STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525431	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clairidge House	1519 60th St Kenosha, WI 53140

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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 record review, interview and observations, the facility did not ensure residents received comprehensive assessments, interventions and treatment, to prevent and heal, pressure injuries. This was observed with 4 (R3, R9, R1 and R16) of 4 residents reviewed with pressure injury. *R3 was at high risk for a pressure injury, developed a facility acquired stage 3 pressure injury, that was not comprehensively assessed upon discovery. R3 did not have interventions revised to promote healing. This resulted in actual harm to R3. *R9 had facility acquired pressure injuries to the left upper posterior thigh area and left medial thigh. On 3/03/2026, Surveyor observed R9's wound treatment which was not completed per the order. R9's pressure injuries were determined to be due to R9 being provided with the incorrect size brief causing medical device related pressure injuries. R9's stage 2 left medial thigh pressure injury was not assessed, and treatment was not put into place until Surveyor questioned the treatment. This resulted in actual harm to R9. *R1 had a Deep Tissue Injury to the left heel when admitted to the hospital on [DATE]. R1 was readmitted to the facility on [DATE] and the left heel pressure injury was not comprehensively assessed until 2/12/2025, one week later. *R16 has a Stage 3 pressure wound on right heel and was observed to not have heels floated during survey process. Review of R16's Treatment Administration Records (TARS) documented missing treatments. R16 has a history of MASD and pressure wound to left heel. Findings include: The facility's policy and procedures Skin Care Treatment, dated 2/25, was reviewed. The Policy documents: It is the policy of this nursing home to provide skin care to residents that includes assessment, prevention of skin breakdown and management of pressure injury and other skin integrity concerns.Protocol:1. Within 4 hours of admission a complete body check is completed by the nurse, using the skin and body assessment form. If any issues are found on this comprehensive body check, documentation will be entered into the pressure injury assessment (for any pressure injuries) or non-pressure wounds (for all other wound types) of folder in ECS (Electronic Chart System). A Braden scale will also be calculated at this time.2. Proactive pressure injury and skin care integrity interventions will be considered and implemented at the time of admission and care planned accordingly this includes but is not limited to pressure relieving support services for bed and chairs wheelchairs frequent repositioning and offloading skin inspection and early detection of issues moisture and incontinence management nutrition and hydration interventions mobility and exercise encouragement and appropriate selection and use of skin care products and equipment3. All resident (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	beds are equipped with pressure reducing relieving or redistributing mattresses all resonant wheelchairs are equipped with pressure reducing you're leaving or redistributing cushions advanced treatment level mattresses and wheelchair cushions are issued to residents with assessed need per the skin treatment management guidelines policy.9. When a resident is admitted with or develops a pressure injury or any other open area, immediate treatment will be initiated.a. Initial wound documentation will be entered into the pressure injury assessment folder for any pressure injuries or non-pressure wounds folder for all other wound types in ECS.b. Comprehensive assessment of pain and implementation of pain control measures prior to treatment is the priority and wound care management.c. Measurements of the area will be done using a wound measuring guide.d. A weekly assessment will be done by the nurse, and all ongoing wound documentation will be entered into the pressure injury assessment folder or non-pressure wounds folder in ECS.e. The treatment protocol will be initiated using the skin treatment management guidelines protocol and the intending physician order.f. The nurse will notify the residents responsible party of any skin integrity issues and or changes in treatment and document this in the nursing progress notes. 1.) R3 was admitted on [DATE] with a diagnosis of stroke. R3's admission Minimum Data Set (MDS) assessment completed on 7/7/25 assesses R3 as non-verbal, tube feeding, totally dependent on staff for positioning, at risk for pressure injury, along with stage 1 pressure injury. R3's Care Area Assessment (CAA) was triggered for Pressure Ulcer but the CAA does not include where the pressure injury is located or risks for pressure injury development for R4. R3's Braden Scale performed on 6/25/25 documents a score 11, indicating that R3 is at high-risk for developing pressure injuries. R3 Plan of Care (POC) Care plan, dated 6/20/25, for Tissue integrity impairment documents under the Interventions section: assess skin status, keep physician informed, medical plan for treatment, reposition every 1.5 hours. Keep skin clean and dry.REVISED on 7/1/25 with ensure floating boots while in bed. R3's New Impairment of skin Integrity, dated 8/18/25, documents the following interventions: Assess skin daily and note any changes, Monitor use of skin protective devices. Bandage as appropriate. Keep clean and dry, check skin under elbow protectors every shift. REVISED 8/26/25 float bilateral elbows with pillows. R3's nursing note written by Wound Nurse-G and dated 8/18/25 documents: A facility acquired pressure injury, stage 3 on the right elbow. The discovery date is 8/15/25. The area measures 2.5 centimeters (cm) by 1.5 by 01. The wound has a moderate amount of drainage. The MD (medical doctor) was notified, and a treatment was ordered. The new interventions include elbow protectors. R3's Skin POC 8/18/25, by WN-G, that the elbow protectors are too tight. The right elbow was elevated with a bath blanket, and the left elbow is also elevated with repositioning. There is no documentation for a comprehensive wound assessment, along with interventions and treatment, to promote healing on 8/15/25. The documentation of the discovery of the wound on 8/18/25 documents that the area was not (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	comprehensively assessed until 8/21/25 by Nurse Partitioner (NP) -Q on 8/21/25. On 3/05/26, at 8:00 AM, Surveyor interviewed WN-G. The WN-G is a Licensed Practical Nurse (LPN) with wound care certification. The WN-G stated when they reviewed the 24-Hour Reports on 8/18/25 (Monday), they noticed on 8/15/25 (Friday) R3 had a wound on their elbow. The Floor Nurse should have let WN-G know about a wound. The WN-G does assessments weekly with the NP-Q. The 24-hour Report Sheet documents on 8/15/25 an old wound reopened on the right elbow. There is no additional documentation related to this open area discovery until 8/18/25. On 8/21/25, NP-Q documented an assessment of a stage 3 pressure ulcer on the right elbow. Measuring 1.5 cm by 1.3 by 0.1. With scant serosanguinous drainage and 100% granulation. The intervention includes, to float elbows in bed. R3's Skin POC had a entry on 8/26/25 of: pressure ulcer correlated to contact wedge pillow used for positioning. Staff instructed to reposition every 1.5 hours and to float elbows with pillows in bed. This was documented by WN-G. On 3/04/2026, at 10:23 AM, Surveyor interviewed the WN -G. The WN-G stated the elbow protectors were black and elastic and too tight. They ordered a larger size. These were ordered after the elbow wound was discovered. The WN-G states the positioning wedge may have caused a wound on the elbow. R3 is not mobile at all. On 8/28/25 the NP-Q documented an assessment of the right elbow. R3 was experiencing a change in their clinical condition and was going to be sent out to the hospital. The elbow wound measures 1.5 cm by 2.8 by 0.1. There is moderate serosanguinous drainage and 100% slough. R3's nursing note documents that R3 returned from the hospital on 9/2/25. The right elbow wound is larger. Wound Nurse-G was documented on the area. This documentation is not in the medical record. Surveyor noted that there was not a comprehensive assessment of the right elbow upon R3's readmission to the facility from the hospital on 9/2/25. R3's right elbow was not assessed until 9/4/25 by NP-Q. On 9/4/25, NP-Q documented an assessment of the right elbow. The elbow is a stage 3 pressure injury with improvement. Measures 1.2 cm by 2.8 by 0.1. There is 50% slough and 50% granulation. No changes in treatment or plan of care. On 9/11/25, NP-Q documented an assessment of the right elbow. The right elbow is deteriorating. Measures 1.8 cm by 2.5 by 0.3. With 50% slough and 50% granulation. The Treatment was changed. There was no change in the POC. On 9/18/25, NP-Q documented an assessment of the right elbow. The right elbow is deteriorating. A Dietary Consult for glucose management. Given the location of the wound and deterioration present this week will order work up for osteomyelitis. Ordered wound culture and lab work. R3 was prescribed Levaquin (antibiotic) on 9/18/25 for wound infection for 7 days. The wound work-up did not show osteomyelitis. The wound culture did not show an infection. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 9/25/25, NP-Q documented an assessment of the right elbow. The right elbow has improved. The wound is unstageable with 80% slough and 20% granulation. Measures 2.5 cm by 2.5 by 0.4. The POC is the same On 10/2/25, NP-Q documented an assessment of the right elbow. The right elbow is improving. The right elbow is a stage 3 with 10 % slough and 90% granulation. There is moderate amount of serosanguinous drainage. Measures 2.5 cm by 2.5 by 0.3. No change in treatment or POC. On 10/9/25, NP-Q documented an assessment of the right elbow. The right elbow is unchanged from the previous week. No changes in treatment or POC. On 10/16/25, NP-Q documented an assessment of the right elbow. The wound has improved. It is a stage with 10% slough and 90% granulation. Measures 1.7 cm by 1.5 cm by 0.2. There is no change to the treatment or POC. On 10/23/25, NP-Q documented an assessment of the right elbow. The measurements unchanged from the week before. There is 100% granulation. There is no change in treatment or the POC. On 10/30/25, NP-Q documented an assessment of the right elbow. The measurements are unchanged from the prior week. There is 40% granulation and 60% epithelial. There is no change in treatment or POC. On 11/6/25, NP-Q documented an assessment of the right elbow. The area is improving. There is 90% granulation and 10% slough with moderate serosanguinous drainage. Measures 1.5 cm by 1.5 by 0.1. The treatment was changed. There was no change to the POC. On 11/14/25, NP-Q was not at the facility. The facility Wound Nurse-G documented on the right elbow. The right elbow measured 1.5 cm by 1.5 by 0.1. with 90% granulation and 10% slough. There was no change in treatment or POC. On 11/20/25, NP-Q documented an assessment of the right elbow. The area has declined, and Bactrim DS 800 mg BID(twice a day) for 10 days was ordered. The area is a stage 3 with purulent drainage and 90% granulation and 10% slough. Measures 2.2 cm by 2.8 by 0.1. The treatment was changed. There was no change in the POC. On 11/26/25, NP-Q documented an assessment of the right elbow. The area is improving. It is a Stage 3, and has moderate serosanguinous drainage, with 90% granulation and 10% slough. Measures 1.9 cm by 1.6 by 0.1 There is no change in the treatment or POC. On 12/4/25, NP-Q documented an assessment of the right elbow. The area is improving. There is moderate serosanguinous drainage with 100% granulation. Measures 1 cm by 1.5 by 0.1. No change to the treatment or POC. On 12/11/25, NP-Q documented an assessment of the right elbow. The area is stable. There is moderate serous drainage with 100% granulation. Measures 1 cm by 1.5 by 0.2. No change in treatment or POC. On 12/18/25, NP-Q documented an assessment of the right elbow. The wound has stalled and concerns for infection. Labs and wound culture ordered. There is moderate serosanguinous drainage (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	with 100% granulation. Measures 1.5 cm by 1.5 by 0.3. There is no change in treatment or POC. There were no infections discovered with wound culture or labs. On 12/30/25, NP-Q documented an assessment of the right elbow. The wound is stable. There is moderate serosanguinous drainage with 90% granulation and 10% slough. Measures 1.5 cm by 1.5 by 0.3. The treatment was changed. There was no change to the POC. On 1/1/26 the facility WN-G documented on the right elbow. The area is a stage 3 with moderate serosanguinous drainage with 90% granulation and 10% slough. Measures 1.5 cm by 1.5 by 0.3. The treatment and POC is unchanged. On 1/15/26, NP-Q documented an assessment of the right elbow. The area has deteriorated. A stage 3 with heavy serosanguinous drainage with 100% granulation. Measures 2 cm by 2.5 by 0.1, No change to the treatment or POC. On 1/22/26, NP-Q documented an assessment of the right elbow. The area is improving. It is a stage 3 with moderate serosanguinous drainage with 100% granulation. Measures 1.8 cm by 2 by 0.1. There is no change in treatment or the POC. On 1/29/26, NP-Q documented an assessment of the right elbow. The area is improving. A stage 3 with heavy serosanguinous drainage with 100% granulation. Measures 1.5 cm by 1.5 by 0.2. There was no change in the treatment or POC. On 2/5/26, NP-Q documented an assessment of the right elbow. The area is improving. A stage 3 with moderate serosanguinous drainage and 100% granulation. Measures 1 cm by 1 by 0.1. There was no change in the treatment or POC. On 2/12/25, NP-Q documented an assessment of the right elbow. The area is improving. Stage 3 with heavy sanguineus drainage and 100% granulation. Measures 0.8 cm by 0.8 by 0.1. There is no change in treatment or the POC. Surveyor noted that there was no comprehensive assessment between 2/12/26 and 2/26/26. On 2/26/26, NP-Q documented an assessment of the right elbow. The area is stable. A stage 3 with moderate serosanguinous drainage and 100% granulation. Measures 1 cm by 1 by 0.1. The treatment was changed. There was no change on the POC. On 3/04/2026, at 7:34 AM, Surveyor observed R3 wound care by WN-G. The treatment was followed. The pressure injury appeared as assessed. The intervention measures were in place. On 3/4/25, at 3:00 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A and Director of Nurses (DON) -B, Surveyor shared the concerns that R3was missing comprehensive assessments, infection that was treated with antibiotics and updates to R3's plan of care. On 3/05/2026, at 10:50 AM, Surveyor interviewed NP-Q. The NP-Q is an outside Consultant that comes to the facility once a week. WN-G will contact the facility with any concerns or new areas. WN-G will look at the wounds when they are not in the facility. NP-Q stated they had pillows and elbow protectors. R3 has respiratory issues, receives tube feeding, bed bound with contractures. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	There were no concerns about wound cultures or labs. The NP-Q thinks the elbow is slow to heal due to R3 clinical condition. There have been no concerns about dressing changes or missed treatments. On 3/5/25, at 1:02 PM, Surveyor shared with NHA-A regarding R3's pressure injury concerns. R3 right elbow was not comprehensively assessed upon discovery. It was assessed as a stage 3 pressure injury and was treated with antibiotics. No additional information was provided. 2.) R9 was admitted to the facility on [DATE], with diagnoses including acute kidney failure (sudden, often reversible loss of kidney function), acquired absence of right foot, and urine retention (the inability to fully or partially empty the bladder). R9's annual MDS (Minimum Data Set) dated 1/21/2026, indicates R9 has a BIMS score of 14, indicating R9 is cognitively intact, does not exhibit rejection of care behaviors, has no impairment in upper extremities, has impairment in lower extremities, is dependent for toileting, dependent on lower body dressing, requires partial/moderate assistance rolling left to right, frequently incontinent of urine, always incontinent of bowels and has an unhealed stage 3 pressure injury. On 03/02/2026, at 9:29 AM, Surveyor interviewed R9. R9 informed Surveyor that R9 has wounds on his butt and thigh that were acquired while at the facility. R9's Facility provided untitled document, dated 12/26/2025 documents: Initial Assessment- Area 1- left posterior thigh; Onset- 12/26/2025; Origin- Facility Acquired; Stage- 3 ; Wound Base- 10% epithelial scab wound edges, 80% granulation, 10% dermis; Measurement in centimeters (cm) (length x width x depth)- 4.2 x 4.8 x 0.1; Exudate- serosanguinous ; Exudate color- bloody; Amount- moderate; Treatment- skin sealant to peri wound, cover with calcium alginate, cover with foam boarded bandage daily. Interventions: support surfaces for bed: Medline advantage select PE support surfaces for w/c: cushion, geo-mat PRT monitor skin integrity and tissue tolerance; minimize risk for sheer and friction; teaching redistributing pressure, reposition and offloading; risk and benefits. Surveyor reviewed R9's Physician orders and noted a treatment for R9's left posterior thigh, initiated 12/26/2025. Surveyor reviewed R9's Skin Integrity care plan initiated on 8/6/24 that documents: R9 has potential for impairment to skin integrity with no current breakdown; Interventions include: Weekly skin assessments; Monitor stumps for presence of edemas and skin integrity; Encourage to wear stump shrinkers; Keep legs elevated on cushion in chair; Assure incontinent cares are complete in timely manner; Encourage to shift body weight when up in chair; Provide moisture barrier if needed; Update wound nurse if impaired skin develops; Monitor dietary intake. Surveyor noted no added interventions to care plan and that R9's skin integrity care plan was discontinued on 1/7/2026. Surveyor noted R9's Care Plan, initiated an intervention on 1/7/2026 that documents: Ensure R9's brief is fitted properly to prevent excessive friction. Surveyor noted R9 was admitted to the hospital for unrelated medical concerns on 1/10/2026 and returned to the facility on 1/14/2026. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R9's Integrated Wound Care document, dated 1/15/2026, indicates: R9 is being seen for evaluation and treatment recommendation regarding a stage 3 pressure injury to the left posterior thigh. R9 was recently hospitalized and upon return stage 3 pressure injury noted to posterior thigh. Measurement- 2 x 1 x 0.1 100% dermis; Treatment recommendations: Apply Thera honey to wound bed, cover with alginate and boarder foam, change daily and as needed. R9's Integrated Wound Care document, dated 1/22/2026, indicates: Wound is improving, new trauma to left medial thigh observed. Pressure Injury left posterior thigh- measurement- 1 x 1 x 0.1 cm; Trauma medial left thigh- measurement 2 x 4 x 0.1; Treatment recommendations: Pressure Injury left posterior thigh- Apply Thera honey to wound bed, cover with alginate and boarder foam, change daily and as needed; Trauma medial left thigh- Thera honey to wound bed, cover with boarder foam, change daily and as needed. R9's Facility provided untitled document, dated 1/23/2026 documents: Area 2- left medial thigh; Onset- 1/22/2026; Origin- Facility Acquired; Stage- 2 medial device related pressure injury (brief); Wound Base- 100% dermis; Measurement in centimeters (cm) (length x width x depth)- 2 x 4 x 0.; exudate- serous; Exudate color- pale red; Amount- small/minimal; R9 went up in brief size to prevent further injury to inner thighs Surveyor noted that R9's stage 3 left posterior thigh stage 3 pressure injury left posterior thigh pressure injury increased in size based on the facility's measurements and a new stage 2 pressure injury to R9's left medial thigh developed on 1/22/2026. R9's Care Plan indicated R9's left medial thigh pressure injury was added to the care plan as a care area on 1/23/2026, indicating R9 has impairment of skin with current pressure injuries to upper left posterior thigh and a medical device related pressure injury to inner thigh with no added interventions. Surveyor noted R9's medical device related pressure injury to R9's left medial thigh, was not assessed by the facility and the treatment was not initiated until 1/23/2026. On 1/29/26, the facility documents that both of R9's pressure injuries healed, and the action plan is to monitor for four weeks. Surveyor noted, 2/6/2026 through 2/20/2026 the Facility continued to observe R9's healed pressure injuries with no changes indicated. R9's Facility provided untitled document, dated 2/23/2026 documents: Area 1- left posterior upper thigh; Facility Acquired; Onset date 2/22/2026; Measurement- 1 x 5 x 0.1 cm; Wound Base- 100% granulation; Medical device related pressure injury; Exudate- serosanguinous; Exudate color- pale red; Amount- moderate; Reoccurred; Stage 3 ; Treatment- Thera Honey to wound base, cover with foam border bandage daily and as needed. R9's Facility provided document, titled Treatments, initiated on 2/23/2026, indicates: Left posterior upper thigh pressure injury- apply Thera Honey to wound base, cover with boarder foam dressing daily. On 03/02/2026, at 9:47 AM, Surveyor observed CNA-R and CNA-I assist R9 with getting undressed and perform a partial bed bath for R9, including incontinence cares. During this time. Surveyor noted dressings in place of R9's left posterior thigh pressure injury and noted a scant amount of red matter, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	consistent with the appearance of blood, to R9's brief around R9's left thigh area. Surveyor observed a large open wound to R9's left medial thigh. R9's left posterior thigh wound did not appear to be open but was left uncovered. R9's brief was changed and appeared to fit snug on R9's body. During conversation with R9, R9 indicated that the wounds are from scratches, some scratches are from R9 on the backside, others are from the staff putting the pamper too tight. R9 indicated sometimes R9 uses the urinal and sometimes is incontinent of urine.ˆSurveyor asked R9 if R9 can feel when the brief is too tight, R9 indicated yes and has mentioned it but most of the time they leave it and do not readjust it. Surveyor observed an open area to R9's left medial thigh, which was not documented in R9's chart. R9's medical chart was reviewed, and Surveyor could not locate any documentation regarding any open area to R9's left medial thigh. On 03/03/2026, at 1:22 PM, Surveyor observed Registered Nurse (RN)-T perform a wound treatment for R9. Surveyor noted R9 did not have a dressing in place to R9's stage 3, posterior left thigh pressure injury. Surveyor observed the open area to R9's left medial thigh, which was open with a small amount of blood visible and no covering over the wound. RN-T applied zinc oxide to R9's inner thighs, posterior thighs, and scrotum. Surveyor asked RN-T if RN-T was providing wound care to R9's pressure injury, RN-T informed Surveyor that RN-T is only performing R9's morning treatment to the denuded areas and the PM shift does the pressure injury wound treatment. RN-T indicated she would call Wound Nurse-G to come up to do the afternoon treatment for R9's pressure wounds. RN-T then went to the computer to verify R9's order and discovered R9's left posterior thigh wound has a different order than the zinc oxide. Surveyor observed R9's left posterior thigh, stage 3, pressure injury uncovered, without the ordered foam dressing in place. Surveyor observed RN-T provide incorrect treatment to R9's left posterior thigh, stage 3, pressure injury by applying Zinc Oxide over the wound, which is not the order for R9's left posterior thigh, stage 3, pressure injury. On 03/03/2026, at 1:41 PM, Wound Nurse-G came to R9's room. Wound Nurse-G informed Surveyor that R9's left posterior upper thigh should have Thera Honey and cover with foam dressing and not zinc oxide applied to it.ˆWound Nurse-G and Surveyor observed the stage 3 left posterior thigh wound, Wound Nurse-G indicated it looks healed but will do treatment as ordered. Wound Nurse-G informed Surveyor the wound is currently uncovered and that R9 has an order to have a foam boarder dressing in place and the zinc oxide for the denuded areas should be around the not on the wound. Wound Nurse-Gˆinformed Surveyor R9's left medial thigh wound has reopened and is new, and called out loud the following measurements, 7 x 1 x 0.1cm. Surveyor informed Wound Nurse-G that Surveyor observed the left medial thigh wound yesterday. Wound Nurse-G indicated Wound Nurse-G was not made aware and expect staff to notify the nurse when it was discovered and the nurse should have notified Wound Nurse-G call the wound Nurse Practitioner (NP)-Q, get an assessment and begin treatment. Wound Nurse-G indicated since that was not done, it caused a delay in R9's wound treatment. Surveyor observed the open wound to R9's left medial thigh on 3/02/2026 and noted the significant size of the wound. Surveyor noted R9's left medial thigh wound was not assessed and no treatment was ordered until 3/03/2026, when Surveyor brought it to Wound Nurse-G's attention. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 03/04/2026, at 3:01 PM, Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Clinical Nursing Officer-C, were informed of the concerns. On 03/05/2026, at 8:13 AM, Surveyor interviewedˆDON-B regarding R9's wound care and pressure injuries. DON-B indicated wounds that are pressure injuries would generally be followed by the outside wound care provider. Surveyor asked DON-B how DON-B oversees wound care information gathered, DON-B indicated DON-B has conversations with Wound Nurse-G to see how things are, if there is anything getting worse or improving and will co-sign the plan of care. ˆDON-B indicated DON-B will do the initial assessments of wounds and Wound Nurse-G will monitor and update R9's care plan. DON-B indicated interventions would be reassessed once recurrence of the wound happened and if not improving an order for ProSource for wound healing would be put in place. DON-B included weekly skin checks were completed by Wound Nurse-G and DON-B, and it is reviewed as a team. When Surveyor informed DON-B of Surveyors observations of improper wound treatment for R9's stage 3 left posterior thigh wound and the delay in reporting a stage 2 pressure injury to R9's left medial thigh, DON-B did not give a response and indicated Wound Nurse-G was tasked with gathering further information and DON-B would look further into everything. Surveyor noted that R9 was not seen by the Wound NP once R9's pressure injuries reopened, and no additional information was provided to Surveyor regarding the delayed reporting, assessment and treatment of R9's left medial thigh pressure injury. On 03/05/2026, at 8:27 AM, Surveyor interviewed Wound Nurse-G. Wound Nurse-G Informed Surveyor that R9's left posterior thigh pressure injury was caused by R9 wearing the incorrect brief size, causing friction. Wound Nurse-G increased R9's brief size and would look more into when exactly it was identified. Wound Nurse-G indicated R9 developed the stage 3 left posterior thigh wound on 12/26/2025 and healed 1/30/2026, was monitored for 4 weeks and was caused by positioning of R9's brief. R9 had the flu in January, which caused R9 to be in bed more and had increased incontinence. Wound Nurse-G noticed R9 wearing 2x briefs and changed them to 3x. Surveyor noted that the root cause of R9's pressure injuries was identified as R9's brief size. On 03/05/2026, at 9:55 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-P and CNA-V. CNA-P indicated R9 was wearing a green, size 2x briefs but they cut into R9 so R9 was switched to 3x briefs but does not remember when. CNA-V indicated the brief size goes based on weight and by seeing if the brief is too snug or too tight. CNA-V informed Surveyor there used to be list in clean hold of all resident sizes but not here anymore, so staff will just look at the person, and based on that, determine what size.ˆ On 03/05/2026, at 12:42 PM, Clinical Nursing Officer- C provided Surveyor with a document titled FITRIGHT How to use the FITRIGHT tape measure and indicated they typically use height and weight to determine brief sizing. For R9 brief size is determined by hip measurement and weight due to R9 having bilateral leg amputations. Surveyor noted could not locate R9's hip measurements in R9's electronic health record. Surveyor noted the last weight documented in R9's electronic health record was on 1/15/2025 under the vitals tab and indicated R9 weighed 258 pounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R9's weights are documented as: 8/18/2025, 256 pounds; 11/11/2025, 270 pounds; 1/19/2026, 270 pounds; 1/21/2026, 255 pounds. Surveyor noted that R9 is a bilateral lower extremity amputee. The facility did not addressR9's weight differences and how it could potentially mislead the facility's choice in brief size causing R9 to develop pressure injuries. On 03/05/2026, at 11:06 AM, Surveyor interviewed Wound Nurse Practitioner (NP)-Q. Wound NP-Q indicated she was supposed to start seeing R9 again last week but R9 was unavailable and will be going to see R9 today.ˆWound NP-Q indicated R9's left upper posterior thigh stage 3 pressure injury has reoccurred and they have now tried different briefs, which seemed to be a benefit and will evaluate effectiveness when seen today. No additional information was provided. 3.) R1 was admitted to the facility on [DATE] with diagnoses of idiopathic aseptic necrosis of the left toe, pneumonia, peripheral vascular disease, nicotine dependence, Type 1 diabetes mellitus, bipolar disorder, insomnia, and neuromuscular dysfunction of the bladder requiring an indwelling urinary catheter. R1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R1 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and had impairment to both arms and legs requiring assistance with all activities of daily living. The MDS documented R1 had one Deep Tissue Injury (DTI) on admission. On 1/29/2026, R1 was assessed by Nurse Practitioner (NP)-Q assisted by MDS/Wound Nurse-G. NP-Q documented R1 had a DTI to the left heel that measured 1 cm x 1 cm x 0.1 cm with 100% epithelial tissue that was dry and maroon in color. A treatment to apply Skin Prep to the area and cover with bordered foam daily and as needed was ordered. On 2/1/2026, R1 was sent to the hospital for evaluation and treatment of kidney pain. R1 was admitted to the hospital at that time. On 2/5/2026, R1 was readmitted to the facility. No documentation of a skin assessment was located. Treatment of the DTI to the left heel continued with Skin Prep and a bordered foam dressing daily and as needed. On 2/12/2026, R1 was assessed by NP-Q assisted by MDS/Wound Nurse-G. NP-Q documented R1's DTI to the left heel measured 3 cm x 3 cm x 0.1 cm with 100% epithelial tissue that was dry and maroon in color. The treatment continued as prior to hospitalization with the exception of the wound was covered by Optiview instead of a bordered foam dressing. On 3/2/2026 at 10:02 AM, Surveyor observed R1 lying in bed on an air mattress. R1 was covered in multiple blankets and had towels under the arms and sides. R1 stated the towels relieved pain to the back and preferred them to be placed there. Surveyor asked R1 if R1 had any wounds or daily treatments

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the physician was consulted with regarding a possible change in condition for 1 (R20) of 1 sampled Residents.On 2/19/26 R20's recorded weight was significantly less than their previous weight. The facility did not consult with R2's physician regarding the possible weight loss.Findings include:The facility's Physician Notification-Consultation Parameters last revised 1/22 documents:Definitions:1. Immediate Notification/Consultation: A physician should be informed and consulted at the time the event occurs (but not later than 1 hour after the condition is identified) directly or via an electronic or telephone call system.2. Non-immediate Notification: The attending physician should be informed of the event during normal office hours, and generally no later than the next regular office day. Consultation with the physician may be required if clinically warranted. If a non-immediate event occurs on a weekend or holiday, licensed nurses must determine if the notification can wait until the next office day or the on-call physician notified during day time hours.Unexplained Weight Loss or Weight Gain-5% or more within 30 days, 10% or more within 6 months.R20 was admitted to the facility on [DATE] with diagnoses of Alzheimer's (progressive disease that destroys memory and other important mental functions), Vascular Dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life) with Behavioral Disturbance, Type 2 Diabetes Mellitus (adult onset of trouble controlling blood sugar), Hypothyroidism (underactive thyroid), Hyperlipidemia (high levels of fat particles in blood), Chronic Kidney Disease (progressive damage and loss of function in the kidneys), and Hypertensive Heart Disease (long term conditions developed from chronic high blood pressure).R20's Significant Change Minimum Data Set (MDS) with an assessment reference date of 12/3/25 assesses R20 has both short- and long-term memory impairments and demonstrates severely impaired skills for daily decision making. R20's MDS assesses R20 has no range of motion impairment, requires set-up for eating. R20's MDS assesses R20 holds food in mouth, no current weight loss, and is on a mechanically altered diet.Surveyor reviewed R20's monthly weights. On 12/17/25, R20's documented weight was 141 pounds. On 2/19/26, R20's documented weight was 118 pounds. The calculated weight loss from 12/12/25 to 2/19/26 is 16.31%.On 2/25/2026, at 6:54 PM, Registered Dietician (RD)-K documented R20 has a significant weight loss of 17 pounds. RD-K discussed with Registered Nurse (RN) who will obtain a re-weight to assess weight accuracy as previously weight has been stable.On 3/04/2026, at 7:53 AM, Surveyor completed a thorough review of R20's electronic medical record (EMR) and paper chart. Surveyor was unable to locate any documentation that R20's physician had been consulted with regarding R20's significant weight loss of 16.31% from 12/12/25 to 2/19/26. R20's re-weight was never obtained. Surveyor reviewed R20's nutrition care plan and notes R20's nutrition care plan has not been updated since 12/9/25.On 3/04/2026, at 12:14 PM, Surveyor spoke to RD-K via telephone. RD-K stated that if R20 had a significant weight loss, RD-K would implement high protein and high calorie added to daily meals. RD-K does not know who notifies a physician of a significant weight loss.On 3/04/2026, at 3:00 PM, Surveyor shared the concern with NHA-A, DON-B, and Clinical Nursing Officer (CNO)-C that R20's physician had not been consulted with regarding R20's significant 16.31% weight loss.On 3/05/2026, at 12:14 PM, Surveyor interviewed Director of Nursing (DON)-B and asked when a physician should be notified. DON-B stated that it would be for weight loss, chance of condition, falls, abnormal labs, etc. DON-B stated there is a form at each nurse's station that states when a nurse should contact a physician either for immediate notification or non-immediate notification.On 3/09/2026, CNO-C sent additional information to review indicating R20 was re-weighed during the survey and R20's weight was 140 pounds. CNO-C stated the facility believes the 2/19/26 weight was wrong. Surveyor shared Surveyor still has a concern that this was not addressed as requested by the registered dietitian (RD)-K and there is no physician notification.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and interview, the facility did not ensure employees were screened for abuse prior to working at the facility. This was observed in 4 (M, N, O and P) of 8 staff reviewed.*Certified Nursing Assistant (CNA)-M was hired on 6/27/25 and worked out of state. The other state background check was not completed by their hire date.*Dietary Manager (DM) - N was hired on 1/9/25. Their Background Information Disclosure (BID) was not signed and dated. The Departement of Justice (DOJ) was not completed until 3/2/26. The Integrated Background Information System (IBIS) was not completed until 3/2/26.*CNA-O was hired on 1/19/26 and worked out of state. The other state background check was not completed by their hire date.* CNA-P was hired on 6/17/25. The DOJ was not completed until 7/2/25. The IBIS was not completed until 7/2/25.Findings include:The facility policy and procedure Resident Safe Abuse Policy dated 3/24 was reviewed. Protocol: 3. Procedures:a. ii. All Employees shall have a criminal background check.1. Initial and any required future background checks will be conducted in accordance with applicable state and federal laws checks may include criminal history, state caregiver registry, Office of the Inspector General (O IG), and exclusion lists. The type, frequency, and timing of checks will be in accordance with applicable state and federal law.1.) Surveyor reviewed the criminal background checks for CNA-M. CNA-M was hired on 6/27/25 and works as needed in the facility. CNA-M completed a BID upon hire and disclosed they worked in another state within the last 3 years. The other state background screening was not completed.On 3/03/2026, at 9:30 AM, Surveyor interviewed the Nursing Home Administrator (NHA) -A, who has been completing the employee background screenings. The NHA-A stated they did not run an out of state background check on CNA-M. 2.) Surveyor reviewed the criminal background checks for DM-N. DM-N was hired on 1/9/25 and works full-time in the facility. DM-N completed a BID and did not sign, or date, the document. DM-N DOJ, and IBIS, was completed on 3/2/26 after their hire date.On 3/03/2026, at 9:30 AM, Surveyor interviewed the Nursing Home Administrator (NHA) -A, who has been completing the employee background screenings. The NHA-A stated there have been changes in staff and they identified the screenings were not being completed.3.) Surveyor reviewed the criminal background checks for CNA-O. CNA-O was hired on 1/19/26 and works part-time in the facility. CNA-O disclosed on a BID upon hire they worked in another state within the last 3 years. The out of state background screening was not completed.On 3/03/2026, at 9:30 AM, Surveyor interviewed the Nursing Home Administrator (NHA) -A, who has been completing the employee background screenings. The NHA-A stated they did not run an out of state background check on CNA-O.4.) Surveyor reviewed the criminal background checks for CNA-P. CNA-P was hired on 6/17/25 and works part-time in the facility. CNA-P's DOJ, and IBIS were completed on 7/2/25, after their hire date.On 3/03/2026, at 9:30 AM, Surveyor interviewed the Nursing Home Administrator (NHA) -A, who has been completing the employee background screenings. The NHA-A stated there have been changes in staff and they identified the screenings were not being completed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility did not ensure the environment remained free of accident hazards with smoking materials for 3 (R1, R2, and R16) of 4 residents reviewed for smoking and residents received adequate supervision to prevent accidents for 1 (R20) of 4 residents reviewed for falls. *R1 was observed to be vaping while lying in bed. R1 did not have smoking assessments completed on a quarterly basis. *R2 was observed to have smoking materials in the room; R2's Care Plan documented R2 may not possess any smoking materials including a lighter and all smoking materials were to be kept with the nurse for distribution as requested. R2 did not have smoking assessments completed on a quarterly basis. *R16 did not have smoking assessments completed on a quarterly basis. *R20 had three falls that were not thoroughly investigated including identifying a root cause analysis. Observations of interventions of call light within reach and to be laid down after lunch were not implemented during the survey. Findings include: The facility policy and procedure titled Smoking, Vaping and Tobacco Free Policy dated 6/2025 documents: Protocol: 1. The facility prohibits smoking, vaping and tobacco use on all company premises in order to provide and maintain a safe and healthy environment for all. a. Company premises is defined as up to the property boundaries* of all facilities. *With the exception of the southeast corner of the courtyard on the east side of the building. Prior to resident smoking, a smoking assessment shall be completed in the electronic charting system. 2. The company defines smoking and tobacco use as the 'act of lighting, smoking or carrying or using a lighted or smoldering cigar, cigarette, pipes of any kind, smokeless or electronic cigarettes/vaping materials, dipping tobacco, or chewing tobacco.' 3. The smoke and tobacco free policy applies to: a. All areas of buildings occupied by residents and employees. b. All vehicles owned or leased by the facility. c. All visitors (customers, vendors and volunteers) on facility premises. d. All contractors and consultants and/or their employees working on facility premises. e. All residents. 5. Employees are not allowed to assist residents in smoking or chewing as they are not allowed to leave the campus property while working. Families that wish to assist residents may do so after signing the resident out of the Resident Sign Out Form and leaving campus property. 6. Residents who violate this smoke and tobacco use policy may be subject to discharge per the facility admission agreement. 1.) R1 was admitted to the facility on [DATE] with diagnoses of idiopathic aseptic necrosis of the left toe, pneumonia, peripheral vascular disease, nicotine dependence, Type 1 diabetes mellitus, bipolar disorder, insomnia, and neuromuscular dysfunction of the bladder requiring an indwelling urinary catheter. R1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R1 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and had impairment to both arms and legs requiring assistance with all activities of daily living. The admission MDS dated [DATE] documented R1 smoked. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/6/2025, R1 had an admission smoking assessment completed that documented R1 was able to verbalized understanding of the policy, follows directions well, cooperative, participative, alert and oriented times four, is able to recall the long past, is able to make decisions which are consistent and reasonable, can hold cigarettes safely, lights and extinguishes cigarettes safely, and is physically capable of managing smoking materials. The assessment determined R1 needed assistance by staff to bring R1 in and out of the facility when R1 goes for a cigarette. No other smoking assessments were documented. R1's Alteration in Health Maintenance Care Plan initiated on 11/14/2025 has the following nursing interventions: -Nurses will perform safe smoking assessment. -(R1) will be educated on facility smoking protocols and designated smoking areas. -(R1) is aware there is to be no smoking in rom and no smoking in proximity of oxygen. -The nurse will assist (R1) with obtaining smoking cessation material if requested. (R1's) Alteration in Health Maintenance Care Plan initiated on 11/14/2025 has the following Certified Nursing Assistant (CNA) interventions: -CNA will assess (R1) for safe smoking and following of facility protocol with routine cares. -All staff will observe (R1) is safely smoking with interactions and following facility protocols. -Any suspected or observed noncompliance will be reported immediately to the nurse. -If (R1) expresses desire for cessation, report to the nurse. On 3/2/2026 at 10:04 AM, Surveyor entered R1's room. R1 was lying in bed on an air mattress, covered in multiple thick blankets. Surveyor asked R1 general questions regarding the care R1 had been receiving and any concerns with that care. As Surveyor was talking to R1, R1 took out from below the covers an electronic cigarette and began smoking. Surveyor asked R1 if R1 was vaping. R1 said yes. Surveyor asked R1 if that was allowed in resident rooms. R1 stated no, but if they do not see it, they cannot take it away. In an interview on 3/3/2026 at 12:35 PM, Surveyor asked CNA-L what the facility policy was for smoking or vaping. CNA-L stated residents are supposed to go outside in the smoking area. CNA-L stated most residents are independent, so they go out on their own. Surveyor asked CNA-L what would be done if a resident was smoking or vaping in their room. CNA-L stated CNA-L would tell the nurse and the nurse would relay it to whomever needed to know. In an interview on 3/3/2026 at 12:40 PM, Surveyor asked Registered Nurse (RN)-D what the facility policy was for smoking or vaping. RN-D stated the residents cannot smoke in their room; there is a designated area in the front with ash trays. RN-D stated if they are caught smoking in their room, the cigarettes are taken away and they are put in the nurse's cart. RN-D stated the residents can ask for their cigarettes on their way outside. Surveyor asked RN-D if there had been any problems in the past with R1 smoking or vaping in their room. RN-D stated R1 and R1's husband are in the room together (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	visiting and you can smell smoke, but they have never been caught smoking in the room. RN-D stated the resident has to be caught in the act of smoking, then they can confiscate the smoking materials, but they must be caught actively vaping. Surveyor shared with RN-D the observation of R1 vaping in the bed the previous morning. RN-D stated RN-D cannot act on hearsay to do anything with R1 and R1's smoking materials. In an interview on 3/3/2026 at 12:49 PM, Surveyor asked Social Service Designee (SSD)-H what the facility policy was for smoking or vaping. SSD-H stated residents cannot smoke in their rooms, they have to be able to take care of their smoking on their own, such as lighting, holding, and extinguishing the cigarette. SSD-H stated a smoking assessment is completed when the resident is admitted where the resident is watched while they smoke to make sure they can be independent. SSD-H reiterated residents cannot smoke in their rooms, they have to be deemed a safe smoker through the assessment, and they must not require any assistance from staff in any way while smoking. Surveyor asked SSD-H what would happen if a resident is caught smoking or vaping in their room. SSD-H stated Nursing Home Administrator (NHA)-A says it cannot be hearsay, someone has to actually see them smoking; it cannot just be the smell of cigarettes or a cigarette butt on the floor. SSD-H stated a letter was distributed to all residents and resident representatives about the smoking policy that stated if a resident is caught smoking somewhere other than the designated smoking area, they will be given a 30-day notice. SSD-H stated the resident has to be physically seen, not just gossip. SSD-H stated NHA-A put smoke detectors in some resident rooms to alert them if someone is smoking in the room. Surveyor asked if the policy applied to vaping as well. SSD-H stated yes. SSD-H stated they will remove smoking materials or vaping materials if the resident is observed doing either in their room. Surveyor shared the observation of R1 vaping during a conversation the day before. SSD-H stated SSD-H will report that to NHA-A. Surveyor shared with SSD-H that Surveyor had reported to RN-D the same observation and RN-D's response of not accepting hearsay and needing to actively see R1 vaping. Surveyor shared with SSD-H R1's response when asked about vaping: R1 admitted to vaping and if facility staff do not see R1 vaping, they cannot do anything about it so R1 does not vape in front of any staff but continues to vape in bed with no one observing. SSD-H stated RN-D should have reported R1 vaping in bed and would do so at that time. On 3/4/2026 at 3:00 PM, Surveyor shared with NHA-A and Director of Nursing (DON)-B the concern R1 was actively vaping in bed while Surveyor was in the room talking with R1. Surveyor shared with NHA-A RN-D's response and the conversation with SSD-H. NHA-A stated SSD-H had communicated the concern with NHA-A and NHA-A would address the issue. Surveyor shared with NHA-A and DON-B the concern R1 had not had a quarterly smoking assessment following the initial admission assessment. 2.) R2 was admitted on [DATE] with diagnoses of Schizoaffective Disorder (mental health condition with hallucinations, delusions, and other mood disorders like depression – this affects how people think, act and feel which can greatly hinder day to day activities), Nicotine Dependence – cigarettes, and Left Hemiballismus (severe movement disorder characterized by involuntary, violent, flinging movements of the left arm and leg). R2's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated R2 is cognitively intact. R2 has no limb impairment. R2 is independent for eating, oral hygiene, toileting, bed mobility; R2 requires set up assist for showering, and personal hygiene, transferring; R2 requires supervision for upper body dressing; R2 requires partial assist with lower body dressing, footwear. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's care plan initiated 3/27/24 documented the following an Alteration in health maintenance, R2 is a long term smoker. Initiated 1/28/26 – nurses will perform safe smoking assessment is educated on facility smoking protocols and designated smoking areas. (R2) may not possess any smoking materials including lighter. All smoking materials are to be kept with the nurse for distribution to (R2) as requested. (R2) is aware no smoking in room and no smoking in proximity of oxygen, nurse to assist (R2) with obtaining smoking cessation material if requested. Initiated 3/27/2024 - nurse aid will assess (R2) for safe smoking and following a facility protocol. Update nurse with suspected noncompliance. R2's Certified Nursing Assistant (CNA) assignment sheet, which indicated to CNA staff how to care for R2, documented (R2) is a smoker, report any safety or health concerns related to smoking to nurse. Resident may not have in his possess any smoking materials such as cigarettes/cigars/lighters. These items must be kept in the nurses station/Med room and (R2) must ask for materials to go outside to smoke and return them to the nurse when returns to floor. No exceptions. Staff to report any smells/ signs of smoking in room to nurse immediately and document on CNA lineup sheets and 24 hour boards. Nurse is to notify administration of any incidents of observing students smoking in the facility or having smoking materials in room. R2's quarterly Smoking assessments documented: 6/6/25 (R2) is able to Verbalize understanding of policy dims equals 13 cooperative participative oriented to time oriented to person oriented to place oriented to situation. Short term memory OK long term memory OK. Able to make decisions which are consistent and reasonable. Hold cigarettes safely yes, lights and extinguishes cigarettes safely yes, physically capable of managing smoking materials yes, residents smoking history our 2 has smoked for many years, expressed desire to quit smoking no, requires assistance to quit no. Independent with all aspects of smoking. 11/3/25 Resident is able to verbalize understanding of policy bims is 13 cooperative participative oriented to time oriented to person oriented to place oriented to situation. Short term memory OK long term memory OK. Able to make decisions which are consistent and reasonable. Physically capable of managing smoking materials 1/23/26 Smoking assessment: extreme cold weather education to resident provided education regarding risks of smoking outdoors and temperatures below freezing. Discussed increased risk of vasoconstriction, elevated blood pressure, and potential for rapid hypothermia/ frostbite due to smoking induced reduced circulation. Patient advised to wear thermal layers, hat, and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves, and to limit outdoor time to less than 5 minutes. Patient verbalized understanding of risks. Educated patient on safety precautions when leaving to smoke during extreme cold advisory. Advised using a buddy system or notifying staff/ family before going out. Recommended having a warm drink immediately upon returning. Residents stated he will follow all suggestions and if possible he will limit his smoking for today due to extreme cold weather. A progress note written by Director of Nursing (DON)-B dated 1/28/26 at 1:05 PM documented: Nurses will perform safe smoking assessment, resident is educated on facility smoking protocols and designated smoking areas. Resident may not possess any smoking materials including lighter. All smoking materials are to be kept with the Nurse for distribution to resident as requested. Resident is aware no smoking in room and no smoking in proximity of oxygen, nurse to assist resident with obtaining smoking cessation material if requested. On 3/2/26, at 9:36 AM, Surveyor interviewed R2 who informed surveyor that R2 was smoking in R2's room and was caught by the facility. R2 stated R2 has to give the nurse R2's smoking materials. R2 stated R2 cannot have smoking materials in R2's room. Surveyor observed a lighter in R2's pocket and multiple cigarettes of various lengths in R2's pocket. Surveyor observed multiple cigarettes of various lengths on R2's windowsill by R2's bed. On 3/2/26, at 3:17 PM, Surveyor interviewed DON-B. DON-B stated all residents are considered independent, some we will collect smoking materials. There are no supervised smokers as the facility cannot force staff to be near cigarette smoke. DON-B stated assessments are done quarterly or if there is a change in smoking status. On 3/3/26, at 9:20 AM, Surveyor interviewed Registered Nurse (RN)-N. RN-N stated R2 is on the list of residents who cannot have smoking materials. RN-N stated RN-N only takes R2's lighter and does not take R2's cigarettes. RN-N stated RN-N should probably take R2's cigarettes as well, but R2 can't smoke without R2's lighter. On 3/3/26, at 11:54 AM, Surveyor observed R2's room. There was 1 cigarette on R2's windowsill and a green lighter in R2's bed. On 3/3/26, at 3:13 PM, Surveyor interviewed DON-B. DON-B stated nurses are to complete the smoking assessments quarterly. DON-B stated the assessments can be completed anytime within the quarter, as long as the assessment is completed. On 3/4/26, at 3:13 PM, Surveyor observed a cigarette on R2's windowsill in R2's room. On 3/4/26, at 3:49 PM, Surveyor informed DON-B that R2 has 3 missing quarterly assessments. January 2025 through March 2025, July 2025 through September 2025, January 2026 through March 2026. Surveyor informed DON-B R2 was observed to have smoking materials in R2's room and possession while not smoking or going to smoke. On 3/5/26, at 7:47 AM, DON-B informed Surveyor all smoking materials are to be collected for R2. This includes cigarettes, vapes, lighters, cigars, chewing Tobacco, and more. The Facility did not have any additional information regarding R2's smoking assessments. 3) R16 was admitted to the facility on [DATE]. R16's Quarterly Minimum Data Set (MDS) completed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/22/26 documents R16's Brief Interview for Mental Status (BIMS) score to be 11, indicating R16 demonstrates moderately impaired skills for daily decision making. R16's comprehensive care plan for alteration in health maintenance effective 4/7/25 indicates: , R16 is a long term smoker. Interventions effective 4/7/25 include: -nurses will perform safe smoking assessment, resident will be educated on facility smoking protocols and designated smoking areas. Resident is aware there is to be no smoking in room and no smoking in proximity of oxygen, nurse will assist resident with obtaining smoking cessation material if requested. CNA (Certified Nursing Assistant) will assist resident for safe smoking and following of facility protocol with routine cares, all staff will observe resident is safely smoking with interactions and following of facility protocols. Any suspected or observed noncompliance will be reported immediately to nurse. If resident expresses desire for cessation-report to nurse On 1/23/26, there is a note in R16's record indicating Director of Nursing (DON)-B documented that they provided education to R16 regarding risks of smoking outdoors in temperatures below freezing. Review of R16's smoking assessments indicate the most recently completed assessment is dated 4/7/25. This assessment indicates R16 is independent with smoking. No other assessments were noted in R16's medical record. On 3/02/2026, at 3:09 PM, Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were interviewed about the facility's smoking policy. NHA-A explained there is no supervised smoking. The policy is that residents will manage smoking materials independently in the smoking area. NHA-A stated the expectation is that smoking assessments are completed quarterly and updated as needed. NHA-A explained if a resident cannot handle their smoking materials, it is handled case by case. NHA-A stated, we can't provide assistance due to the clean air act. Surveyor asked what other options for smoking the facility provides. NHA-A stated the facility would provide gum or the patch. On 3/03/2026, at 3:04 PM, Surveyor interviewed DON-B about R16's smoking assessments and that one has not been completed since 4/7/25 despite R16 still smoking. DON-B shared that either themselves or the Minimum Data Set nurse (MDS)-G completes the smoking assessments, and the expectation is that the smoking assessments are to be completed on a quarterly basis. On 3/04/202, at 3:00 PM, Surveyor shared the concern with NHA-A, DON-B, and Clinical Nursing Officer (CNO)-C that R16's smoking assessment had not been completed on a quarterly basis. On 3/05/2026, at 8:00 AM, Surveyor was provided a completed smoking assessment dated [DATE] documenting R16 is independent with all aspects of smoking. 4) R20 was admitted to the facility on [DATE] with diagnoses of Alzheimer's (progressive disease that destroys memory and other important mental functions), Vascular Dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life) with Behavioral Disturbance R20's Significant Change Minimum Data Set (MDS) with an assessment reference date of 12/3/25 documents for assessment R20 has both short- and long-term memory impairments and demonstrates severely impaired skills for daily decision making. R20's MDS documents R20 has no range of motion impairment and is always incontinent of bowel and bladder. R20 is dependent on toileting hygiene, showers, upper and lower dressing and requires substantial/maximum assistance for mobility and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transfers. R20's MDS also documents that R20 has had falls since the last assessment. The following completed fall assessments document: 6/2/25-continue current care plan for risk of falls 9/8/25-is at risk for falls due to unstable gait, continue current plan of care 11/25/25-is at risk for falls and prefers to nap and will be transferred to bed after lunch for a rest period 12/3/25- is at risk for falls and will revise fall care plan 2/12/26- is at risk for falls and staff to follow care plan transfer to bed following lunch for a rest period R20's comprehensive care plan documents: Potential for Trauma-falls injury manifested by history of falls 10/18/22 Interventions in place: -Nurses-observe, record, and report all unsafe conditions and situations, assess change in level of consciousness, encourage to ask for assistance, assure resident is wearing proper fitting shoes 7/30/24 -CNA (Certified Nursing Assistant) -ensure footwear properly fitting or wearing gripper socks 9/9/23 -CNA-call light in reach, encourage to ask for assistance, monitor whereabouts, report wandering behavior to nurse on unit, monitor for presence of wanderguard every shift, report to nurse if not present, update nurse if shoes are not fitting 7/30/24 -CNA-resident can be assisted to room after lunch meal for rest period in bed 11/25/25 R20's CNA Assignment Sheet documents there should be a pool noodle on the headboard of the bed. Assist resident to bed after lunch for afternoon nap. Ensure that resident's head is away from footboard/headboard to prevent accidental bump. R20 Resident assist of 1 at times, assist of 2 if resident is weak. R20 has had 4 falls since 11/25/25: Review of R20's record indicates on 11/25/2025, R20 had an unwitnessed fall sometime during NOC (night) shift. R20 was found about 7:30 AM on the ground. R20 sustained 0.1 x 3.5 x 0.1 laceration at right eyebrow. Documentation indicates: intervention applied immediately is to have R20 in day room during the day, to watch for behaviors, and decrease risk of R20 hitting head on headboard. Surveyor requested the full fall investigation for this fall which was not provided by the facility during the survey (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/25/2025, at 2:30 PM, R20 had a 2nd fall. This fall was a witnessed fall in the living room. The documented intervention applied immediately was for R20 to be taken to room and made comfortable in bed for afternoon rest period. The facility's 11/25/25 fall investigation documents that Certified Nursing Assistant (CNA)-P was in the living room with R20 but did not see R20 fall. CNA-W and Nurse Manager (NM)-E stated that they observed R20 stand from couch, lean forward, and reach for the second couch when R20 fell. The intervention post fall is to assist R20 to bed after lunch. On 1/04/2026, at 7:10 PM, R20 had an unwitnessed fall and was found on the ground in R20's room. The documented intervention applied immediately post fall is gripper socks/appropriate footwear. The facility's fall investigation dated 1/4/26 does not document a root/cause analysis. The fall investigation has no documented staff statements. The fall investigation documents R20's care plan will not be updated. Post fall despite recommended immediate interventions suggested for R20 to wear gripper socks/appropriate footwear. On 2/12/2026, at 2:00 PM, R20 had an unwitnessed fall and was found on the ground in the television room. The documented intervention applied immediately post fall was to assist R20 to bed for rest period after lunchSurveyor noted that after the 11/25/25 fall, the intervention for safety was for R20 to be assisted to bed after lunch for a rest period. R20 fell again in the living room area at 2:00 PM at which time R20 should have been in bed resting according to their recommended post fall interventions documentation. The facility's fall investigation dated 2/12/26 does not document a root/cause analysis. The fall investigation has no documented staff statements. On 3/02/2026, at 11:44 AM, Surveyor observed R20 in bed sleeping and noted a pool noodle on the top of R20's headboard. Surveyor observed R20's call light on the floor, not within reach. On 3/02/2026, at 1:43 PM, Surveyor observed R20 sitting in a high back chair in the left hand corner of R20's room. R20 had an overbed table in front of them. R20's call light was on the floor, not within reach. On 3/03/2026, at 7:07 AM, Surveyor observed R20 in bed sleeping, and the call light was observed to be on the floor. On 3/03/2026, at 9:29 AM, Surveyor observed R20 sitting in a high back chair with the overbed table in front of R20. Surveyor observed the call light was on the floor, not within reach of R20. On 3/03/2026, at 12:59 PM, Surveyor observed R20 sitting in a high back chair in same spot as earlier with the overbed table in front of them. Surveyor observed the call light was on the floor not within reach. On 3/03/2026, at 1:01 PM, Surveyor interviewed CNA-I. CNA-I informed Surveyor that R20 can use the call light and has used it in the past. CNA-I stated that R20 used the call light a lot in the past. On 3/03/2026, at 3:31 PM, Surveyor observed R20 in bed sleeping. R20's call light was observed to be on the floor. On 3/04/2026, at 7:15 AM, Surveyor observed R20 in bed sleeping. R20's call light was observed to be (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on the floor. On 3/04/2026, at 12:46 PM, Surveyor observed R20 sitting on the edge of the bed with the overbed table in front of R20. Surveyor observed the call light on the floor, not within reach. Surveyor then observed R20 lay down on the bed from a sitting position. R20's call light remained on the floor out of R20's reach. On 3/03/2026, at 3:04 PM, Surveyor interviewed Director of Nursing (DON)-B about the facility fall assessments. DON-B stated that it is the responsibility of the staff nurse to complete the facility fall investigations along with the incident report. There is a checklist that they are to use to review the elements of care plan changes, including making changes to interventions. The falls are reviewed by the IDT (interdisciplinary team). DON-B stated that the CNA assignment sheet should also be updated with changes in fall interventions.

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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 record review and interviews, the facility did not ensure allegations of misappropriation of funds and neglect for two (R19 and R10) of 2 sampled residents were not reported as required. *R19 informed staff of missing money on 1/21/26 and this allegation was not reported to the State Survey Agency. *An allegation of neglect directly affecting R10 was not reported to the State Survey Agency. Findings include: The facility's Resident Safety Abuse Policy last revised 2/22 documents: Purpose: It is the policy of our facility to maintain a work and living environment that is professional and free from threat and/or occurrence of harassment, abuse (verbal, physical, mental, or sexual), neglect, corporal punishment, involuntary seclusion, physical or chemical restraints not required to treat the resident's medical symptoms, exploitation and misappropriation of resident property. Providing a safe environment is one of the most basic and essential duties of the facility. Employees have a unique position of trust with vulnerable residents. Having access to private information, being in a physically intrusive position and having elevated status and special relationships with residents, makes ethical and professional behavior essential. Our facility promotes an atmosphere of sharing with residents and staff without fear of retribution. Residents have the right to be free from abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, visitors, friends, or other individuals. This system cannot guarantee that abuse will never occur. It can only assure that the facility is doing all that is within its control to prevent occurrences. 8. Reporting Suspected Violations: a. The supervisor on duty shall IMMEDIATELY safeguard the resident(s) and immediately report all alleged violations involving abuse, neglect, mistreatment, exploitation, including injuries of unknown source and misappropriation of resident property to the facility administrator. The administrator will notify the director of nursing and/or others as appropriate. b. The administrator will report a reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from the facility to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located. c. The administrator shall report immediately, but not later than 2 hours after forming the suspicion, if (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. f. The administrator shall also report the results of all investigations to other officials in accordance with state law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 1.) R19 was admitted to the facility on [DATE]. R19's Quarterly Minimum Data Set (MDS) completed 2/10/26 documents R19's Brief Interview for Mental Status (BIMS) score to be 5 indicating R19 demonstrates severely impaired skills for daily decision making. On 3/02/2026, at 9:28 AM, R19 informed Surveyor that R19 does not know what is happening with R19's money. On 3/03/2026, at 9:22 AM, R19 greeted Surveyor by name as Surveyor approached R19. R19 was able to provide the current day, month and year to surveyor. R19 informed Surveyor that R19 recalls withdrawing $110 and reported approximately $60 missing to a staff member downstairs. R19 shared it was about 7 days after they took the money out. R19 called her Red because she had red hair, white, bigger girl, still works here and would go to the store for me. Not sure if it was her. R19 reported being left $13. R19 reported it but does not know if the facility did an investigation. On 3/03/2026, at 12:25 PM, Surveyor interviewed R19's Guardian via telephone. (Guardian)-U informed Surveyor that Guardian-U is unaware of R19 having any missing money. On 3/03/2026, at 1:41 PM, Surveyor was provided with a withdrawal slip dated 1/17/26 documenting R19 signed for $110 received. On 3/04/2026, at 10:20 AM, Surveyor interviewed Social Services Designee (SSD)-H. SSD-H had no knowledge of R19 alleging money was taken. On 3/04/2026, at 10:44 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and asked about R19's allegation of funds being taken. NHA-A confirmed NHA-A was aware of that R19 alleged they were missing money. NHA-A informed Surveyor that NHA-A did not report R19's allegation of missing money because R19 is confused and uncertain as to exactly how much was actually missing. NHA-A shared R19 has a history of false accusations, and it is care planned. NHA-A also stated, Doesn't it matter that the guardian doesn't think anything happened? Surveyor shared it is a concern that there was an allegation of misappropriation of funds, and a facility reported incident (FRI) was not submitted. 2.) R10 was readmitted to the facility on [DATE]. R10's Quarterly MDS, dated [DATE], indicates R10 has a Brief Interview for Mental Status (BIMS) score of 14 with intact cognition, no behaviors or rejection of care, requires supervision or touching assistance to sit to stand, supervision or touching assistance with transfers, able to walk 10 feet with supervision or touching assistance, takes high risk medications and had 2 or more falls since admission/reentry. The Facility provided document, titled Grievance Investigation, dated 11/25/2025 indicates the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Summary Statement: Adult Protective Services (APS) received an anonymous complaint regarding (R10) having a fall on 10/26/2025 and staff refused to send (R10) to the hospital. The complaint also indicates (R10) had a fall on 11/1/2025 and staff did not come to assist (R10) after putting on the call light. Name and title of person(s) interviewed: APS attempted to interview R10 but was unable to answer questions. APS discussed competency evaluation and guardianship referral. Steps taken to investigate grievance: APS visited R10 again on 12/3/2025, no new concerns expressed. Summary of Investigation findings and conclusion: -file/incident review- no incident on 11/1/2025 -10/26/2025- observed on floor, daughter was called and was not at the Facility -readmit 10/16 post psych inpatient stay -10/31 hip pain while in therapy, spoke with daughter, no verbal complaints. On 11/1/2025 R10 went to target with daughter, daughter took R10 to hospital for evaluation then R10 returned to the Facility via ambulance. Per daughter, R10 was placed in car funny and complained of left hip pain. Was grievance confirmed or not confirmed? Not confirmed Signed by Nursing Home Administrator (NHA)-A on 12/3/2025. On 03/05/2026, at 12:05 PM, Surveyor interviewed NHA-A. NHA-A indicated APS reached out to him regarding a complaint involving R10 falling on 10/26/2025 and allegations staff refused to send R10 to the hospital. After APS reached out, NHA-A began to look at the fall history for R10 and piece things together. NHA-A indicated the allegation was staff refused to send R10 to the hospital, but NHA-A did not see that occurred during the investigation. NHA-A indicated he did not interview staff but did a record review and could see in the record that R10 did not go out to the hospital and what NHA-A found is that the incident on 11/1/2025 occurred while R10 was with R10's daughter from a nurse's note. NHA-A does not believe this allegation should have been sent to the State Agency because the allegation could not be verified and questioned the validity of the allegation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility did not ensure allegations involving potential misappropriation of funds and neglect were thoroughly investigated for 2 Residents (R19 and R10) of 2 sampled Residents. *R19 informed staff of missing money on 1/21/26 and this allegation was not thoroughly investigated by the facility. *An allegation of neglect directly affecting R10 was not thoroughly investigated by the facility. Findings include: The facility's Resident Safety Abuse Policy last revised 2/22 documents: Purpose It is the policy of our facility to maintain a work and living environment that is professional and free from threat and/or occurrence of harassment, abuse (verbal, physical, mental, or sexual), neglect, corporal punishment, involuntary seclusion, physical or chemical restraints not required to treat the resident's medical symptoms, exploitation and misappropriation of resident property. Providing a safe environment is one of the most basic and essential duties of the facility. Employees have a unique position of trust with vulnerable residents. Having access to private information, being in a physically intrusive position and having elevated status and special relationships with residents, makes ethical and professional behavior essential. Our facility promotes an atmosphere of sharing with residents and staff without fear of retribution. Residents have the right to be free from abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, visitors, friends, or other individuals. This system cannot guarantee that abuse will never occur. It can only assure that the facility is doing all that is within its control to prevent occurrences . 9. Procedure For Investigation: a. All alleged violations will be thoroughly investigated, and all investigations are conducted by or coordinated through facility administration. d. The supervisor will ensure that resident(s) is/are protected from further potential abuse, neglect, mistreatment while the investigation is in progress. e. An incident report and investigation must be completed for any violations of this policy using the facility incident report in ECS or narrative statements. i. All witnesses or involved parties will be interviewed giving their own description of the incident and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will be recorded by QAPI Leader and/or supervisor on duty. These records will become part of the permanent investigation file. -The QAPI Leader and/or supervisor on duty will interview the residents as well as any nursing, housekeeping, laundry, dietary, activity, or social service staff, any visitors or other who may have knowledge of the occurrence or who may have been in the vicinity at the time the incident happened. l. The Administrator will be the custodian of all documents generated during the course of the investigation. m. The facility must have evidence that all alleged violations are thoroughly investigated. n. These documents will be identified as QAPI documents and will be reviewed by the QAPI Committee for re-evaluation of the policies and procedures and for revision of the same policies and procedures if warranted to prevent further occurrences. 1.) R19 was admitted to the facility on [DATE]. R19's Quarterly Minimum Data Set (MDS) completed 2/10/26 documents R19's Brief Interview for Mental Status (BIMS) score to be 5 indicating R19 demonstrates severely impaired skills for daily decision making. On 3/02/2026, at 9:28 AM, R19 informed Surveyor that R19 does not know what is happening with R19's money. On 3/03/2026, at 9:22 AM, R19 greeted Surveyor by name as Surveyor approached R19. R19 was able to provide the current day, month and year to surveyor. R19 informed Surveyor that R19 recalls withdrawing $110 and reported approximately $60 missing to a staff member downstairs. R19 shared it was about 7 days after they took the money out. R19 referred to the person they gave the money to as Red because she had red hair, white, bigger girl, still works here and would go to the store for me. Not sure if it was her. R19 reported being left $13. R19 reported it but does not know if the facility did an investigation. On 3/03/2026, at 12:25 PM, Surveyor interviewed R19's Guardian via telephone. (Guardian)-U informed Surveyor that Guardian-U was unaware of any missing money from R19. On 3/03/2026, at 1:41 PM, Surveyor was provided with a withdrawal slip by the facility dated 1/17/26 documenting R19 signed for $110 received. On 3/04/2026, at 10:44 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A confirmed NHA-A was aware that R19 had communicated an allegation of missing money. NHA-A informed Surveyor that NHA-A did not report or investigate R19's allegation of missing money because R19 is confused and R19 was uncertain as to exactly how much was actually missing. NHA-A shared R19 has a history of false accusations, stating it is care planned. Surveyor reviewed documentation provided by NHA-A indicating R19 did submit an allegation of missing money on 1/21/26 and Social Services Designee (SSD)-H submitted the Missing Item Notification Form. Surveyor noted there is 1 staff statement and another statement from R19's guardian. There are no other staff statements and no statements obtained from other Residents. 2.) R10 was readmitted to the facility on [DATE]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10's Quarterly MDS, dated [DATE], indicates R10 has a Brief Interview for Mental Status (BIMS) score of 14 with intact cognition, no behaviors or rejection of care, requires supervision or touching assistance to sit to stand, supervision or touching assistance with transfers, able to walk 10 feet with supervision or touching assistance, takes high risk medications and had 2 or more falls since admission/reentry. The Facility provided document, titled Grievance Investigation, dated 11/25/2025 indicates the following: Summary Statement: Adult Protective Services (APS) received an anonymous complaint regarding R10 having a fall on 10/26/2025 and staff refused to send R10 to the hospital. The complaint also indicates R10 had a fall on 11/1/2025 and staff did not come to assist R10 after putting on the call light. Name and title of person(s) interviewed: APS attempted to interview R10 but was unable to answer questions. APS discussed competency evaluation and guardianship referral. Steps taken to investigate grievance: APS visited R10 again on 12/3/2025, no new concerns expressed. Summary of Investigation findings and conclusion: -file/incident review- no incident on 11/1/2025 -10/26/2025- observed on floor, daughter was called and was not at the Facility -readmit 10/16 post psych inpatient stay -10/31 hip pain while in therapy, spoke with daughter, no verbal complaints. On 11/1/2025 R10 went to target with daughter, daughter took R10 to hospital for evaluation then R10 returned to the Facility via ambulance. Per daughter, R10 was placed in car funny and complained of left hip pain. Was grievance confirmed or not confirmed? Not confirmed Signed by NHA-A on 12/3/2025. On 03/05/2026, at 12:05 PM, Surveyor interviewed NHA-A. NHA-A indicated APS reached out to him regarding a complaint involving R10 falling on 10/26/2025 and allegations staff refused to send R10 to the hospital. After APS reached out, NHA-A began to look at the fall history for R10 and piece things together. NHA-A indicated the allegation was staff refused to send R10 to the hospital, but NHA-A did not see that occurred during the investigation. NHA-A indicated he did not interview staff or other residents but did a record review and could see in the record that R10 did not go out to the hospital and found that the incident on 11/1/2025 occurred while R10 was with R10's daughter from a nurse's note. NHA-A was not able to show details to indicate staff and other residents were interviewed regarding the allegations of neglect.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not document a summary of information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS) for 2 (R3, and R1) of 5 sampled residents. * R3's admission MDS, completed 7/7/25, Pressure injury Care Area Assessment (CAA) does not contain a comprehensive summary of triggered areas. *R1 had 10 Care Area Assessments (CAAs) triggered to be completed for the admission Minimum Data Set (MDS) assessment dated [DATE]. Documentation of summary information of the ten CAAs was not completed. Findings include: The facility's policy and procedure Resident Assessment Instrument and Person -Centered Care Planning, dated 4/25, was reviewed. The Purpose documents:The RAI (Resident Assessment Instrument) is an OBRA (Omnibus Budget Reconciliation Act of 1987) required process for conducting initial and periodic standardized, reproducible assessments of the functional capacity of all nursing home residents. It consists of the MDS (Minimum Data Set), CAA (Care Area Assessment) process and Utilization Guidelines. It is to be completed by the IDT (Interdisciplinary Team) per RAI guidelines to identify the strengths, goals, life history and preferences of the resident to develop a person-centered care plan, to provide the appropriate care and services for each resident and to modify the care plan and care services based on the resident's status.The Protocol:2. Completion of the CAAs.a. The Care Area Assessments systematically interpret the information recorded on the MDS and trigger areas of concern (CAT).b. Using evidence based clinical resources (in [ECS-name of electronic medical record system]) each IDT assessor will assess potential problems in their completed sections that trigger the CAA and determine whether to proceed to the care plan.c. The CAA summary (section V of the MDS) provides the location of areas that have triggered and decision as to whether to proceed to care plan. 1.) R3 was admitted to the facility on [DATE]. R3 is non-verbal and dependent on staff for all Activities of Daily Living (ADL). The admission MDS was completed on 7/7/25 and the Pressure Injury CAA (care area assessment) was triggered. The CAA documents, through checked boxes R3 is at risk for pressure injury, is totally dependent on staff, non-verbal, and has a stage 1 pressure injury. The CAA Summary documents: R3 triggered CAA due to requiring full cares related to pressure ulcer present on admission. The CAA Summary does not document the analysis of the information or the rationale on whether to proceed with care planning and why the decision was made for R3. On 3/04/2026, at 1:34 PM, Surveyor interviewed MDS Nurse-G. The MDS Nurse -G stated they were trained in completing CAAs by the previous MDS Nurse. MDS Nurse-G has not had any training on specifically completing the MDS CAA. MDS Nurse-G shared they do not conduct any additional assessments/analysis for the triggered CAA separate from the MDS assessment. On 3/4/26, at 3:00 PM. At the facility exit meeting with Nursing Home Administrator (NHA) -A and (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nurses (DON) -B, Surveyor shared the concerns regarding R3's CAA Summary. 2.) R1 was admitted to the facility on [DATE] with diagnoses of idiopathic aseptic necrosis of the left toe, pneumonia, peripheral vascular disease, nicotine dependence, Type 1 diabetes mellitus, bipolar disorder, insomnia, and neuromuscular dysfunction of the bladder requiring an indwelling urinary catheter. R1's admission Minimum Data Set (MDS) assessment dated [DATE] triggered Care Area Assessments (CAAs) for Activities of Daily Living, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Dental Care, Pressure Ulcer, Psychotropic Drug Use, Pain, and Return to Community Referral. No documentation of summary information, including the rationale to proceed to care planning or not for each CAA triggered area was found. In an interview on 3/4/2026 at 1:34 PM, Surveyor asked MDS/Wound Nurse-G about the CAAs for residents. MDS/Wound Nurse-G stated MDS/Wound Nurse-G was trained by the staff to complete the MDS assessments but had not been trained on writing CAAs. MDS/Wound Nurse-G stated the information that was clicked on the triggered area is put in the care plan; no additional assessments were done to complete the CAAs and assist with determining the plan of care. On 3/4/2026 at 3:00 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern R1 did not have any CAAs completed with the admission MDS assessment.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure they notified the state mental health authority promptly for a resident review after a significant change in mental condition for 1 (R10) of 1 resident reviewed for PASARR. *R10 demonstrated increased mood related symptoms which required an extensive inpatient psychiatric stay. Following the hospitalization R10 was prescribed psychotropic medication to treat symptoms. R10 was readmitted to the facility and a new PASARR (Preadmission Screening and Resident Review) was not completed and submitted to the state authority to ensure R10 received care and services in the most appropriate setting. Findings include:R10 was admitted to the facility on [DATE] and has diagnoses that include general anxiety disorder, bipolar disorder, and current episode of depression, severe, with psychotic features. R10's Quarterly Minimum Data Set (MDS), dated [DATE], indicates R10 has a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition, no behaviors concerns, receives antipsychotic medication, antianxiety medication, and antidepressant medication. R10 was readmitted to the Facility in June 2025, after a psychiatric hospitalization related high anxiety, panic attacks, decreased appetite, and significant depression with suicidal ideation. R10's hospitalization included medication adjustments with orders for Invega 117 mg (milligrams) (antipsychotic medication) injection monthly, Depakote DR 250 mg (anticonvulsant and mood -stabilizing medication) three times a day, and trazadone 50 mg (antidepressant medication) at bedtime. R10's medical record documents, Psychiatric Follow up, dated 7/17/2025, documents R10 reports depression is not good and getting worse every day. R10 was previously at a psychiatric facility for manic symptoms of bipolar and had during hospitalization, R10's lithium, buspirone, and hydroxyzine were discontinued. Depakote 250 milligrams (mg) was increased to 3 times per day and Trazodone 50 mg at bedtime was added. R10's Invega 117mg monthly injection did not change. R10's medical record documents, Psychiatric Follow up, dated 9/18/2025, documents R10 having lots of depression, expressing wanting to give up, feels suicidal and indicated wanting to save medications to overdose. Plan reviewed with staff and staff have been watching R10 take R10's medications to ensure swallowing. R10's Psychiatric evaluation dated 2/27/26, documents a Risk Assessment: [R10] Reports chronic episodes of suicidal thoughts. States she does not have a plan or access to means. Denies homicidal ideation. Plan and Assessment: Bipolar disorder, current episode depressed, severe, with psychotic features. Status: Inadequately Controlled. Chronicity Level: Chronic. Patient presents with severe depressive episode with psychotic features, reporting delusional thoughts and visual and auditory hallucinations. Reports chronic episodes of suicidal thought; currently denies active plan or access to means. Continue close safety monitoring at facility given history of suicidal ideation and current severe depressive symptoms. On 03/05/2026, at 2:02 PM, Surveyor interviewed Social Services Designee (SSD)-H, who indicates PASSAR's are done on admission and is the only time SSD-H completes them. SSD-H indicated SSD-H only completed 1 PASSAR for R10, which was done on R10's initial admission but will look if one was done after readmission and medication changes. On 03/05/2026, at 3:25 PM, Nursing Home Administrator (NHA)-A was informed of the concern the facility did not notify the state mental health authority promptly after R10 experienced a significant change in mental condition and psychotropic medications were prescribed.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure 1 (R20) of 1 resident reviewed for diminishing abilities in activities of daily living, received the appropriate treatment to maintain or improve the ability to carry out activities of daily living.Findings include: The facility did not provide a policy and procedure for maintaining or improving activities of daily living (ADL(S)). R20 was admitted to the facility on [DATE] with diagnoses of Alzheimer's(progressive disease that destroys memory and other important mental functions), Vascular Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life) with Behavioral Disturbance, Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Hypothyroidism(underactive thyroid), Hyperlipidemia(high levels of fat particles in blood), Chronic Kidney Disease(progressive damage and loss of function in the kidneys), and Hypertensive Heart Disease(long term conditions developed from chronic high blood pressure). R20 currently has an activated Health Care Power of Attorney (HCPOA).R20's Quarterly Minimum Data Set (MDS) completed 9/25/25/25 documents R20 has both and short and long term memory impairments and demonstrates severely impaired skills for daily decision making. R20 has not range of motion impairment. R20 requires set-up for eating. R20 requires substantial/maximum assistance for toileting hygiene, showers, and lower dressing. R20 requires partial/moderate assistance for upper dressing. R20 is independent for mobility and transfers and is always incontinent of bowel and bladder. There is no documented weight loss for R20 and R20 has a regular diet. R20 is documented as walking 150 feet with assistance. R20's Significant Change Minimum Data Set (MDS) with an assessment reference date of 12/3/25 assesses R20 has both short- and long-term memory impairments and demonstrates severely impaired skills for daily decision making. R20's MDS documents R20 has no range of motion impairment, requires set-up for eating, and is always incontinent of bowel and bladder. R20 is dependent on toileting hygiene, showers, upper and lower dressing and requires substantial/maximum assistance for mobility and transfers. R20's MDS documents R20 holds food in mouth, no current weight loss, and is on a mechanically altered diet. R20's MDS also documents that R20 has had falls since the last assessment. Walking R20 was not attempted due to medical condition.Surveyor notes that documentation and comparison of R20's MDS from September to December states that R20 had a significant decline in ADL status. In September, R20 was independent in mobility and transfers and required partial/maximum assistance for other ADLS. R20 was not pocketing R20's food when eating and R20 was able to walk 150 feet with assistance. In December, R20 required substantial/maximum assistance for mobility and transfers, was pocketing food when eating and changed to a pureed diet and walking R20 with assistance was not attempted. R20's Annual Nutrition Care Area Assessment (CAA) dated 12/9/25, is blank with no documentation. R20's Annual CAAs dated 12/9/25 for Falls, Activities of Daily Living (ADL), Cognitive and do not document a comprehensive summary of triggered symptoms and interventions to be put in place.Surveyor reviewed R20's comprehensive care plan which documents:On 1/23/23, R20 has a self-care deficit manifested by incomplete ADL's, ADL functional deficit, increased need for ADL assistance effective 12/9/25. The only interventions updated on 12/9/25 was to assess functional level, administer medications, observe for side effects and effectiveness, note changes in functional level, reorient as able, calm, gentle approach, offer simple instructions to encourage to participate, explain procedures, speak clearly. Surveyor notes that R20's comprehensive care plan do not document person-centered interventions to address R20's increased need for ADL assistance. On 2/27/26, Physician (MD)-X documents R20 had a decrease in mobility and has had multiple falls. On 10/16/2025, at 3:00 PM, documentation states that Psych Nurse Practitioner (Psych NP)-Y increased R20's Depakote 125 mg from 2 times a day to 3 times a day. On 11/25/2025, at 12:33 PM, documentation states that R20's diet changed from regular to (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pureed due to R20 pocketing food and holding food in mouth, delayed swallowing.On 12/03/2025, at 2:54 PM, documentation states that staff have reported to writer that R20 has required more assistance with ADLs. R20 is chair fast now, dressing, transfer and bed mobility ability has decreased, and R20 tires easily. Surveyor observed R20 throughout the survey process. R20 was either laying in bed or sitting in a high back chair with an overbed table in front of R20. R20 was not observed ambulating at all during the survey process. Surveyor only observed R20 eating independently. Surveyor did not observe R20 leave R20's room. On 3/03/2026, at 9:34 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-I who has been employed at the facility for 27 years. CNA-I informed Surveyor that CNA-I knows R20 really well. CNA-I states that R20 has had a need for increased assistance. CNA-I states R20 is incontinent of bowel and bladder and has always been as long as CNA-I has known R20. On 3/03/2026, at 9:38 AM, Surveyor interviewed Registered Nurse (RN)-D. RN-D informed Surveyor that R20's ADL assistance decreased around the time R20's medications were being played with due to R20's behavior of playing with feces. RN-D then starting falling, and R20's medications were reduced back down. RN-D acknowledged that R20's ADL status has changed significantly but believes R20's dementia has progressed. On 3/04/2026, at 8:35 AM, Surveyor was informed by the facility that there are no therapy notes or referrals for R20. On 3/04/2026, at 10:21 AM, Surveyor interviewed Social Worker Designee (SSD)-H. SSD-H informed Surveyor that R20 is not doing much. SSD-H states that R20 definitely has had a change. SSD-H used to take her outside almost daily and walk around the facility with R20. SSD-H states SSD-H is a CNA and will help R20 with ADLs. SSD-H states SSD-H was helping CNA-I the other day with R20's ADLs and it was difficult for R20 to stand. SSD-H informed Surveyor that SSD-H asked CNA-I if this was normal and CNA-I informed SSD-H that it was normal and R20 does not do much. On 3/04/2026, at 12:59 PM, Surveyor interviewed Nurse Manager (NM)-E. NM-E confirmed that R20 is weaker. NM-E thinks R20's change is medication provoked due to medication changes. NM-E states that R20 couldn't stay calm unless R20 was in bed. NM-E states that a therapy referral was not discussed or attempted. On 3/04/2026, at 1:10 PM, Director of Nursing (DON)-B informed Surveyor, we probably discussed therapy but therapy was never attempted. DON-B does not believe R20 would be able to follow directions for therapy. On 3/04/2026, at 3:00 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, DON-B, and Clinical Nursing Officer (CNO)-C that R20 has had a significant decrease in ADL abilities and the facility has not implemented interventions to improve R20's ADL abilities. Surveyor shared the concern that once R20's diminished ADL abilities was identified by staff, a therapy evaluation was not initiated in order to attempt to improve R20's ADL abilities. The facility has not provided at this time additional information as to why the facility has not implemented interventions in an attempt to restore and/or improve R20's ADL abilities.The facility provided a Rehabilitation Referral dated 2/25/26 that documents: staff reports R20 was ambulatory previously, caregiver staff reports decline in functional mobility with increased assistance required for bed mobility and transfers. The facility also provided a Therapy Payer Verification/Communication Form dated 3/3/26(one day after survey started) listing R20 has Medicare B and Medicaid.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure resident (R20) maintained acceptable parameters of nutritional status for 1 (R20) of 1 sampled residents with weight loss.R20's medical record indicated a deviation in R20's weight that reflected the potential for a severe weight loss. The facility did not reweigh R20 or requested assessment by the registered dietitian with the documented weight changes. The facility did not ensure R20's intake was monitored as care planned. Findings include:The facility's Weight Management policy and procedure last reviewed 9/25 documents:Purpose:An accurate body weight obtained at individually assessed intervals is one of the most reliable, inexpensive and non-invasive ways to identify when a resident is not obtaining adequate nutrition and/or hydration.6. Resident's weight information is reported by Certified Nursing Assistant (CNA) to licensed nurse then recorded in the medical record by the licensed nurse in the electronic medical record.7. The licensed nurse will determine if an additional (third) reweight is required and accompany the CNA to monitor the process.8. The licensed nurse notifies the Dietary Director/Registered Dietitian (RD) of residents with a significant/severe weight change.10. The Dietary Director/RD assesses each resident with a significant or severe weight change as soon as practicable, makes appropriate recommendations to physicians and updates the residents' plan of care.The facility's Persons at Risk Program (PAR) last revised 2/22 documents:Purpose:It is the policy of this facility to proactively and holistically address the status of residents who are considered to be at risk.Weight Lossi. Definition of PAR Residents1.Residents who have lost or gained 10% or more of their body weight over a six month period which was undesired or unplanned.ii. Areas of Review1. Review weight-current and trends2. Review nurse's notes3. Review medications4. Review labs5. Review supplement use and acceptance6. Review diagnosis listing7. Review RD and dietary manager documentation8. Review intake and output documentation, if applicable9. Review speech therapy documentation, if applicable10. Develop interventions, consider all possible consequences of weight loss and care plan for prevention of associated problems12. Update care plan13. Complete nursing note14. Document changes on 24 hour report sheet15. Update CNA assignment sheetsR20 was admitted to the facility on [DATE] with diagnoses of including Alzheimer's (progressive disease that destroys memory and other important mental functions), Vascular Dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life) with Behavioral Disturbance, and Type 2 Diabetes Mellitus (adult onset of trouble controlling blood sugar).R20's Significant change Minimum Data Set (MDS) with an assessment reference date of 12/3/25assesses R20 has both short- and long-term memory impairments and demonstrates severely impaired skills for daily decision making. R20 has no range of motion impairment and requires set-up for eating. R20 holds food in mouth, has no current weight loss, and is on a mechanically altered diet.R20's CNA Assignment Sheet during the survey documents pureed diet, thin liquids. Encourage (R20) to drink fluids during day to stay hydrated; (R20) likes juice vs plain water.R20's comprehensive care plan documents:10/18/22 Potential for weight fluctuation potential for alteration in nutrition 12/9/25 related to disease process, psychological factors, Alzheimer's, or other dementia, recent diet texture change, taking thyroid replacement medication potential for weight gain or loss manifested by fluctuation in weight gain or loss, diet change from regular to pureed.-11/28/23 Monitor weights, high protein supplement, administer medications as ordered, observe for side effects and effectiveness, monitor food intake-12/9/25 Record food intake, offer snacks, assist with eating as needed, encourage rest periods, monitor fluid intake with meals, in between meals, set up meal for (R20)-10/18/22 Provide ordered diet, determine food likes, provide pleasant meals, offer extra snacks, RD consult at neededThe 12/9/25 care plan for Potential for altercation in nutrition related to change in chewing/swallowing regular texture food manifested by (R20) observed holding/pocketing food in mouth, unable to swallow food due to not chewing (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thoroughly-12/9/25 Record food intake, provide snacks, ensure (R20) is set up for meals and that current diet order of puree is followed, report to nurse any chewing/swallowing/episodes of chokingReview of R20's medical record indicates R20's diet was changed from regular to pureed texture due to R20 pocketing food, holding in mouth and delayed swallowing 11/25/25.Review of R20's weights documents R20's weight on 12/17/25 was 141 pounds. On 2/6/26 and 2/19/26 R20's weight was recorded as 118 pounds. This would be a 16.31% weight loss.Surveyor reviewed R20's intake records for December of 2925 and January 2026. Surveyor noted: December has 15 meal intakes with no documentation. January has 46 meal intakes with no documentation.On 2/25/2026, Registered Dietitian (RD)-K documented in their Quarterly Assessment, R20 has a significant weight loss of 17 pounds times 3 months. Discussed with Registered Nurse [(RN)-D] who will obtain a re-weight to assess weight accuracy as previously weight had been stable. Will continue to monitor. Encourage MedPass three times daily.Surveyor notes a re-weight was not obtained.On 3/04/2026, at 12:14 PM, Surveyor interviewed RD-K via telephone. RD-K stated RD-K discussed with RN-D the concern of R20's weight loss. RD-K stated RD-K asked for a re-weight. When asked about assessments, RD-K indicated they would assess R20's intake. Surveyor asked RD-K about care plan revisions and goals. RD-K stated they are not part of the care plan process so any goals and interventions related to nutrition would be documented in a note. RD-K stated if R20 has a weight loss, RD-K would add high protein and high calorie items to R20's meals. When asked about the change in consistency to R20's diet, RD-K stated that it was a physician's decision to downgrade R20's regular diet to pureed. RD-K indicated they were not a part of that decision.On 3/04/2026, at 12:59 PM, Surveyor interviewed Nurse Manager (NM)-E. NM-E did not know about the need for a reweight for R20.On 3/04/2026, at 3:00 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Clinical Nursing Officer (CNO)-C that R20 has had a documented 16.31% weight loss, and a re-weight was not completed per RD-K's request. Surveyor shared that the facility has not had any follow-up including person-centered interventions regarding R20's weight loss. Surveyor shared staff are not monitoring R20's intake at meals as care planned.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide necessary treatment and services to 1 (R16) 1 sampled residents with a history of substance abuse.R16 has a diagnosis of alcohol abuse and had sustained falls following episodes of drinking. The facility did not review and offer necessary supports toR16 to address substance abuse and to ensure R16's safety when drinking.Findings include:R16 was admitted to the facility on [DATE] with diagnoses including Alcohol Abuse (pattern of drinking that interferes with day to day activities), and Major Depressive Disorder (persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities).R16's Quarterly Minimum Data Set (MDS) assessment completed 1/22/26 documents a Brief Interview for Mental Status (BIMS) score for R16 of 11, indicating R16 demonstrates moderately impaired skills for daily decision making. R16's MDS documents minimal depressive symptoms and no behaviors.R16's comprehensive care plan initiated 4/7/25 Resident (R16) has a history of alcohol abuse and misuse due to a diagnosis of alcohol dependence with withdraw, resident continues to drink alcohol. Interventions dated 4/7/25:-Monitor/report to MD for suspected resident intoxication and use of alcohol, re-educate on risks of continued alcohol abuse, manage appropriate medications to decrease adverse effects-Report behaviors, changes in mental status, behaviors, slurred speech, lethargy, respiratory failure to nurse promptly, provide for safety and wellbeing of resident, staff, yourself and other residentsSurveyor notes that R16's care plan for alcohol abuse has not been updated with interventions since 4/7/25.On 12/6/25 R16 had a fall the facility determined was related to R16's drinking alcoholic beverages and intoxication. The post fall intervention was for R16 to not drink. Surveyor noted there were no supports or interventions to try and implement R16 not drinking.On 12/13/25 R16 fell again with the facility documenting drinking alcohol was a causal factor. Changes to R16's care plan and offered support continued to not be assessed or addressed by the facility regarding R16's drinking.Review of R16's medical record indicates there was an order dated 2/20/26 for Psychiatric services to evaluate and consult regarding R16.Surveyor was not able to locate any psychiatric evaluation in R16's electronic medical record or paper chart to indicate the consult was scheduled/completed as ordered.On 3/05/2026, at 10:34 AM, Surveyor interviewed Social Service Designee (SSD)-H regarding R16 and R16's continued consumption of alcohol. SSD-H informed Surveyor that SSD-H only completes the discharge care plan for residents. SSD-H does not know who completes the psychosocial, behavior, mood, etc. care plans. SSD-H informed Surveyor that SSD-H has no training other than leadership training. SSD-H recalls offering Alcoholic Anonymous (AA) one time to R16 but didn't document offering that service. SSD-H confirmed that SSD-H did not implement any other interventions. SSD-H understands and agrees with Surveyor concerns that R16 has not been offered any services or implemented interventions to address R16's continued consumption of alcohol beverages.On 3/9/26 the facility sent additional information for consideration regarding R16. The information indicated SSD-H spoke to R16 on 3/6/25 asking if R16 was interested in alcohol treatment programs and R16 did not want services. The facility also sent information stating on 3/6/25 R16 knows he is an alcoholic. The facility also indicated R16 has a history of poor health decisions. Surveyor noted this does not address the recent concerns of falls due to intoxication and not following through on physician orders for a psychiatric consult.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility did not provide appropriate treatment and services for 1 (R20) of 1 sampled residents with a diagnosis of dementia with behavioral symptoms to allow them to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.* R20 was observed during the survey to not receive activities or stimulation based upon individual preferences and identified interests with a diagnosis of dementia. R20 was observed engaging in behaviors of repeatedly tapping and banging objects on tables without redirection or encouragement to do participate in an activity.Findings include:The facility's Dementia Management policy and procedure last revised 9/22 documents:Purpose:To ensure that facility staff members understand the needs of resident who display or are diagnosed with dementia and provide appropriate treatment and services to meet the highest practicable physical, mental, and psychosocial well-being of these individuals.Protocol:2. Staff will understand the expectation to observe residents condition throughout the shift they work and report to the nurse immediately any sudden change or worsening from baseline in the residents' expressions or actions.4. Every effort will be made to complete a preferences for Everyday Living Inventory (PELI) with the resident to help inform the person-centered care plan.5. The management team will complete routine observations of care and activities of daily living to ensure staff members are consistently implementing the person-centered care plan that reflects the resident's goals and maximizes the resident's dignity, autonomy, privacy, socialization, independence, and choice.6. The effectiveness of interventions will be monitored and adjustments to interventions based on effectiveness, as well as any adverse consequences related to treatment will be discussed with Interdisciplinary Team (IDT) and made as needed throughout each shift.8. Upon admission to the facility and routinely throughout the course of the resident's stay, they IDT will gather and review information from medical records, observations, and resident/resident representative interviews to determine:a. Resident's usual and current cognitive patterns, mood, and behaviorb. Any underlying root causes of behavioral expressions or indications of distressc. How the resident typically communicates an unmet need such as pain, discomfort, hunger, thirst9. The IDT will develop and implement a comprehensive resident-centered care plan from this evaluation and assessment that includes specific targeted behaviors and expressions of distress, measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs, the resident's goals, desired outcomes, and preferences.10. The nursing staff will update the resident-centered care plan as changes and maintain a current copy which will identify changes in condition and dementia care approaches.11. Dementia care interventions may include the following:a. Identifying unmet needs or root causes such as pain/hunger/thirst/boredom/lonelinessb. Underlying behavioral expressions such as restlessness, anxiety, aggression, screamingc. Using a soft, low voice and speaking facing resident so lips can be read and face can be seen clearlyd. Not approaching resident from behind so you do not startle them.e. Providing adequate time during resident care and meals.g. Encouraging maximal independence that resident could perform themselvesh. Encouraging time outdoors in engaged activity or relaxation.i. Encouraging meaningful resident-centered physical activity.j. Providing meaningful stimulation (to avoid boredom).k. Ensuring an adequate number and type of activities on all shifts.n. Assess for sensory deficits and how it impacts cognition, provide adaptive equipment if needed.o. Assess and evaluate if appropriate for music-memory program and implement according to resident interest.R20 was admitted to the facility on [DATE] with diagnoses including Alzheimer's (progressive disease that destroys memory and other important mental functions), Vascular Dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life) with Behavioral Disturbance.R20's Significant Change Minimum Data Set (MDS) with an assessment reference date of 12/3/25 assesses R20 has both (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	short- and long-term memory impairments and demonstrates severely impaired skills for daily decision making. R20 no range of motion impairment.Surveyor reviewed R20's comprehensive care plans which documents:(R20) has potential for impaired adjustment related to dementia, confusion, perpetual motion manifested by walking in hallways and room tapping on various surfaces, and anxiety. 10/9/24-12/5/23 Social Service-1:1 (one on one) visits, involve family, reorient as needed, (R20) wanders at times.-12/5/23 Activities-1:1 visits, (R20) enjoys [NAME] music. Engage in activities. Enjoys playing cards, singing and Christmas music. (R20) is Catholic and engages in Mass. Enjoys pet visits when LPN (licensed practical nurse) brings cats.(R20) has potential for disruptive interaction 10/18/22 related to Dementia 12/9/25 manifested by digging in brief, spreading contents of soiled brief, difficult to redirect at times.-10/18/22 Provide calm environment, offer diversion, provide 1:1, redirection-10/18/22 1:1 visits, encourage activity participation-10/18/22 Provide activities of choice for (R20)12/9/25 Maintain safety of (R20) and other residents, and other staff. Praise positives.On 11/24/25, Psychiatric Nurse Practitioner (Psych NP)-Y documented that R20 was recently started on risperidone by primary physician for continued tapping behaviors and playing with R20's feces.R20's current physician orders document the following medications:3/21/25 Sertraline 50mg for depression and anxiety12/10/25 Depakote Sprinkles 125mg 2 times daily for dementia with mood disorder1/15/26 Risperidone .25mg 2 times daily for behavioral disorders associated with dementia was increasedSurveyor reviewed R20's Medication Administration Records (MARS) from November to March and notes that nursing staff are documenting that R20 is displaying no targeted behaviors.Staff identified a significant change in R20's activities of daily living (ADL) functional abilities in December 2025 and attributed the significant change to R20's medications. R20's medications were decreased at that time.On 3/02/2026, at 11:44 AM, Surveyor observed R20 in bed sleeping.On 3/02/2026, at 1:43 PM, Surveyor observed R20 sitting in a high back chair in the left-hand corner of R20's room. R20 had an overbed table in front of R20. R20 was continuously tapping their hand on the overbed table. Surveyor observed there were no items on the overbed table. There was no music playing or television on to provide stimulation.On 3/03/2026, at 7:07 AM, Surveyor observed R20 in bed sleeping.On 3/03/2026, at 9:29 AM, Surveyor observed R20 sitting in the high back chair with the overbed table in front of R20. Surveyor observed R20's call light is on the floor; not within reach of R20.On 3/03/2026, at 12:59 PM, Surveyor observed R20 sitting in the high back chair in same spot with overbed table in front. Surveyor observed R20 banging R20's water cup on the overbed table. Surveyor noted there was no music playing or television on to provide stimulation.On 3/03/2026, at 3:31 PM, Surveyor observed R20 in bed sleeping.On 3/04/2026, at 7:15 AM, Surveyor observed R20 in bed sleeping.On 3/04/2026, at 7:55 AM, Surveyor observed R20 awake in R20's room. Surveyor noted they have not observed R20 out of R20's room during the survey. R20's care plan states R20 enjoys music and playing cards. Surveyor has not observed R20 participating in any activities. On 3/04/2026, at 12:46 PM, Surveyor observed R20 sitting on the edge of the bed with the overbed table in front of R20. Surveyor again noted there is no music or television on providing stimulation.On 3/04/2026, at 7:28 AM, Surveyor interviewed Activity Director. (AD)-F regarding R20's activities. AD-F stated R20, on occasion, will attend online church and movies but needs 1:1 monitoring when in an activity. AD-F stated, I am one person, so it is hard to bring (R20) to activities. AD-F stated they only provide 1:1 visits 1 time a week and usually it is to read R20 a devotion.On 3/05/2026, at 10:34 AM, Surveyor spoke to Social Services Designee (SSD)-H. Surveyor asked SSD-H if the facility has programs and activities for residents with dementia. SSD-H informed Surveyor the facility does not have a dementia program and believes that dementia training is very important. SSD-H stated hospice came in awhile ago and provided dementia training. SSD-H stated that dementia care is very important and understands Surveyor's concern that the facility has not been providing dementia care to R20.On 3/05/2026, at 1:45 PM, Surveyor interviewed AD-F again. AD-F confirmed that AD-F does not provide dementia activity programming for the residents with diagnoses of dementia or demonstrating signs/symptoms of dementia.R20 has a diagnosis of Alzheimer's Disease (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Dementia. R20's MARS for daily behavior monitoring per shift does not document any targeted behavior. There has been no comprehensive assessment with individualized interventions of R20's behaviors and implementing person-centered interventions focusing on dementia care. The facility does not conduct dementia assessments.On 3/04/2026, at 3:00 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Clinical Nursing Officer (CNO)-C that Surveyor observed R20 not being provided person-centered interventions for dementia care during the survey.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility did not ensure 1 (R10) of 1 resident reviewed received medically related social services to attain their highest practicable mental and psychosocial well-being.* On 1/14/2025, R10 was committed for 6 months on a locked unit at a psychiatric facility for Suicidal Ideation (SI), mania and psychosis with substantial probability of physical harm to self, manifested by overt attempt or threat. R10 readmitted to the facility without a suicidal care plan put into place and no person-centered interventions specific to SI prevention in R10's care plan. Social Service Designee (SSD)-H was not aware of R10's history of SI and was not involved in R10's psychosocial care planning or follow up.Findings include:R10 was admitted to the facility on [DATE] with diagnoses including Major depressive disorder and generalized anxiety disorder.R10's Quarterly MDS, dated [DATE], indicates R10 has a Brief Interview for Mental Status (BIMS) score of 14 with intact cognition, no behaviors or rejection of care, Patient Heath Questionnaire (PHQ)9 total severity score of 1 indicating minimal depression.R10's health records document that R10 was committed to a psychiatric facility due to suicidal ideation.R10's court order commitment dated 01/14/2025 and indicates that the court found grounds for commitment and documents: The subject is mentally ill, dangerous because of substantial probability of physical harm to him or herself under statute 51.20(1)(a)2.a. As manifested or shown by: a recent overt act, attempt or threat to act under statute 51.20(1)(a)2.a. or b. Wis. Statute. The court orders the subject is committed for 6 months from 1/14/2025.R10's Facility provided document titled Care Plan dated 8/11/2024 indicates the following: Bipolar disease, major depression and anxiety disorderSocial Services: 1:1 visit; Allow to vent; Teach relaxation techniques; Involve family; Make referral for counseling if needed; Inform of activities4/01/2025- Potential for Alteration in thought process related to psychotropic medications, history of bipolar and major depression, interventions include:Surveyor noted that R10 does not have an identified suicidal ideation care plan with person centered interventions to manage and prevent suicide attempts. R10's Psychiatric note, dated 7/17/2025, documents: R10 seen today for follow up of bipolar disorder, generalized anxiety disorder, insomnia, and mild cognitive impairment. R10 recently returned from psychiatric hospitalization within the past month. Mental Status Evaluation- thinks about harming self, denies having a plan or access but states I wish I could. Assessment and plan: continue to monitor mood/behaviors, symptoms of anxiety, sleep status and encourage socialization with peers.R10's Psychiatric note, dated 9/18/2025, documents: Mental Status Evaluation- Suicidal Ideation- R10 reports significant depression, wants to give up, expresses a plan to save up medications to overdose. Assessment and plan: Staff reports they have been watching R10 take medications and will continue to monitor and observe R10 while taking R10's medications to prevent R10 from hoarding medications. Will continue current medication regimen, will closely monitor R10's mood, behaviors and SI. Encourage activities to improve mood.Surveyor noted no documented monitoring of SI or medication hoarding in R10's Medication Administration Record (MAR), Treatment Administration Record (TAR), orders, Care Plan or Certified Nursing Assistant Care Card.Surveyor reviewed R10's electronic health record and noted R10 was admitted to a psychiatric facility on 10/2/2025 and readmitted back to the facility on [DATE], following an inpatient psychiatric stay for SI.R10's discharge summary titled, SBH-Discharge Summary and dated 10/16/2025 documents:Reason for admission: R10 was seen at an outside Emergency Department for SI with no plan or intent. Discharge plan: to return to Facility with medication adjustments.Surveyor reviewed R10's Psychiatric note, dated 11/24/2025, which indicates: Chief Complaint: Follow up psychiatric visit sadness, isolation, SI, nervousness and difficulty sleeping. Mental Status Evaluation: Suicidal Ideation- not assessed during visit.R10's Psychiatric note, dated 1/15/2026, which documents: Chief Complaint: Psych follow up for difficulty sleeping, nervousness, bipolar disorder, and psychotropic (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication management. R10 indicated having bad depression, indicating R10 does not want to live anymore at first denied a plan, but then indicated R10 will take pills. R10 denied having access to pills or having pills in R10's room. Suicidal Ideation: present, reports depression is bad and severe, states she does not want to liveanymore, initially denied having a plan then states will take pills. Denies having access to pills or pills in room.Assessment and plan: continue close safety monitoring at facility, including supervised medication administration/observed swallowing and on-going monitoring for worsening suicidality.R10's Psychiatric note, dated 2/27/2026, which documents: Chief Complaint: follow up, bipolar disorder Goal 2: Maintain safety and monitor for suicidal ideation with on going risk assessment. Initial completed. Currently denying plan. Continues to require close safety monitoring at facility level given history. Suicidal Ideation: chronic episodes, deny current plan, denies means.On 03/05/2026, at 10:36 AM, Surveyor interviewed Social Service Designee (SSD)-H. SSD-H informed Surveyor that the admission nurse will do the initial care planning for behaviors and psychiatric services. SSD-H stated that Psych Nurse Practitioner (NP) will send SSD-H the follow up vist information, and SSD-H will put the documentation in residents charts. SSD-H indicated SSD-H does not review the notes and stated that she will scan the documents and will only work on discharge planning. SSD-H indicated that SSD-H is not aware of R10 being or ever being suicidal. SSD-H indicated that, if R10 would tell SSD-H that R10 is suicidal SSD-H would contact crisis and visit R10 more frequently. SSD-H informed Surveyor that R10 does not have history of SI but was living in a car and ended up going to the hospital, then came to the facility for therapy. SSD-H stated that R10 does have bipolar but nothing in R10's medical chart documents anything about suicide, and if there were a history of SI, R10 would absolutely have a care plan and SSD-H would be involved.On 03/05/2026, at 10:54 AM, Surveyor interviewed DON-B. DON-B informed Surveyor that SSD-H oversees all social services related behaviors, psych, care planning and DON-B will review, Psych NP will discuss with us prior to leaving facility. DON-B indicated that R10 has history of suicidal ideation and indicated that it should be in R10's care plan. DON-B informed Surveyor DON-B does not see personalized interventions in R10's care plan relating to SI or prevention. DON-B informed Surveyor there is no monitoring of R10 for SI and medication administration observations. On 03/05/2026, at 3:25 PM, Surveyor notified the facility of the lack of a SI care plan and interventions to prevent and manage SI for R10. No additional information was provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure pharmaceutical services were provided to 1 (R10) of 1 sampled residents receiving pain medications. R10 was seen in the emergency room (ER) on 11/1/25 for hip pain. R10 returned to the facility with recommendations to take Tylenol 650mg 3 times per day with or without ibuprofen 600mg twice a day, as needed for pain. There is no indication this recommendation was reviewed with R10's physician or medication orders at the time were adjusted to implement this recommendation for pain management. Additionally, R10 received multiple doses of as needed (PRN) Tramadol for pain management without a rating of R10's pain prior to administration or documentation of the effectiveness of the medication. Findings Include:The facility's policy, titled Pain Recognition and Management, last revised 4/2025, documents: . 8. Quality Assurance/Performance Improvement Considerations: a. For residents experiencing ongoing/unresolved moderate to severe pain, review the resident's current pain medication regimen to determine if changes in the regimen are necessary. i. Chart the resident's daily pain level in ECS (name of facility electronic medical record software), using an appropriate care planned pain scale. ii. Reassess medication's effectiveness and work with medical provider to adjust dosage to best meet the resident's pain goals. Monitor for repeated PRN requests, which may indicate the need to reevaluate the current medication regimen. Iii. Search for causes, location and severity of the pain, the potential benefits of pain medication, risks and adverse consequences, and the resident's desired level of relief and tolerance for adverse consequences. R10 was admitted to the facility on [DATE] with diagnoses including fracture of fourth lumbar vertebra, chronic anal fissure (a small, painful tear in the lining of the anus), and Major Depressive Disorder (persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities). R10's Quarterly Minimum Data Set(MDS) completed 1/28/2026 documents R10's Brief Interview for Mental Status(BIMS) score to be 14 indicating R10 is cognitively intact for daily decision making. R10's MDS documents no mood or behavior symptoms during the assessment period. R10 has no range of motion impairment on either side. R10 requires supervision or touching assistance rolling left to right, partial/moderate assistance with dressing, is on a scheduled pain regimen and received non-medication interventions for pain. R10's comprehensive care plan documents:Problem: Potential for alteration in comfort related to pain not of recent onsetInitiated 7/22/2025 Interventions Initiated 1/9/2024:Nurses ----Assess physical symptoms-Administer pain meds-Monitor/record: med effectiveness, med side effects, Teach pain relievers: Document pain level, Notify MD prn-Minimize/relieve pain: Discuss exacerbation of pain with resident stressors, Nurse Aide ----Encourage rest periods-Offer diversion-Assist with repositioning-Encourage self-care-Assist with Activities of Daily Living (ADL)'s as needed-Promote rest, provide quiet dark environment-Report pain to nurse Social Services ----1:1 visits-Allow to vent-Teach relaxation techniques-Involve family Surveyor reviewed R10's Electronic Health Record (EHR) and noted the following progress note, dated 11/1/2026:(R10) was out on pass with a family member, and after shopping at (name of store) (R10) complained of pain to (R10's) left hip after getting into the car. (R10) requested to go to ER for evaluation and treatment. (R10) had no injuries and will be coming back to the Facility with no new orders except, to continue with current pain medications. Surveyor reviewed R10's After Visit Summary, dated 11/1/2025 and indicates the following:Instructions: Take Tylenol 650mg 3 times per day with or without ibuprofen 600mg twice a day, as needed for pain. Surveyor reviewed R10's current physician orders with discontinued entries and documents:-Tramadol 50mg- by mouth twice a day as needed (PRN) for pain. start date 5/21/2025-Acetaminophen (Tylenol) 325mg- 2 tablets by mouth every 6 hours as needed for pain and/or fever. Start date 2/19/2026 Surveyor noted Tylenol at the recommended dosage from November 2025 was not added to R10's medication orders until 2/19/2026. Surveyor reviewed R10's (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility provided pain assessments and noted the following: 11/3/2025- PRN Tamadol given at 3:21 PM- no pain level before given, no description of pain and no location of pain. 11/4/2025- PRN Tamadol given at 5:36 PM - no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/5/2025- PRN Tamadol given at 3:19 PM - no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/7/2025- PRN Tamadol given at 7:44 PM - no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/8/2025- PRN Tamadol given at 6:55 PM - no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/9/2025- PRN Tamadol given at 3:25 AM - no pain level before given, no description of pain, no location of pain and no follow up pain level of effectiveness.PRN Tamadol given at 7:05 PM - no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/10/2025- PRN Tamadol given at 7:04 PM - no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/12/2025- PRN Tamadol given at 8:33 AM - pain unchanged no indication anything further was done.PRN Tamadol given at 7:44 PM - no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/13/2025- PRN Tamadol given at 7:02 PM - no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/14/2025- PRN Tamadol given at 7:14 PM - no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/18/2025- PRN Tamadol given at 7:01 PM - no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/21/2025- PRN Tamadol given at 11:22 AM - no pain level before given, no description of pain and no follow up of effectiveness.PRN Tamadol given at 6:27 PM - no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/22/2025- PRN Tamadol given at 3:05 PM - no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/23/2025- PRN Tamadol given at 7:36 PM - no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/24/2025- PRN Tamadol given at 10:02 AM - no pain level before given, no description of pain, and no follow up of effectiveness.PRN Tamadol given at 6:53 PM - no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/26/2025- PRN Tamadol given at 7:57 PM - no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/27/2025- PRN Tamadol given at 3:22 PM - no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/28/2025- PRN Tamadol given at 6:56 PM- no pain level before given, no description of pain, no location of pain and no follow up of effectiveness. 11/29/2025- PRN Tamadol given at 8:34 AM - no pain level before given, no description of pain, and no follow up of effectiveness.12/1/2025- PRN Tamadol given at 12:10 PM - no follow up of effectiveness assessment. 12/2/2025- PRN Tamadol given at 4:06 PM - no description of pain, and no follow up of effectiveness assessment. 12/3/2025- PRN Tamadol given at 7:13 PM - no pain level before given, no description of pain, and no follow up of effectiveness assessment. 12/4/2025- PRN Tamadol given at 7:13 PM - no pain level before given, no description of pain, and no follow up of effectiveness assessment. 12/5/2025- PRN Tamadol given at 7:37 AM - no pain level before given, no description of pain, and no follow up of effectiveness assessment.PRN medication given at 7:10 PM - no pain level before given, no description of pain, and no follow up of effectiveness assessment. 12/6/2025- PRN Tamadol given at 3:21 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/7/2025- PRN Tamadol given at 3:22 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/10/2025- PRN Tamadol given at 8:10 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/11/2025- PRN Tamadol given at 3:41 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/12/2025- PRN Tamadol given at 7:32 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/15/2025- (continued on next page)

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Clairidge House	1519 60th St Kenosha, WI 53140

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PRN Tamadol given at 11:32 AM - no follow up of effectiveness assessment.PRN Tamadol given at 7:14 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/16/2025- PRN Tamadol given at 3:24 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/17/2025- PRN Tamadol given at 3:41 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment.PRN Tamadol given at 9:00 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/19/2025- PRN Tamadol given at 3:28 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/20/2025- PRN Tamadol given at 7:50 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/21/2025- PRN Tamadol given at 7:32 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/22/2025- PRN Tamadol given at 1:15 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment.PRN Tamadol given at 7:36 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/24/2025- PRN Tamadol given at 8:34 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/25/2025- PRN Tamadol given at 10:37 AM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/26/2027- PRN Tamadol given at 3:13 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/27/2025- PRN Tamadol given at 8:45 AM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/28/2025- PRN Tamadol given at 3:41 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/29/2025- PRN Tamadol given at 7:26 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/30/2025- PRN Tamadol given at 1:09 PM - no follow up of effectiveness assessment.PRN Tamadol given at 7:26 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 12/31/2025- PRN Tamadol given at 7:00 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 1/2/2026- PRN Tamadol given at 3:26 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 1/3/2026- PRN Tamadol given at 3:30 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment.1/4/2026- PRN Tamadol given at 7:28 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 1/5/2026- PRN Tamadol given at 4:46 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 1/7/2026- PRN Tamadol given at 7:02 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 1/8/2026- PRN Tamadol given at 8:01 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 2/20/2026- PRN Tamadol given at 3:24 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 2/23/2026- PRN Tamadol given at 3:24 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 2/27/2026- PRN Tamadol given at 3:11 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. 2/28/2026- PRN Tamadol given at 6:58 PM - no pain level before given, no description or location of pain, and no follow up of effectiveness assessment. Surveyor noted, 23 out of 43 pain evaluations were not thoroughly completed for November and on 11/12/2025- PRN Tamadol given at 8:33 AM - pain unchanged no indication anything further was done, 30 of 40 pain assessments were not thoroughly completed in December 2025, 6 of 7 pain assessments were not thoroughly completed in January 2025 and 4 of 5 pain assessments were not thoroughly completed in February 2026. On 03/03/2026, at 11:59 AM, Surveyor interviewed R10, R10 indicated R10 is not currently having pain and pain has been managed at the Facility as of recently.On (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/05/2026, at 1:55 PM, Surveyor interviewed Director of Nursing (DON)-B. DON-B indicated the expectation is R10 should have a pain evaluation, including location, numerical pain value, description/location and follow up for R10's PRN pain medication administrations. DON-B was unsure of why R10's Tylenol order was not implemented until 2/19/2026 following R10's ER visit on 11/1/2025. DON-B indicated will look further into it. On 03/05/2026, at 3:25 PM, Surveyor informed the Facility of the above concerns regarding R10 not having pain assessments completed prior to administration of PRN pain medication, no follow up pain assessments post PRN pain medication, incomplete pain assessments and the recommendation for R10 to receive Tylenol not being addressed until about 3 months later.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure a resident received an antibiotic medication with adequate indications for use for 1 (R5) of 6 sampled residents.*R5 was prescribed, and administered, the antibiotic (Macrobid) without adequate indications of an infection.Findings include: R5 was admitted to the facility on [DATE] and is currently receiving hospice services. The Nurses Note dated 2/11/2026, at 5:29 PM, By Registered Nurse (RN)-D documents: (R5) complained of burning sensation to her vagina area. RN-D called the hospice nurse and received orders to start Macrobid 100 mg (milligram) Po (oral) BID (twice a day) times 7 days. RN-D faxed order to primary and (name of) pharmacy. RN-D placed R5 on alert charting times 7 days.R5's February 2026 Medication Administration Record documents Macrobid 100 mg was administered, BID from 2/12 - 2/17/26, for a Urinary Tract Infection (UTI).R5's medical record does not have documentation of clinical indications for the antibiotic or Physician documentation, to support the administration of antibiotic medication.On 3/03/2026, at 10:55 AM, Surveyor interviewed the Director of Nursing (DON)-B who is also the facility Infection Preventionist. Surveyor requested clinical information for R5's antibiotic medication use.On 3/04/2026, at 8:31 AM, DON-B spoke with Surveyor. The DON-B was not aware of hospice ordering the antibiotic. DON-B informed Surveyor the antibiotic medication R5 received did not meet the clinical definitions of use. DON-B shared there is no further clinical information regarding the UTI or antibiotic. On 3/4/26, at 3:00 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A and DON-B, Surveyor shared R5's medication concern.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (R9) of 5 residents observed with Enhanced Barrier Precautions (EBP).*R9 has a Facility acquired pressure injury to the left upper posterior thigh area and left medial thigh. On 3/02/2026, Surveyor observed R9's incontinence care and on 3/03/2026, observed R9's wound treatment. The Facility staff did not wear the proper Personal Protective Equipment (PPE) while performing R5's wound treatment or incontinence cares.Findings include:The Facility's police, titled Standard and Transmission-Based Precautions, with a last revised date of 2/2024, indicated, . 11. Enhanced Barrier Precautions . a. When required, Enhanced Barrier Precautions are used IN ADDITION TO Standard Precautions. i. Enhanced Barrier precautions are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. They are indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: 1. Wounds or indwelling medical devices, regardless of MDRO colonization status, . 1. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include:DressingB. Bathing/showeringC. TransferringD. Providing hygieneE. Changing linensF. Changing briefs or assisting with toiletingG. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilatorH. Wound care: any skin opening requiring a dressing . R9 was admitted to the facility on [DATE], with diagnoses including acute kidney failure (sudden, often reversible loss of kidney function), acquired absence of right foot, and urine retention (the inability to fully or partially empty the bladder).R9's Quarterly Minimum Data Set (MDS), dated [DATE], indicates R9 was a Brief Interview for Mental Status (BIMS) score of 14 indicating R9 is cognitively intact, has no impairment in upper extremities, has impairment in lower extremities, requires partial to moderate assistance rolling left to right, requires substantial/maximal assistance with toileting, is occasional incontinent of urine, always incontinent of bowels, does not have any skin conditions, and is at risk for developing pressure injuries.R9's most recent comprehensive MDS, dated [DATE], indicates R9 has a BIMS score of 14, indicating R9 is cognitively intact, does not exhibit rejection of care behaviors, has no impairment in upper extremities, has impairment in lower extremities, is dependent for toileting, dependent on lower body dressing, requires partial/moderate assistance rolling left to right, frequently incontinent of urine, always incontinent of bowels and has an unhealed stage 3 pressure injury.On 03/02/2026, at 9:29 AM, Surveyor interviewed R9. Surveyor noted there was no EBP sign on R9's door and there was no Personal Protective Equipment (PPE) in or near R9's room. R9 informed Surveyor that R9 has wounds on his butt and thigh that were acquired while at the Facility. Surveyor asked R9 if R9 is ok with Surveyor watching staff preform cares for R9, R9 indicated yes.On 03/02/2026, at 9:47 AM, Surveyor observed Certified Nursing Assistant (CNA)-R and CNA-I enter R9's room without EBP PPE. Surveyor observed CNA-R and CNA-I assist R9 with getting undressed and perform a partial bed bath for R9, including incontinence cares. During this time, Surveyor observed R9 to have 2 square adhesive dressings to R9's right and left buttock. Surveyor noted no other dressings in place and noted a scant amount of red matter, consistent with the appearance of blood, to R9's brief around R9's left thigh area. Surveyor noted a large open wound to R9's left medial thigh. CNA-R and CNA-I finished cleaning R9 and assisted R9 with getting dressed, used a Hoyer lift to transfer R9 into R9's wheelchair. Surveyor noted CNA-R and CNA-I did not use EBP PPE while performing cares and transfers for R9.On 03/03/2026, at 1:22 PM, Surveyor observed CNA-S and CNA-P assist R9 with getting undressed and prepare R9 for Registered Nurse (RN)-T to perform a wound treatment for R9. Surveyor noted R9 still had 2 adhesive dressings in place to R9's right and left butt cheeks. Surveyor observed the open area (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to R9's left medial thigh. Surveyor noted that CNA-S and CNA-P were only wearing gloves and were not wearing EBP PPE while providing cares. RN-T then came into R9's room and provided a treatment to R9's denuded areas, while doing this, RN-T provided treatment to R9's stage 3 left posterior thigh pressure injury not as ordered. (please see F686 for further information). Surveyor asked RN-T if RN-T was providing wound care to R9's pressure injury, RN-T informed Surveyor that RN-T is only performing R9's morning treatment to R9's denuded areas and was unsure but thinks all the wounds are the same. RN-T indicated she would call Wound Nurse-G to come up to do the afternoon treatment for R9's other wounds.On 03/03/2026, at 1:41 PM, Wound Nurse-G came to R9's room. Wound Nurse-G indicated R9 did not have PPE available by R9's room and did not have a EBP sign on R9's door. Wound Nurse-G informed Surveyor that R9 should have EBP in place and staff should be using EBP PPE due to R9's pressure injuries.On 03/04/2026, at 3:01 PM, Surveyor informed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and Clinical Nursing Officer-C made aware of concerns regarding no EBP and no PPE for R9.On 03/05/2026, at 8:09 AM, Surveyor observed R9 to now have EBP sign on door and PPE available.On 03/05/2026, at 8:13 AM Surveyor interviewed DON-B. DON-B indicated EBP is used for any open wounds or indwelling medical devices and R9 requires EBP to be in place. DON-B believes R9 was on EBP at one point but must have healed and was not put back into place.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not offer the influenza immunization for 2 (R16 and R5) of 5 residents reviewed for immunizations.R5 and R17 were not offered the influenza (flu) immunization on admission to the facility and the facility did not document if the immunizations were offered and declined.Findings Include:The facility policy titled Influenza Immunization - Resident Reviewed 2/25, Revised 2/21 documented:All residents will receive vaccination annually between October 1st and mid November, at the direction of the facility medical director and Q API committee.Residents admitted during the winter months (October 1st through March 31st) will receive influenza vaccination at admission, if they have not already received it unless there is a medical contraindication.If a resident refuses vaccination, the refusal is to be documented in the nurse's notes of the residence record, and his statement included which states that the resident was made aware of the risks of refusing the vaccination. Risk information is contained in the VIS. Any refusal will be placed on the MAR to ensure follow up within 30 days following the initial refusal of the vaccine and document.On 3/5/26, at 10:23 AM, Surveyor interviewed Director of Nursing (DON)-B regarding R5 and R16 not being offered the influenza vaccine and there was no documentation of refusal. DON-B stated the Facility will try to locate correspondence that R5 was offered an influenza vaccine. DON-B stated R16 was not offered the influenza vaccine, as R16 was admitted after the Facility's influenza vaccine clinic. Surveyor noted the Facility's policy for Influenza vaccines stated if the resident is admitted [DATE]st to March 31st the resident will receive the influenza vaccine on admission.1.) R5 was admitted to the facility on [DATE] with diagnoses of Acute Respiratory Failure With Hypoxia (the lungs cannot properly get oxygen to the body) and Unspecified asthma (chronic inflammation and swelling of the airways and lungs causing shortness of breath),On 3/4/26, at 12:49 PM, Surveyor reviewed R5's Electronic Medical Record (EMR). Surveyor was unable to locate any information pertaining to R5 receiving the influenza vaccination. There was no documentation that R5 received education regarding the benefits and potential side effects of the influenza immunization. There was no documentation in R5's medical record that R5 either received the influenza immunization or did not receive the influenza immunization due to medical contraindication or refusal.2.) R16 was admitted to the facility on [DATE] with diagnoses of dyspnea (difficulty breathing), Emphysema (chronic progressive lung disease that causes shortness of breath), and Chronic respiratory failure with hypoxia (the lungs cannot properly get oxygen to the body).On 3/4/26, at 12:49 PM, Surveyor reviewed R16's Electronic Medical Record. Surveyor was unable to locate any information pertaining to R16 receiving the influenza vaccination. There was no documentation that R16 received education regarding the benefits and potential side effects of the influenza immunization. There was no documentation in R16's medical record that R16 either received the influenza immunization or did not receive the influenza immunization due to medical contraindication or refusal.No additional information was provided from the Facility regarding R5's and R16's influenza vaccine status.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not offer the COVID-19 immunization for 1 (R16) of 5 residents reviewed for immunizations.R16 was not offered the COVID-19 immunization on admission to the facility and the facility did not document if the immunizations were offered and declined.Findings Include:The facility policy titled Coronavirus (COVID-19) Vaccination - Resident. Last reviewed 3/24, last revised 4/25 documented:Coronavirus vaccination is strongly recommended and applies to all the residents. When COVID-19 vaccination is available to the facility, each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident has already been immunized.Before offering COVID-19 vaccine, each resident or the resident representative is provided with education regarding the benefits and risks and potential side effects associated with the vaccine. In situations where COVID-19 vaccination requires multiple doses, the resident or resident representative is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses.Any resident (or resident representative) the declines to be vaccinated against coronavirus must sign the coronavirus COVID-19 vaccine declination form, which serves as proof of education of the risks and benefits of the vaccine and encouragement to receive vaccination. The refusal will also be documented in the nurse's progress notes of the residence's medical record.The resident's medical record includes documentation that indicates the following: that the resident or resident representative was provided education regarding the benefits and the potential risks associated with COVID-19 vaccine by way of the coronavirus COVID-19 vaccine declination form. R16 was admitted to the facility on [DATE] with diagnoses of dyspnea (difficulty breathing), Emphysema (chronic progressive lung disease that causes shortness of breath), and Chronic respiratory failure with hypoxia (the lungs cannot properly get oxygen to the body).On 3/4/26, at 12:49 PM, Surveyor reviewed R16's Electronic Medical Record. Surveyor was unable to locate any information pertaining to R16 receiving the COVID-19 vaccination. There was no documentation that R16 received education regarding the benefits and potential side effects of the COVID-19 immunization. There was no documentation in R16's medical record that R16 either received the COVID-19 immunization or did not receive the COVID-19 immunization due to medical contraindication or refusal.On 3/5/26, at 10:23 AM, Surveyor shared concerns with Director of Nursing (DON)-B that R16 was not offered the COVID-19 vaccine and there was no documentation of refusal. DON-B stated R16 was not offered the COVID-19 vaccine, as R16 was admitted after the Facility's vaccine clinic. Surveyor noted the Facility's policy titled ?Coronavirus (COVID-19) Vaccination - Residents stated before offering the vaccine, the resident or representative is provided with education. Surveyor noted there is no documentation of education provided.No additional information was provided from the Facility regarding R16's COVID-19 vaccine status.