anxiety related to Dementia. May give 1-2 tabs every hour as needed. Surveyor reviewed R13's Medication Administration Record and noted that staff started using Lorazepam on 9/6/25 at 5:37 PM and again at 6:39 PM after the order was entered.R13's hospice nurses visit note dated 9/7/25 documents, in part: .Reminded [RN] of the [as needed] meds for agitation, Lorazepam and how and when to give. Reminded can give every hour if needed. [Nurse] verbalized [nurse] knows this.On 9/11/25 at 1:24 AM, Surveyor interviewed HCM-O. Surveyor reviewed R13's case with HCM-O. Surveyor noted that R13 had multiple falls. Surveyor asked what HCM-O thinks is the cause of R13's falls. HCM-O stated that R13 needs to be closely monitored. HCM-O stated that facility staff have not utilized the list of hospice medications like Lorazepam effectively. On 9/15/25 at 11:15 AM, Surveyor interviewed Director of Nursing (DON)-B about R13's hospice medications. Surveyor asked why Lorazepam was not put in place until 9/6/25 and Hydromorphone was not put into place until today, 9/15/25, when it was ordered by hospice on 7/29/25. DON-B stated that facility staff was concerned that Lorazepam was going to increase R13's fall risk and could be considered a chemical restraint. DON-B stated that facility was working to use other non-pharmacological interventions before implementing the medication and that is why facility staff decided not to put the hospice medication orders in.On 9/15/25 at 11:24, DON-B returned to Surveyor and stated that ordering Lorazepam and Hydromorphone on 7/29/25 was missed and that facility staff should have caught that the medications were not ordered. DON-B stated that DON-B would change it today. R13's physician order with a start date of 9/15/25 documents: Hydromorphone 2 mg by mouth every 1 hour as needed for moderate pain/shortness of breath AND give 4 mg by mouth every 1 hour as needed for severe pain/shortness of breath.Surveyor noted that R13's Hydromorphone order was placed after only Surveyor brought it to the facility's attention.FALLSR13's hospice nurse's note dated 7/29/25 documents, in part: . [R13] has not tried to leave [R13's] unit but has had multiple falls when trying to get up alone. Last fall was 2 days ago.Staff has made changes to patient environment with bed low to the ground, padding/pillows on floor next to bed, moving [R13] to the nurse's station during wake times for more visibility.Surveyor reviewed R13's facility's comprehensive care plan and noted that the interventions listed in this hospice note are not documented in the facility's care plan for R13.R13's progress note dated 8/4/25 documents: Writer walked into [R13's] room and noticed [R13] on the floor, [R13] didn't know how [R13] got down there, [R13] was assessed and placed into Broda chair. Vitals signs [within normal limits], no [complaints of] pain [or] injuries. Denies hitting head, neuro checks in place, [Assistant Director of Nursing], [POA-Q] and [Nurse Practitioner] all notified of fall.On 9/10 25 at 11:52 AM, DON-B informed Surveyor that the above progress note was a late entry for a fall that R13 had on 8/2/25. DON-B provided the fall investigation to Surveyor.Surveyor reviewed R13's facility fall investigation and noted facility staff did not document that R13's hospice was made aware of the fall on 8/2/25.On 9/11/25 at 1:24 PM, Surveyor interviewed Hospice Case Manager (HCM)-O. Surveyor asked if facility staff should contact the hospice team with any falls. HCM-O stated yes. HCM-O confirmed that hospice was not made aware that R13 fell on 8/2/25.R13's progress note dated 8/9/25 at 8:30 PM documents: At about [8PM] writer was informed by one [of] the CNAs that [R13] was on the floor. Upon arrival, [R13] was laying on [R13's] buttock, alert, no bruise, bleeding noted, denied pain. Assessed pain, obtained vital signs and neuro check. Notified case manager [name of hospice company], [provider], [POA-Q] [and] [NHA-A]. [R13] was assisted back to bed, bed on lower level, call light within reach and precaution mat placed on the floor. Continue check on R13.Surveyor noted that the wrong hospice (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	company was notified of R13's fall on 8/9/25.On 9/11/25 at 1:24 PM, Surveyor interviewed HCM-O. HCM-O confirmed that hospice was not made aware that R13 fell on 8/9/25.R13's progress note dated 8/19/25 at 10:03 PM documents, in part: [R13] was sitting up at the nursing station and slid out of [R13's] Broda chair, when writer look up and notice[d] [R13] was sliding out, [R13] was placed into [R13's] Broda chair, no injuries were noted, [Provider], [DON-B] aware of fall, writer left message with. [POA-Q].On 9/10 25 at 11:52 AM, DON-B informed Surveyor that the above progress note was a late entry for a fall that R13 had on 8/18/25. DON-B provided the fall investigation to Surveyor.Surveyor noted facility staff did not document that hospice was made aware of the fall on 8/18/25. On 9/11/25 at 1:24 PM, Surveyor interviewed HCM-O. HCM-O confirmed that hospice was not made aware that R13 fell on 8/18/25.R13's progress note dated 9/2/25 at 12:32 PM documents: [R13] found on the floor sitting in front of a chair with [R13's] feet in front of [R13] directly next to [R13's] Broda chair. Vitals stable. No new injuries. Safely transferred [R13] into Broda chair. Neuro checks negative. Denies any pain. Alert and baseline behavior noted. Presently up eating lunch with [POA-Q].Surveyor noted facility staff did not document that hospice was made aware of the fall on 9/2/25. On 9/11/25 at 1:24 PM, Surveyor interviewed HCM-O. HCM-O confirmed that hospice was not made aware that R13 fell on 9/2/25.On 9/11/25 at 1:24 AM, Surveyor interviewed HCM-O. Surveyor asked how the communication is between the facility and hospice. HCM-O stated that it is good, but that hospice was not notified of all the falls R13 has had at the facility. HCM-O stated that HCM-O only found out about the falls on 8/2, 8/9, 8/18, and 9/2 through POA-Q, who told HCM-O that POA-Q was worried about all of R13's falls. HCM-O stated that HCM-O then had a conversation with DON-B to let DON-B know that staff need to call hospice with every fall.HOSPICE BINDERR13's hospice nurse visit note dated 8/30/25 documents, in part: . No hospice binder to leave note in on 2nd floor or 1st floor nurses' station. Hospice binder at 2nd floor nurses' station however has sticker on side over that states CNAs and Nurses (appears facility has used binder for their paperwork).Surveyor noted hospice nurse could not locate R13's hospice binder on 8/30/25.On 9/11/25 at 9:24 AM, Surveyor interviewed HCM-O. Surveyor asked how facility staff and hospice staff communicate with each other. HCM-O stated that HCM-O will speak to staff whenever HCM-O comes to visit R13. HCM-O stated that the facility also has a hospice binder for R13. HCM-O state that the binder is a way that staff from both teams can communicate back and forth. HCM-O stated that HCM-O received a call on 9/8/25 from a hospice music therapist who asked where the hospice binders are located because the music therapist could not locate it. HCM-O stated that the hospice music therapist did not locate the binder. HCM-O stated that HCM-O had used the binder the previous week but stated that the binder seems to go missing at times.On 9/10/25 at 7:47 AM, Surveyor interviewed Medication Technician (MT)-V. Surveyor asked how communication between facility staff and hospice works. MT-V stated that each resident has a hospice binder at the nurses' station.On 9/10/25 at 7:52 AM, Surveyor observed R13's nurse's station located on the 2nd floor of the facility. Surveyor could not locate R13's hospice binder.On 9/15/25 at 7:47 AM, Surveyor observed R13's nurse's station located on the 2nd floor of the facility. Surveyor could not locate R13's hospice binder.On 9/15/25 at 8:37 AM, Surveyor interviewed DON-B. Surveyor asked how communication with hospice services is. DON-B stated that communication is varied. DON-B stated that every time the hospice nurse visits, the hospice nurse is to fax the visit note from that day to the Assistant Director of Nursing (ADON) who leads communication from the facility's standpoint. DON-B stated that the notes are not always faxed and the ADON or DON-B will have to reach out to hospice to get the notes. The notes are then scanned into the facility's electronic medical record. Surveyor asked if residents are supposed to have a hospice binder at the nurse's station. DON-B stated that DON-B asks that hospice set up a binder for each resident on hospice. Surveyor informed DON-B that Surveyor was unable to locate R13's hospice binder. DON-B stated that DON-B reached out to hospice last Friday about the hospice binder. DON-B indicated that DON-B now thought R13's binder was at the nurse's station on the 2nd floor. DON-B stated that DON-B will have to look into that. Surveyor asked if DON-B finds R13's hospice binder, if (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor could have a copy of what is in the binder. DON-B stated yes.DON-B did not return to Surveyor with R13's hospice binder or copies of what is in the binder.On 9/15/25 at 2:56 PM, Surveyor informed Nursing Home Administrator (NHA)-A and DON-B of the concerns that hospice ordered Lorazepam and Hydromorphone on 7/29/25 and facility staff did not enter active MD orders for the Lorazepam until 9/7/25 and Hydromorphone until 9/15/25. R13 had multiple falls that the hospice team was not made aware of. R13's hospice binder with communication between hospice staff and facility staff was not provided to Surveyor and hospice binder was not observed at R13's 2nd floor nurse's station.No additional information was provided.