STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Manor of Lacrosse	2902 East Avenue South LA Crosse, WI 54601

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure staff provided adequate supervision to prevent an accident for 1 of 4 residents reviewed for falls (R1). R1 sustained a fall from bed on 1/6/26, resulting in a closed right clavicle (collarbone) fracture after a certified nursing assistant (CNA) failed to follow R1's care plan, which required the assistance of two staff members for cares. CNA C performed R1's morning cares on her own.This is evidenced by: Facility policy titled Integrated Fall Management, effective 8/24/17, states in part, .Policy: Residents are assessed for their risk of falls upon admission, significant change and quarterly thereafter. Residents with risk for falling will have interventions implemented through the resident centered care plan. R1 admitted to the facility on [DATE] and has diagnoses that include, in part: acquired absence of left foot, vascular dementia (moderate) without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (cognitive decline without other emotional or behavioral symptoms present), end stage renal disease (failure of kidney function), dependence on renal dialysis, type 2 diabetes mellitus with diabetic polyneuropathy (high blood sugar affecting nerves throughout the body), depression, and gout (inflammatory arthritis). R1's Quarterly MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 11/1/25, indicates R1 is cognitively intact, with a BIMS (Brief Interview for Mental Status) score of 15 out of 15. On 1/21/26, Surveyor reviewed R1's Care Plan and CNA Care Guide in place before the fall on 1/6/26: R1's Care Plan stated, in part:-Category: Mobility - I am dependent on staff for my bed mobility, transfers and locomotion on and off unit. / Approach start date: 8/13/25 - Assist of 2 with full body hoyer lift for transfer.-Category: Bowel & Bladder: Resident is frequently incontinent of bladder and incontinent of bowel. Resident has impaired mobility and is dependent on staff for toileting. / Approach start date: 3/10/25 - Toileting plan: Staff assist per Mobility Care Plan for Resident to use bedpan/check and change every 3-4 hours as needed per resident preference.-Category: Falls I am at risk for falls d/t (due to) left sided weakness, generalized weakness. / Approach start date: 2/25/25 - Educate on prevention/reduction precautions per facility protocol. R1's CNA Care Guide stated, in part:ADLs (activities of daily living): Ax2 (assist of two)Transfer: Ax2 hoyerToileting: Ax2 R1's Progress Notes, dated 1/6/26, include in part: 8:30 AM - RN (Registered Nurse): Staff reported that the resident fell out of bed while being assisted with cares, being rolled onto his left side. Noted resident on the floor, face down. Neuros (neurological signs) are unremarkable. Denies pain. Logged [sic] rolled resident on his back. Noted cuts on residents [sic] left side forehead, under eye, and under nose. Applied cold compress on face. Called POA (power of attorney) and agreed to sending him in for evaluation. Reported to nurse manager. Facilitated transfer. Resident was assessed by first responders.left building around 0800 (8:00 AM). 11:00 AM - RN: Prior to returning to facility, writer received update from [Hospital] ED (emergency department) RN that resident did obtain a closed right clavicle fracture noting ‘it was quite small.' Resident is to wear a sling (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER Benedictine Manor of Lacrosse		STREET ADDRESS, CITY, STATE, ZIP CODE 2902 East Avenue South LA Crosse, WI 54601	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	for comfort to RUE (right upper extremity) which was provided by the ED. 11:45 AM - RN: Return [sic] returned to facility at this time via facility van and staff. R1's emergency department Discharge summary, dated [DATE], indicates in part:-History of present illness: Patient states that he was getting ready for the day and staff was assisting him getting dressed. Patient states that he rolled over and proceeded to fall out of the bed, hitting his head on the floor. No loss of consciousness. Patient reports facial pain and right shoulder pain.-Diagnostic x-ray - right shoulder: Impression: equivocal minimally offset fracture of the distal right clavicle, not visible on all views.-Impression and plan: .Discussed with patient finding of distal right clavicle fracture. Patient was placed in a shoulder sling for comfort. Recommend gentle range of motion of the right upper extremity and close outpatient follow up with primary care provider. He may also use acetaminophen for pain. Surveyor reviewed the facility's investigation summary of the incident. The incident summary indicates, in part: .At the time of the incident, it was identified that the resident's plan of care was not followed. Surveyor reviewed the facility's corrective action form, dated 1/8/26, for CNA C, the staff member taking care of R1 on the morning of his fall on 1/6/26. The form states, in part: Description of behavior/actions: During your shift on 1-6-26 you did not follow a resident's careplan [sic] for bed mobility. The resident required two staff for bed mobility and you did bed mobility on your own. This caused an injury to the resident. On 1/21/26 at 11:57 AM, Surveyor interviewed CNA C regarding R1's fall. CNA C indicated she typically works as a restorative aide but gets pulled into the halls sometimes when extra help is needed. On 1/6/26, CNA C was asked to help get residents up and went in to help R1. CNA C rolled R1 onto his left side and was performing toileting cares when he rolled off the bed and onto the floor, hitting the chair next to his bed on the way down. CNA C believed R1 was a one person assist, but he was actually a two person assist. CNA C indicated care guide sheets for each resident are inside of the linen closet door on each hallway. CNA knew this prior to helping R1 and indicated she should have looked at the sheet to verify if another staff member was needed to assist her with R1's cares. This information would have been found in the ADLs category. CNA C indicated DON B (Director of Nursing) followed up with her and pointed out this information on R1's care guide. CNA C indicated she was given education on care plans and DON B watched her perform cares before she was allowed to return to work. CNA C indicated she will look at the care plan for each resident before providing cares or performing transfers going forward. On 1/21/26 at 12:04 PM, Surveyor interviewed DON B. DON B indicated she was informed of R1's fall on 1/6/26 when she arrived at the facility that day. DON B said she found out R1's care plan had not been followed. R1's care guide had indicated he needed an assist of two staff members for ADLs. This is what staff members followed for bed mobility tasks. The care guides are posted in CNA linen closets on each hallway. CNAs can look at the guides and make copies for the day, if they choose to. They can either make a copy of the posting or have a nurse print a copy, which can be shredded at the end of the shift.CNA C was suspended pending an investigation into R1's fall. Bed mobility is now listed as a separate item on residents' care plans. Bed mobility is also listed separately on CNA care guides. A facility-wide air mattress sweep was done to ensure all air mattresses were functioning properly. DON B and maintenance checked R1's air mattress. An outside medical company and the facility's hospice vendor checked the rest of the air mattresses in the facility. No issues were found with the air mattresses or bolsters. Surveyor reviewed R1's Care Plan and CNA Care Guide in place after the fall: R1's Care Plan states, in part:-Category: Mobility - I am dependent on staff for my bed mobility, transfers and locomotion on and off unit. / Approach start date: 1/6/26 - Staff assist of 2 with bed mobility. R1's CNA Care Guide states, in part:ADLs: Ax2Bed Mobility: Ax2 with bed mobilityTransfer: Ax2 hoyerToileting: Ax2 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/6/26 the facility recognized the deficient practice and immediately implemented a corrective action plan as evidenced by the following: -Post-fall assessments were completed on R1 along with additional post-fall monitoring (skin and pain assessments).-All residents requiring a two-person assist and/or having air mattresses were reviewed for bed mobility. Care plans and care guides were updated to include this information.-The facility interviewed R1, CNA C, other staff members working at the time of R1's fall, and other residents regarding care plans being followed.-CNA C was suspended until the investigation into R1's fall was complete and received a written warning. CNA C was required to complete education and demonstrate cares before returning to work.-Air mattress inspections were conducted.-Education regarding following the plan of care was provided to licensed nurses and CNAs. Surveyor reviewed staff signatures. Most of this education was completed on 1/6/26. Surveyors interviewed several staff members on 1/21/26 regarding the education and they were able to verbalize the education.-Ongoing education provided upon hire, annually, and as-needed.-Bed mobility audits and following care plan audits being completed on a six-week tapered schedule. Date of last audits reviewed by surveyor: 1/19/26. Completed audits will be brought to the facility's Quality Council meeting to discuss.