STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525438	A. Building B. Wing	06/18/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure that every resident was treated with dignity and respect when providing activities of daily living for 3 of 18 residents (R24, R40, R42) reviewed and 3 supplemental residents (R53, R62, R61). Surveyor observed 2 staff assisting 6 residents with their meal. 4 residents were made to wait until their turn to receive dining assistance while their plate of food sat on the table in front of them. CNA/Restorative Aide E kept getting up to assist at two different tables and reported that she is not able to converse with residents and sit alongside them while she assists them with dining, because of how many she is trying to assist. R42 was not assisted with her meal in a dignified and home-like manner. R53 was not assisted with his meal in a dignified and home-like manner. Evidenced by: Facility's admission Packet, undated, includes: . Every facility resident has the right to be treated as an individual with courtesy, respect, and dignity. The facility must maintain or enhance each resident's dignity and self-worth. The facility is pleased to offer Integrative Health services. Integrative Health is a philosophy of care that focuses on the well-being of the whole person; body, mind, and spirit. R62 admitted to the facility on [DATE] and her diagnoses include: Rhabdomyolysis (a serious and potentially life-threatening medical condition involving the rapid breakdown of damaged skeletal muscle), dementia without behavioral disturbances, moderate protein calorie malnutrition, adult failure to thrive, and cerebrovascular disease (condition that affects blood flow to your brain). R62's Comprehensive Care Plan, initiated 10/23/26, includes: Staff to provide verbal cues, set up tray, pour liquids, cut foods, and apply condiments with each meal, assist with eating as needed. R24 admitted to the facility on [DATE] and his diagnoses include: dementia. R24's Comprehensive Care Plan, initiated 10/16/23, includes: Staff to provide setup and supervision assist with feeding. Staff to provide verbal cues, set up tray, pour liquids, cut food, and apply condiments with each meal. R40 admitted to the facility on [DATE]. Her diagnoses includes: cerebrovascular disease, hospice, (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	adult failure to thrive, vascular dementia, and disturbances of salivary secretion. R40's Comprehensive Care Plan, initiated 3/11/25, includes: Provide regular diet order with pureed textures and thin liquids as tolerated for comfort. Staff provide as needed assistance with all by mouth intake. Meals eaten in the restorative main dining room. Meals provided on a divided plate. R42 admitted to the facility on [DATE] and his diagnoses include: Congenital hydrocephalus (an abnormal buildup of cerebrospinal fluid in the brain's ventricles). R42's Comprehensive Care Plan, initiated 9/22/25, includes: Staff to provide total assist with feeding. Feeding assistance at meals- alternate liquids and solids, slow rate of intake. R53 admitted to the facility on [DATE]. Her diagnoses include: Neurocognitive disorder with Lewy bodies, Parkinson's disease, feeding difficulties, and cognitive communication deficit. R53's Comprehensive Care Plan, initiated 2/15/21, includes: Staff provide feeding assistance/supervision as needed. R61 admitted to the facility on [DATE]. R61's MDS, with ARD of 3/27/26, indicates R61 requires setup and clean up assistance with eating. On 6/3/26 at 8:23 AM Surveyor observed CNA/Restorative Aide E (Certified Nursing Assistant) sitting between R42 and R53, assisting them with their meals. Surveyor also observed CNA/Restorative Aide E turn around to another table where she assisted R24 and R61. CNA/Restorative Aide E was going from one resident to the next assisting them by giving bites, placing forks or drinks in their hands, and providing verbal cues. Surveyor observed RN C seated between R40 and R62 assisting them with their meals. (It is important to note together the 2 staff were assisting 6 residents with dining.) On 6/3/26 at 9:53 AM Surveyor shared observation with NHA A (Nursing Home Administrator). NHA A indicated it would be hard for 2 staff to assist 6 residents with dining services. NHA A indicated staff should be seated next to a resident/s and assist them for the duration of the meal. On 6/3/26 at10:50 AM CNA/Restorative Aide E stated, I have been trying to tell them that we need more help in the dining room. There are usually more residents to assist too. CNA/Restorative Aide E indicated she does not think residents should get a bite and then have to wait for three others to take a bite before they get their next bite. CNA/Restorative Aide E indicated she would like to be able to sit next to one or two residents and be able to converse with them while assisting them with their meal, but she is unable to do that when she is trying to make sure four or more residents get a hot meal and they keep going. On 6/3/26 at 11:17 AM RN C (Registered Nurse) indicated there is usually one to two staff in dining room to assist 6 or more residents. RN C indicated more help is needed to assist residents in a dignified way. RN C indicated staff should not be getting up and going from resident to resident giving one bite to each like a circuit. RN C indicated she is not sure how the facility decides who will assist in the dining room, but she knew CNA/Restorative Aide E needed assistance so she came to help. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/3/26 at 12:16 PM DON B (Director of Nursing) indicated staff should sit next to one or two residents and assist them for the duration of their meal while conversing and interacting with that resident/s. DON B indicated CNA/Restorative Aide E going in between 4 residents does not allow CNA/Restorative Aide E to assist residents in a dignified way and leaves a lot of opportunity for missed hand hygiene. Example 2: R53 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease (a progressive nervous system disorder that affects movement) and muscle weakness. R53's quarterly MDS (Minimum Data Set) assessment, with an assessment reference date of 3/8/26, indicates R53 requires substantial/maximal assistance for eating. On 6/1/26 at 12:22 PM, Surveyor observed CNA E (Certified Nursing Assistant) assisting R53 with her lunch meal. CNA E was standing up next to R53 while providing feeding assistance to R53. CNA E continued to provide feeding assistance while standing for the entirety of R53's meal. Surveyor observed CNA E use the clothing protector on R53's chest as a napkin. CNA E used the clothing protector to wipe R53's mouth. On 6/1/26 at 12:33 PM, Surveyor interviewed CNA E. CNA E indicated she usually feeds multiple residents at one time, and standing allows her to move faster between the residents. CNA E indicated R53's nose drips frequently and CNA E was assisting R53 to wipe her nose and that is why CNA E used the clothing protector. Example 3 R42 was admitted to the facility on [DATE] with a diagnosis of quadriplegia (the partial or total loss of motor and sensory function in all four limbs and the torso). R42's quarterly MDS (Minimum Data Set) assessment, with an assessment reference date of 3/4/26, indicates R42 is dependent on staff for eating. On 6/1/26 at 12:23 PM, Surveyor observed CNA D (Certified Nursing Assistant) assisting R42 with his lunch meal. CNA D was standing up next to R42 while providing feeding assistance to R42. CNA D continued to provide feeding assistance while standing for the entirety of R42's meal. Surveyor observed CNA D use the clothing protector on R42's chest as a napkin throughout the meal. CNA D continued to use R42's clothing protector to wipe his mouth during the meal. On 6/1/26 at 12:53 PM, Surveyor interviewed CNA D. CNA D indicated while assisting with feeding she watches and supervises all the residents in the dining room. CNA D indicated she stands while assisting R42 with his meal because R42's wheelchair is higher, and it is awkward to reach the utensil up to R42's mouth in a sitting position. CNA D indicated she uses the clothing protector in place of a napkin because the clothing protector is cleaner than the napkin. On 6/3/26 at 11:20 AM, Surveyor interviewed RN C (Registered Nurse). RN C indicated staff should be seated when proving feeding assistance to a resident. RN C indicated napkins should be use as it is not dignified to use clothing protectors as a napkin. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/3/26 at 12:16 PM, Surveyor interviewed DON B (Director of Nursing). DON B indicated staff should be seated when providing feeding assistance to a resident. DON B indicated staff should not be using clothing protectors as napkins.

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety 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 interviews, observations, and record reviews, the facility failed to ensure that 2 of 3 residents (R5 and R40) reviewed for pressure injuries out of a total sample of 21, received care to prevent the development of pressure injuries and/or promote the healing of existing pressure injuries.R5 had a chronic left heel ulcer and was at risk for the development of additional pressure injuries. The facility implemented a Rooke Boot but did not include interventions for staff to follow related to removal of the boot. Staff interviews found that staff did not consistently remove the boot and/or did not complete a thorough skin inspection with cares. R5 developed a stage 4 pressure injury to the left calf. When the pressure injury showed signs of worsening, the physician was not consulted to determine if there was a need to change treatments. Observations found that R5 would lie on his back with the left calf resting directly on the mattress without pressure relieving devices in place. In addition, wound care was not completed in a manner that would promote the healing of the pressure injury.These failures created a finding on immediate jeopardy that began on 4/28/26. NHA A (Nursing Home Administrator) was notified of the immediate jeopardy on 6/4/26 at 1:07PM. The immediate jeopardy was removed on 6/5/26, however the deficient practice continues at a scope/severity of G (actual harm/isolated) based on the following example:R40 was admitted to the facility without pressure injuries. While at the facility, R40 developed avoidable pressure injuries. Weekly wound assessments were not completed and R40's mid upper back pressure injury worsened to an unstageable pressure injury and required antibiotics. Evidenced by:The facility's policy and procedure dated 9/1/18 includes, .A resident centered care plan is implemented/updated for skin risk with interventions based on areas of risk, resident assessment, Braden evaluation score of 15 or less, clinician assessment/evaluation, resident preferences. Members of the care team are notified and consulted as necessary. Skin integrity is monitored and abnormal findings are documented. Skin is observed daily with cares.Weekly skin audits are performed by a licensed nurse.Evaluate current pressure reduction interventions and revise resident centered care plan.Notify the attending provider.if the pressure injury has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Re-evaluate plan of care as appropriate.The NPIAP (National Pressure Injury Advisory Panel) classifies a PI as follows: Stage 4: Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts may be associated with Stage 4 pressure ulcers. Unstageable: Obscured full-thickness skin and tissue loss full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation reveals a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the extent of tissue injury, or many resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness pressure injury. (Unstageable, Stage 3 or Stage 4). 1) R5 was originally admitted to the facility in January 2020 and readmitted to the facility on [DATE] with diagnoses of disease of spinal cord, type 2 diabetes, and diabetic neuropathy.R5's MDS (Minimum Data Set) assessment, dated 2/3/26 indicates R5 has moderate cognitive impairment, has upper and lower extremity impairments on both sides, and is dependent on staff for bed mobility. The MDS also indicates R5 is at risk for pressure injuries, and had 1 unstageable pressure injury.R5's care plan, (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dated 1/24/20 included a focus area of skin impairment. Interventions included:~Observe for alteration in skin integrity and report to care provider. Skin inspected by licensed staff weekly on bath day. (1/24/20)~CNAs (Certified Nursing Assistants) to observe skin with cares and report abnormalities to the nurse. (1/24/20)~Followed by wound nurse weekly. (7/22/25)~Float heels off bed. (7/22/25)~Encourage laying down between meals. (3/20/26)R5's care plan, dated 6/13/25 included a focus area of dependent on staff for bed mobility, transfers. Interventions included:~Staff to ensure call light in in Resident's reach.(6/13/25)~Staff to assist with doors, elevators, inclines, and tight spaces as needed. (6/13/25)~Assist with repositioning every 2-3 hours and as needed. Assist of 2 for bed mobility. (2/9/26)On 2/9/26, a Braden Scale was completed with a score of 15. This indicates R5 is at risk for pressure injuries.A progress note on 4/14/26 at 2:47 a.m. states, Wound to left calf noted when completing heel TX (treatment). Wound has a small amount of sanguineous drainage which was noted dried onto his boot as well as on the pillow that supports the resident's leg. Wound edges are not approximated; skin surrounding is reddened. Inner wound bed has seemed to have scabbed over, however the outside wound bed has split from the healthy skin and appears to have some sloughing. Resident expressed pain to the area.A progress note from wound rounds on 4/14/26 at 11:40 a.m. states, .Resident has new area to left calf measuring 4.5x6cm (centimeters). Necrotic/slough tissue to wound bed. Has foul smelling odor.new orders include: Dakins gauze to area, Vaseline to peri wound, wrap with ABD (abdominal pad) and Kling. Complete BID (twice a day). Change Rooke boots back to green offloading boots. Orders carried and dressing complete.There is no documentation indicating when the Rooke Boot was implemented. There were no approaches related to the care staff were to provide to R5 in relation to the Rooke Boot including how often it should be removed and the need to complete skin inspections.On 6/3/26, DON B (Director of Nursing) brought Surveyor a Rooke Boot. The inside of the boot was made of soft material. Surveyor could feel a straight hard backing that ran down the back of the boot from the ankle to the top edge.On 4/15/26, PA-U (Physician Assistant) documented, .updated on rounds.that a new wound was noted to R5's calf.CNA reports R5 has been having more leg pain, though it was assumed this was related to his chronic left heel ulcer.He is at risk for poor wound healing and wound complications due to complete immobility, frailty, diabetes, and poor nutritional status. Left posterior calf with necrotic, foul smelling ulcer, with moist tan periwound tissue. Mild surrounding erythema. Area is very painful for R5.Pressure ulcer of left leg.Wound is currently unstageable, though it appears it will be a stage 4 wound.I recommend getting a new pair of Rooke Boots or switch back to green boots.4/15/26 11:37 a.m. Wound Management Detail Report for R5's left calf includes 4.5cm x 1 cm, light serous exudate, foul odor with necrotic tissue in the wound bed.4/15/26 physician's order included, left calf treatment: cleanse. Apply Vaseline to periwound. Dakins 0.125% to gauze on wound bed. Cover with ABD. Secure with Kling. Change BID and PRN (as needed).On 4/16/26, R5's skin integrity care plan was updated to include interventions of, Treatment to left calf per MD (Medical Doctor) order.Green multi podous [sic] boot on at all times to bilateral lower extremities.4/22/26 wound rounds documentation at 1:08 p.m. states, .Resident's ulcer to left calf measures 5 x 2x 0.5 cm. Foul smell and continues to have necrotic tissue. Dressing completed.continue dressing changes at this time.4/22/26 Wound Management Detail Report for R5's left calf includes 5 x 2 x 0.5, light serous exudate, foul odor, necrotic tissue, surrounding skin with erythema/blanchable.R5's wound has gotten larger and the skin surrounding the wound has changed since the 4/15/26 assessment.A 4/24/26 progress note states, IDT (Interdisciplinary Team) review of chronic pressure injuries to left heel and left calf. Resident changed from rooke boots back to pressure relieving boots, DC (discontinue) elevated foot pillow. Resident encouraged to alternate between bed and chair.On 4/24/26, a physician's order was added, Remove pressure relieving boots and observe skin. Document if adverse findings. This was to occur each morning. Prior to this order, there were no directions to staff on removal of a device and inspection of the skin under the device. On 4/29/26, R5 enrolled in hospice care.4/29/26 wound round notes state, Continues to have necrotic ulcer to left calf and mepilex (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	applied. Continues to have necrotic ulcer to left calf measuring 4.5x1x.5. Depth can be measured now. Foul smell noted. Dressing was changed. Area was review with PA, no new orders at this time.4/29/26 Wound Management Report documents 4.5 x 1 x 0.5 cm, light serous drainage, foul odor present, Stage 4, necrotic tissue, surrounding skin pink/normal.5/4/26, Braden Scale was completed with a score of 11, indicating R5 is at high risk for pressure injury development. R5's previous score was 15 or high risk for pressure injury development.5/6/26 wound round note for R5's left calf states, .continues to have necrotic area to left calf and heel.left calf is declining, measuring 6x2x.5. Necrotic tissue with redden skin around wound bed. Mild drainage noted to old dressing.No new treatment orders at this time.5/6/26 Wound Management Detail Report indicates R5's left calf wound to be 6 x 2 x.5, light seropurulent drainage, foul odor, stage 4 necrotic, surrounding skin pink/normal.R5's pressure injury has increased in size, and the drainage is no longer clear, but contains pus. Despite this change, there is no indication that the physician was consulted.R5's 5/13/26 Wound Round note states, Resident continues to have necrotic areas to left calf and heel. Treatments completed. Left calf is stable, measuring 7x2x1cm. Necrotic tissue with slough in wound bed, with reddened skin around wound bed. Mild drainage note to old dressing. No s/sx (signs or symptoms) of infection. No new orders at this time.5/13/26 Wound Management Detail Report indicates R5's calf wound is 7cm x 2cm x 1cm, moderate seropurulent drainage, foul odor, unstageable-deep tissue.R5's left calf pressure injury has increased in size and depth and has increased drainage. The staff completing this documentation has documented that this is an unstageable deep tissue injury; however, that is incorrect as it was previously documented as a stage 4. Despite the increasing size and depth and increasing drainage, there is no evidence the physician was consulted for potential change in treatment.R5's 5/20/26 Wound Round note states, Resident continues to have neurotic areas to left calf and heel. Treatments completed. Left calf is stable measuring 7x2x1cm. Necrotic tissue with slough in wound bed, with reddened skin around wound bed. Mild drainage noted to old dressing.R5's 5/27/26 Wound Round note states, Resident continues to have necrotic areas to left calf and heel. Treatments completed. Left calf is stable, measuring 7x2x.5. Necrotic tissue with slough in wound bed, with reddened skin around wound bed. Mild drainage noted to dressing.5/27/26 Wound Management Detail Report indicated R5's left calf pressure injury is 7 x 2 x 0.5 cm with light serous drainage, with foul odor. Pressure injury is unstageable due to the presence of slough and the surrounding skin is pink/normal.On 6/3/26, Surveyor observed R5's wound treatment performed by WCN V (Wound Care Nurse) who was assisted by RN C (Registered Nurse). Upon entering R5's room, Surveyor observed R5 lying on his back in bed. The green boots were in place, however his left calf was lying directly on the mattress without any pressure relieving interventions. RN C removed both the heel and the calf dressing at the same time. (Of note: Current standards of practice recommend that wound care be performed on one wound at a time, from the complete removal of the dressing through thorough cleansing and placement of a clean dressing, before moving to the next to complete the wound care consecutively and concurrently.)While removing the heel dressing, RN C placed a gloved hand directly on R5's soiled left calf dressing causing R5 to say Ow, and groan. RN C did not remove soiled gloves and complete hand hygiene after handling the soiled dressings. WCN V then proceeded to spray wound cleanser on the calf pressure injury and wipe the area with gauze. WCN V then turned the same piece gauze over and used it to wipe the heel wound after spraying it with wound cleanser.(Of note: Cleansing of the wound should be completed with clean gauze with each cleansing and soiled or used gauze should not be reused on another wound.) Surveyor noted a foul odor during the observation and asked if the odor was coming from both the heel and the calf wound. WCN V confirmed the odor was coming from both wounds. WCN V indicated the left calf pressure injury was a large and deep wound with visible slough and beefy red tissue. WCN V did not measure the depth of the calf pressure injury. WCN V indicated that the calf used to be 1 open area, however a bridge of new skin had formed. WCN V then proceeded to place 1 wet dressing over both areas and the bridge of new skin. Placing a wet gauze over intact skin can cause maceration to the newly (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	formed skin creating a potential for skin impairment. On 6/3/26 at 3:59 p.m., Surveyor interviewed WCN V and DON B. WCN V confirmed that she had removed both R5's heel and calf dressings at the same time. WCN V also confirmed that the treatments were also done at the same time and they should have been done consecutively rather than concurrently. WCN V also confirmed that she did use the same piece of gauze to cleanse both wounds but agreed that she should have used a different piece of gauze for each wound. Surveyor asked what the expectation is for someone who touches a soiled dressing. WCN V stated that person should complete hand hygiene. Surveyor asked WCN V if measurements were completed of R5's left calf pressure injury. WCN V stated she did not measure the depth.On 6/3/26 at 1:35 p.m., Surveyor observed R5 sitting up in bed with the left calf resting directly on the mattress.On 6/3/26, Wound management detail report indicates that R5's left calf pressure injury is 8 cm x 3.5 cm x 0.5 cm, with light serosanguineous drainage with odor present. The stage is documented as Unstageable - Deep Tissue with slough and surrounding skin is pink/normal. The pressure injury is currently unstageable because the wound base is obscured by slough; unstageable implies there is full-thickness skin and tissue loss in the affected area.On 6/3/26, NHA A (Nursing Home Administrator) provided Surveyor with their investigation into the development of R5's left calf pressure injury. Witness statements included:~4/24/26: I don't remember seeing it. He did complain of increased pain/discomfort kind of all over. I reported it to my nurse. I usually give him a bed bath on Mondays per his preference.~4/24/26: Couldn't remember why skin check observations were not completed.~4/26/26: I don't remember seeing it. When I take his tubi-grips off, I inspect the front of his legs but not really the back.~4/29/26: R5 doesn't recall how he obtained the area. Resident states his leg hurt all over and not in one specific spot.On 6/4/26 at 8:30 a.m., Surveyor interviewed PA U (Physician Assistant) and asked when she was first made aware of R5's left calf pressure injury. PA U indicated she was notified on 4/15/26 and assessed the wound that day as she was already in the facility. Surveyor shared with PA U the observation of the Rooke Boot and the hard material that ran the length of the boot. PA U indicated she was not aware of that. Surveyor asked PA U if she thought adding pillows or a cushion would have been effective in reducing pressure to R5's calf. PA U indicate that an air mattress would be more effective. On 6/4/26 at 9:00 a.m., Surveyor interviewed DON B and RDCS L (Regional Director of Clinical Services). Surveyor asked what interventions were tried for R5. DON B indicated elevator pillows were tried, but they were uncomfortable for R5. DON B did not share any additional pressure relieving device attempts after the elevator pillows were not effective. The failure to monitor R5's skin condition under a medical device and the failure to consult with a physician when the left calf pressure injury worsened, created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The facility removed the jeopardy on 6/5/26 when it had completed the following:Resident (R5) is no longer a resident of the facility.Residents with medical devices are at risk. This has the potential to impact 14 residents.Residents with pressure injuries are also at risk. This has the potential to impact 6 residents.All licensed nurses will be educated on the importance of inspecting skin daily with removal of medical devices.All licensed nurses will complete education on Preventing Skin Infections (POL_IP093), Hand Hygiene (POL_IP054), and Prevention and Treatment of Skin Breakdown (POL_NS1702). All licensed nurses will be educated on assessing residents for pain pre- and post-treatment.All nursing staff will be educated on ensuring pressure relieving interventions are implemented and/or followed.All education noted above to be completed by next working shift. Any nursing staff who do not complete the education will not be scheduled until completed. Residents who have medical devices will have order set placed to remove device daily and complete skin inspection.Residents with pressure injuries will have order set placed for pre- and post-treatment pain assessment.Residents with medical devices and pressure injuries had care plan interventions reviewed and revised as necessary.The Hand Hygiene and Prevention and Treatment of Skin Breakdown policies were reviewed for accuracy. No revisions were needed.DON or Designee will conduct the following audits daily for 2 weeks, 2x times weekly for 2 weeks, 1x weekly for 8 weeks, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525438	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and monthly for 3 months:Skin Assessments with Proper Removal of Medical DevicesHand Hygiene with Wound CarePain Assessments Completed Pre- and Post-TreatmentPressure Relieving InterventionsResults of audits will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.The facility assessment was reviewed for accuracy as it relates to pressure injuries. No revisions were needed. The deficient practice continues at a scope/severity of a G (actual harm/isolated), based on the following example: 2.) R40 was admitted to the facility on [DATE] with diagnoses including cerebrovascular disease, adult failure to thrive, epilepsy, type 2 diabetes, and vascular dementia. R40's most recent Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/24/26 indicates R40 has a Brief Interview for Mental Status score of 0 out of 15, indicating severe cognitive impairment. Section GG indicates R40 has lower extremity impairments on both sides and is dependent on staff for rolling left and right in bed. Section M indicates R40 is at risk for developing pressure injuries and has one stage two pressure injury and one unstageable pressure injury. R40's Comprehensive Care Plan states, in part:Problem: Resident needs assist with bed mobility, transfers, ambulation, and locomotion due to impaired mobility, generalized weakness, and impaired cognition. Problem Start Date: 9/17/25.Approach: -Staff assist of 2 with bed mobility. Approach Start Date: 1/6/26.Problem: Resident needs assist with dressing, personal hygiene, and bathing due to impaired mobility, impaired cognition, and generalized weakness. Problem Start Date: 9/17/25.Approach: Assist of 2 for ADLs (Activities of Daily Living).Problem: I am at risk for potential skin integrity issues related to impaired mobility. I have failure to thrive, incontinence, seizure d/o (disorder), weakness, impaired cognition, urinary incontinence, and DMII (Diabetes Mellitus Type 2) which may affect my abilities. Problem Start Date: 3/20/25.Approach: -Staff will observe for alterations in my skin integrity and report these findings to NP/PA/MD as necessary. My skin is inspected by licensed staff on a routine basis. Approach Start Date: 3/20/25-Staff will use a lift sheet to move me in bed. Approach Start Date: 3/20/25.-Apply creams as ordered. Approach Start Date: 3/20/25.-Followed by wound team weekly. Approach Start Date: 12/11/25. On 1/8/26, R40's Care Plan was updated to include the approach: Alternating air mattress from hospice. Call hospice with concerns. On 1/20/26, R40's Care Plan was updated to include the problem: Resident receives hospice services related to cerebral vascular disease from [Hospice Agency Name and Contact Information.] The approach is listed as: Facility will coordinate with hospice providers and reference hospice care plan located in resident's chart. On 2/9/26, a hospice note was written that states in part: . Hospice Integumentary (skin). Issues: decubitus ulcer. Additional Comments: 2/9/26: Red/blanchable hot area to mid spine on bony prominence. Mepilex applied. Q (every) 72hrs (hours) change or if soiled. LDA (Line/drain/airway) and Wound Assessment. midline back pressure injury.Pressure Injury Stage: 1. Base: blanchable; red.Periwound: intact; moist. Encounter Notes. R-Recommendations: -Pillow, repositioning for pressure offloading to back -Mepilex.(Of note: No measurements of the pressure injury were taken at this time. Additionally, this note, along with all other hospice notes, are inaccessible to floor staff. No record of a pressure injury assessment being documented in the facility's electronic medical record.)On 2/13/26, a hospice note was written that states in part: . Hospice Integumentary. Additional Comments: 2/13/26: Wound on back is still red and blanchable, but small gray/black circle noted in middle of the wound. Encounter Notes. -Mepilex changed on back. Red and blanchable [sic]. New gray/black circular area in the center of the redness. R-Recommendations: -Reposition [Resident Name] to deload pressure off middle of back New orders written and/or care plan changes: n/a (not applicable).(Of note: Wound has now declined compared to previous assessment. No measurements or staging is recorded in the note) On 2/17/26, a hospice note was written that does not contain wound bed characteristics, measurements, or staging. On 2/25/26, a hospice note was written that states in part: . LDA and Wound Assessment. Active Wound. midline back pressure injury. additional comments: Red blanchable area to mid spine [sic] on bony prominence. Drainage Amount: scant. Encounter Notes. (continued on next page)

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	525438	A. Building B. Wing	06/18/2026

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A-Assessment/Observation or issues this visit:. -Dressing changed on her back. New scant drainage. Wound does not appear to be open yet, question if it opened and closed again? .(Of note: No provider notification is documented with the change in drainage and possible opening of the wound) On 3/2/26, a hospice note was written that does not contain wound bed characteristics, measurements, or staging. On 3/13/26, a hospice note was written that states in part: . Hospice Integumentary. Additional comments: 3/13/26: Wound on back is changing. periwound no longer red. but middle area is now open/gray, [sic] larger and has drainage with [sic] sloughing skin. LDA and Wound Assessment. Base: gray; red. Gray center looks more pronounced and larger in area, appears open with scant drainage. Sloughing skin noted. R-Recommendations: -Position off center of back.(Of note: this recommendation is not entered into the care plan. Additionally, there is no documentation of a provider notification regarding the changes in R40's pressure injury.) On 3/19/26, R40's Care Plan was updated to include the approach: Encourage repositioning q (every) 2-3 hours and PRN (as needed.) On 3/23/26, a hospice note was written that does not contain wound bed characteristics, measurements, or staging. On 3/26/26, a hospice note was written that does not contain wound bed characteristics, measurements, or staging. On 3/30/26, a hospice note was written that does not contain wound bed characteristics, measurements, or staging. Additionally, there is no documentation regarding the Mepilex dressing change being completed. On 4/3/26, a hospice note was written that does not contain wound bed characteristics, measurements, or staging. On 4/7/26, a hospice note was written that states in part: . LDA and Wound Assessment. Dressing Appearance: moist drainageBase: moist; slough. superficial opening, scant serosanguinous drainagePeriwound: moist; redness; warm DrainDrainage Characteristics/Odor: yellowDrainage Amount: scant. Encounter Notes. A-Assessment/Observation. -wound dressing changes. Wound appears to have more yellow drainage with some skin peeling. blanchable redness peri-wound and moist. R-Recommendations: -cleanse wound with dressing changes. New orders written and/or care plan changes: per [Name} NP -utilize anapest for wound cleansing if tolerated.On 4/7/26, a physician order was placed that states: Cleanse wound and apply anasept and Mepilex to bony prominence on back that has blanchable redness. Change every 72 hours or if soiled.(Of note: This is the first time R40's mid upper back pressure injury treatment has changed since its identification on 2/9/26)On 4/9/26, a hospice note was written that states in part: . LDA and Wound Assessment. Base: dry; slough. superficial opening, scant serosanguineous drainage.On 4/20/26, a hospice note was written that does not contain wound bed characteristics, measurements, or staging.On 4/13/26, a hospice note was written that does not contain wound bed characteristics, measurements, or staging.On 4/22/26, a hospice note was written that states, in part: . A - Assessment/Observation. - [Resident Name] ?s wound on back is gray, slough, serosanguineous drainage. R - Recommendations: - Apply aquacell to wound beds for [Resident Name]'s back and coccyx. New orders written and/or care plan changes: -Per [Name] PA-C, -Apply aquacell to wound bed of back and coccyx wound. Change dressing every other day.On 4/22/26, a note was written by PA U (Physician Assistant) that states in part: . Chief Complaint. Worsening pressure wounds to back and coccyx. Interval Update:. I was updated at [Facility Name] that [Resident Name] had developed a new wound to her coccyx and the pressure area over her mid spine had deteriorated, now with a very dark purple/black wound bed. The area on her spine was being covered with a Mepilex dressing for protection. Z-guard was being used to her coccyx. Physical Exam. Skin. Lower back over spine has an unstageable DTI (Deep Tissue Injury) with about 50% of the wound open with dark tissue in the wound bed. Impression/Plan. 1. Pressure injury of back, unstageable. We will encourage her to lay down between meals and offload side to side. Treatment is changed to Aquacel cut to fit wound beds and cover with Mepilex, changing QOD (every other day) and prn if soiled.(Of note: This is the first note indicating a provider assessed R40's mid-spine pressure injury.)On 4/22/26, a Wound Assessment completed by WCN V included: 2 cm x 1 cm x unable to measure; no exudate; necrotic tissue; pink/normal skin surrounding wound. On 4/23/26, R40's Care Plan was updated to include the approaches: Tx (Treatment) to upper mid back per MD order; and (continued on next page)

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	525438	A. Building B. Wing	06/18/2026

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	encourage resident to off load side to side.On 4/29/26, a Wound Assessment completed by WCN V included: 1.5 x 1.5 x unable to measure; light serosanguineous exudate; no odor; necrotic tissue; pink/normal skin surrounding wound. On 5/6/26, a Wound Assessment completed by WCN V included: 2 x 1.5 x unable to measure; light seropurulent exudate; no odor; necrotic tissue; pink/normal skin surrounding wound. On 5/7/26, R40's Care Plan was updated to include the approach: When repositioning, ensure shirt is not bunched up in the back.On 5/20/26, a Wound Assessment completed by WCN V included: 2 x 1.5 x unable to measure; no exudate; no odor; Stage unstageable - slough and/or eschar; necrotic tissue; pink/normal skin surrounding wound; healing status declining. On 5/27/26, a Wound Assessment completed by WCN V included: 2 x 1.5 x unable to measure; light serosanguineous exudate; foul odor present; unstageable - slough and/or eschar; necrotic tissue; pink/normal skin surrounding wound; healing status declining. A Progress Note dated 6/1/26 at 17:26 (5:26 PM) states in part: New orders received from [Name] PA-C. Cefadroxil (Antibiotic) 500mg BID x7 days for dx (diagnosis) of cellulitis of back - pressure wound.On 6/3/26, a Wound Assessment completed by WCN V included: 4 x 1.5 x unable to measure; light serosanguineous exudate; no odor; unstageable - slough and/or eschar; necrotic tissue; pink/normal skin surrounding wound. A Progress Note dated 6/3/26 at 16:59 (4:59 PM) states in part: WOUND ROUNDS: resident continues having necrotic area to mid back measuring 4x1.5cm. Resident is being treated with antibiotics for infection of wound. Area around wound is red and swollen. Treatment completed.On 6/3/26 at 10:21 AM, Surveyor observed R40's wound treatment R40's wound treatment performed by WCN V (Wound Care Nurse) who was assisted by RN C (Registered Nurse.) Surveyor observed WCN V don (put on) a glove on her right hand, then use her ungloved left hand to touch and maneuver bedding. WCN V then donned a glove on her left hand without performing hand hygiene and proceeded with the wound treatment. Surveyor observed wound to mid back with tissue that appeared to be black, with some yellow or tan tissue within the darker, black tissue. Surveyor asked WCN V how she would describe the tissue in the wound bed. WCN V indicated she sees necrotic and slough tissue in the wound bed. Surveyor also observed periwound skin to be red and swollen. Surveyor asked WCN V to describe the periwound. WCN V indicated the periwound is more red and swollen than it was during R40's previous assessment last week. Surveyor observed WCN V prepare the Medihoney with Aquacel gauze, hold it up to the wound bed, where Surveyor observed the gauze contact the wound bed. WCN V then removed the gauze, cut it to size, then placed it back on the wound bed.On 6/3/26 at 2:36 PM, Surveyor interviewed CNA O (Certified Nursing Assistant.) Surveyor asked CNA O if CNAs or nurses complete weekly skin checks. CNA O indicated nurses do the weekly skin checks with showers or baths. Surveyor asked CNA O what she does if she notices a resident has a skin change. CNA O indicated she tells a nurse right away. Surveyor asked CNA O how she knows which residents have pressure relieving interventions. CNA O stated the interventions are hard to miss, but I also know if there is an order for barrier cream. It's also on the care plan. Surveyor asked CNA O if there is a way for staff to keep track of when residents are turned when they have a turning / repositioning schedule. CNA O indicated, no, I don't think so. Surveyor asked CNA O what she does if a resident refuses their pressure-relievi

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	525438	A. Building B. Wing	06/18/2026

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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. Based on interview and record review, the facility failed to ensure each resident receives adequate supervision to prevent accidents for 1 of 5 residents (R21) reviewed for accidents.R21 self-transferred and fell backwards while grabbing for her walker, hitting her head. Subsequently, R21 sustained a laceration to the back of her head that required staples. CNA K (Certified Nursing Assistant) stated to Surveyor that R21 ambulates independently 3-4 times each shift. There is no evidence that risks and benefits associated with self-ambulating have been discussed with R21's APOAHC (Activated Power of Attorney for Health Care.) There is no evidence of increased monitoring to prevent further self-ambulation and potential injuries. Evidenced by:The facility policy and procedure, Integrated Fall Management, undated, documents in part, as follows: Purpose: Fall risk assessment, identification, and implementation of appropriate interventions as necessary, to maintain resident safety, prevent falls and reduce further injury from falls. 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.Procedure:.3. Residents at risk for falls have an individualized resident centered care plan developed. Care plan interventions are based on the finding of the fall risk assessment. 4. Additional professionals may be contacted to provide assessment and/or interventions regarding fall risk and prevention, including but not limited to, attending physician/provider, pharmacist, physical therapist, occupational therapist, and speech therapist.Definitions: Fall - Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground.Fall with Injury: A fall with injury is when there is any resultant change in resident's physical condition following a fall. This includes skin tears, abrasions, lacerations. R21 was admitted to the facility 2/13/25 with diagnoses including, but not limited to, the following: cerebrovascular disease, vascular dementia, generalized anxiety disorder, osteoarthritis, pain, and weakness.R21's Annual MDS (Minimum Data Set) dated 2/13/26 documents a score of 10/15 on her Brief Interview for Mental Status, which indicates R21 is moderately cognitively impaired. Section J indicates R21 has sustained one (1) fall with no injuries since Admission/Entry/Reentry. R21 has an APOAHC (Activated Power of Attorney for Health Care.) R21's Mobility comprehensive care plan, dated 8/26/25, documents in part, as follows: Resident needs assist with bed mobility, transfers, ambulation, and locomotion on and off unit due to dementia, malnutrition, adult failure to thrive, and osteoarthritis. Has a hx (history) of self-transferring despite staff education and reapproach. Is aware of my risks/benefits.R21's Falls comprehensive care plan, edited 5/27/26 documents: Problem: Resident is at high risk for falling due to confusion, incontinence, medication use, cardiac dysrhythmias (irregular heartbeat,) visual and hearing deficits, hx (history of) falls, and agitation. Goal: (Edited 5/27/26) resident will not have fall related injuries during this quarter.Approach:(Start Date 5/19/26) Keep walker next to resident when in recliner(Start Date 2/23/26) Keep w/c (wheelchair) close to resident when in recliner(Start Date 6/26/25) Offer to toilet between 2-4PM as resident likes to have bowel movement around that time some days(Start Date 5/28/25) Colored call don't fall sign placed in room(Start Date 4/7/25) Resident prefers to have slippers with grippy bottoms(Start Date 3/4/25) I like to self-transfer, keep my walker close to me and remind me to use it(Start Date 3/4/25) Resident to wear grippy socks when up, staff to ensure that grippy is not worn down on socks(Start Date 2/14/25) I require staff to toilet me every 2-3 hours and PRN (as needed) On 12/29/25, R21's Fall Investigation documents in part, as follows:Event Date: 12/29/25 3:24 PMLocation of Fall: Resident BathroomWas the fall witnessed: NoWho was the resident found by: NurseActivity at time of fall: BlankResident Description of Fall: I pooped my pants and was trying to get to the bathroom. (Note: R21 fell while self-transferring)Staff Description of Fall: Sitting against (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	bathroom wall, sitting on top of walker, gripper socks on.Were there any injuries: NoLast time rounding was completed/resident was observed: 3:15 PMLast time resident was toileted: 3:00 PMContributing Physiological Factors: Incontinent Indicate Interventions implemented to prevent future fall/injury: Review toileting needs and adjust toileting plan Evaluation Note: IDT (Interdisciplinary Team) review of fall on 12/29/25. Resident reports she had to use the bathroom and self-transferred. Resident experienced unwitnessed fall without injuries. Resident denies pain/discomfort. No latent injuries noted. Resident has hx (history) of self-transferring. Initial fall intervention not appropriate. Fall intervention: Offer toileting between 2-4:00 PM A progress note for R21 dated 2/13/26 at 7:59 AM documents as follows: Resident had a fall at 7:30 this morning. Writer was outside her room when it happened. She said she was going to go to the bathroom. It appeared that she was using the tray table as her walker and it broke and she fell down. She was laying on the leg of the tray table and she was holding her head up. No injury noted. Resident able to do range of motion with her arms and legs. Neuros and vitals within normal limits. Writer updated provider (name) and the DON (Director of Nursing at that time.) Writer left a message with her POA (Power of Attorney) to call the facility for a non-emergency update. Interventions are to have her wheelchair by her and a sign that says to call don't fall. (IDT review 2/13/26. Resident noted to self-transfer to the bathroom. Resident utilizing tray table over walker. No injuries noted. Intervention: Have w/c (wheelchair) close to resident and call don't fall sign. R21's Fall Investigation dated 2/13/26 documents in part as follows:Event Date: 2/13/26 7:43 AMFall Details: Resident RoomWas the fall witnessed: NoWho was the resident found by: NurseActivity at the time of Fall: BlankResident Description of Fall: was going to go to the bathroom (Note: R21 fell while self-transferring)Staff Description of Fall: Describe the fall details from the staff perspective: BlankWere there any injuries: No Last time rounding was completed/resident was observed: 6:45 AMLast time resident was toileted: 6:45 AMEvaluation: IDT (Interdisciplinary Team) review of fall on 2/13/26, resident noted to self-transfer to the bathroom. Resident utilizing tray table over walker. No injuries noted. No pain/discomfort noted. Fall intervention of have wheelchair close to resident and call don't fall sign. R21's Progress Note dated 2/15/26 at 5:25 PM documents as follows: Fall: Absent s/sx (signs/symptoms) latent fall injury. Staff continue to encourage call-light use. R21's Progress Note dated 2/23/26 at 2:17 PM documents as follows: IDT (Interdisciplinary Team) review of fall on 2/13/2026. Resident noted to self-transfer to the bathroom. Resident utilizing tray table over walker. No injuries noted. No pain/discomfort noted. Fall intervention of have wheelchair close to resident and call don't fall sign. R21's Progress Note dated 3/17/26 at 12:20 PM documents as follows: It was reported to nursing by activity staff that they found resident self-transferring to the bathroom. Call light was within reach. Resident made it to the toilet without [sic] but reminded to call for staff assist with transfers. R21's Progress Note dated 3/25/26 at 7:11 AM documents as follows: Resident was found to be wandering overnight. CNA (Certified Nursing Assistant) staff redirected resident back to room and left resident momentarily to finish resident cares. Resident again wandered and was found to be in an unoccupied resident room. No apparent injuries noted. No skin issues noted. VSS (vital signs stable). On 3/30/26, R21's PT (Physical Therapy) evaluation documents in part, as follows:Precautions: Fall risk, vascular dementia, poor hearingReason for referral: Patient is a long term resident at this SNF (Skilled Nursing Facility) who recently received PT orders to evaluate and treat for safety with transfers.Patient goals: Patient would like to be able to safely ambulate with FWW (front wheeled walker)Plan level of function: Patient requires Ax1 (1 staff assist) for all transfers and ambulation. Requires Ax1 for dressing and ADLs (Activities of Daily Living). CNA staff report patient has been becoming more active and frequently self-transfers indicating PT orders.Previous therapy: Patient has trialed PT services in the past and was able to achieve transfer status of Ax1 with FWW (front wheeled walker.)Therapy Necessity: Patient requires skilled PT to address impairments/deficits which include poor safety awareness when attempt transfers and ambulating tasks requiring cues and guidance to correct. Furthermore, patient has been reported to be (continued on next page)

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	525438	A. Building B. Wing	06/18/2026

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F 0689 Level of Harm - Actual harm Residents Affected - Few	self-transferring more frequently putting patient at risk of increased risk of falls and injury. Patient would require skilled PT services to improve balance, safety and independence, and ambulation in order to prevent further self transferring and risk of falling. On 4/16/26, PT documented in part the following:Clinical Impression: Patient demonstrates gradual progress regarding her functional mobility and therapy related goals. At the time of discharge, patient remains Ax1 (1 staff assist) with FWW for all transfers and ambulation. Able to transfer and ambulate safely at an assist of one level. No changes to transfer status at this time.Anticipated Discharge Plan: Recommend patient remain Ax1 for all transfers and ambulation using FWW. Recommend patient attend daily exercise class. R21's Progress Note dated 4/21/26 at 3:22 PM documents as follows: Status: Pt (patient) walked into hallway. Distraught affect. Looking for dentures. Those should never leave my side. Pt had been napping and the dentures were soaking. Writer gave pt her dentures and she put them into her mouth independently.4/23/26 5:33 PM Status: Pt displaying more anxious affect. Several self-transfers to bathroom. Pt upset she can't find her dentures, Someone comes in here and steals them. Dentures were in her mouth. Staff encouraged to play rec therapy game. PT did go and mood improved after activity. R21's Progress Note dated 5/19/26 at 11:22 AM documents as follows: Staff member witnessed resident grab for her walker and she fell backwards, hitting the back of her head, resident is bleeding from the back of her head, unable to see the wound due to the bleeding. Writer received order from provider (name) to send resident to ER (emergency room) for head injury from fall. POAs have been called and messages left that she is being sent out. Ambulance (name) called at 11:25. R21's hospital report dated 5/19/26 at 12:06 PM documents in part as follows: .Presents from facility after a fall. Patient is unable to provide history, and family not present during event, however able to provide collateral information. Patient is wheelchair-bound, family was told as was EMS (ambulance) report that she was moving from a chair to her wheelchair unsure whether assisted by herself when she sustained a fall and hit the back of her head. Patient does have a laceration to the back of the scalp. Although she denies pains anywhere, firm palpation of comprehensive musculoskeletal system performed and patient thankfully does not yelp or complain of any pain nor is there any obvious deformity or bruising.R21's Physical Exam documents in part: Mental Status: Mental status at baseline. She is confused. A CT (Computed Tomography) of R21's head and C-spine obtained with the following impressions:No acute intracranial process.Chronic stroke in the left occipital lobe.Scalp injury posteriorly on the left.Impression:No acute abnormality of the cervical spineMultilevel degeneration changes of the cervical spineDischarge Instructions: .She (R21) did sustain a cut to the back of her head which was repaired with 2 staples. The staples will need to be removed in 7-10 days. Please follow-up with your primary care provider urgent care or the emergency department to have this done. R21's Progress Note dated 5/19/26 at 12:19 PM documents as follows: Attempted to reach POA (name) regarding fall unsuccessfully. Called Alternate POA (name) who stated that his family member (name) had reached him and the POA (name) and family member (name) is attempting to reach (name.) Advised that resident had a fall and hit her head resulting in a laceration to resident's head and that she was transported to ED (emergency department) for evaluation and treatment. R21's Progress Note dated 5/19/26 at 2:48 PM documents as follows: Fall: Pt (patient) returned from hospital. Has staples on her head and roll bandage dressing. Visible blood in hair. Pt denied pain. Vitals and neuros WNL (within normal limits.) Pt self-transferred to toilet x1 this PM. R21's Progress Note dated 5/19/26 at 3:41 PM documents as follows: Immediate fall intervention: Keep walker next to recliner when resident is in recliner chair. R21's Fall Investigation on 5/19/25 documents as follows:Description: Resident fell backwards when attempting to reach for her walker. (Note: R21 fell while self-transferring)Location of Fall: Resident roomWas the fall witnessed: YesActivity at time of fall: Transferring without assistResident description of fall: Resident unable to describe what happened.Staff Description of Fall: Staff witnessed the fall and stated resident grabbed her walker and then she fell backwards, hit her head on the bed and then the floor.Were there any injuries: YesLocation: Back of HeadDoes the resident exhibit signs or complaints of pain related to the fall: (continued on next page)

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	525438	A. Building B. Wing	06/18/2026

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F 0689 Level of Harm - Actual harm Residents Affected - Few	YesWhere is pain located: back of her headOn a scale of 0-10, how does resident rate intensity of pain if able or indicated based on observation: 4 - Moderate pain (Distression [sic], Miserable) Range of Motion: ROM (Range of Motion) without pain/limitations in both upper and lower extremitiesPositioning of Extremities: No Rotation/Deformity/Shortening NotedLast time rounding was completed/resident was observed: 10:00 AM*Last time resident was toileted: 8:30 AMWhat footwear did the resident have on at the time of the fall: ShoesPost Fall Actions: cold compress to back of headInterventions: Place walker on left side of recliner when resident is in her recliner.Contributing Environmental Factors: Not applicableContributing Physiological Factors: Not applicableContributing Mental Factors: Impaired MemoryResident's ambulation status: Assist of 1 with deviceLevel of Consciousness: Alert wakefulness - perceives the environment clearly and responds appropriately to stimuli.Facial Muscle Movement: StrongUpper Left Extremity Movement/Grasps: StrongUpper Right Extremity Movement/Grasps: StrongLower Left Extremity Movement: StrongLower Right Extremity Movement: StrongLeft Eye Pupil Size: 3 mm (millimeters)Left Eye Pupil Response/Shape: Round/BriskRight Eye Pupil Size: 3 mmRight Eye Pupil Response/Shape: Round/BriskDoes resident respond to the following: NameDoes resident exhibit or complain of any of the following since the fall: Resident sent to ER (emergency room), unable to answer at this time.Speech: ClearPost-Fall Actions: cold compress to back of headIndicate Interventions implemented to prevent future fall/injury: Other: Place walker on left side of recliner when resident is in her recliner.Evaluation: IDT (Interdisciplinary Team) review of fall on 5/19/26. Resident unable to voice what she was trying to attempt when fall occurred. Laundry aide did observe resident standing, go for walker, and then fall backwards. Resident noted to have bleeding from back of head. Resident was not moved and provider updated with orders to send to ER for eval (evaluation). Resident returned with staples to back of head. Resident offered no complaints of pain discomfort noted r/t (related to) fall. Resident has a hx of self-transferring despite staff reminders and education. Neuros and vitals were within normal limits. Immediate intervention was to keep walker next to resident when in recliner. R21's Progress Note dated 5/20/26 at 10:50 PM documents as follows: Post fall: resident denies pain associated with fall. Resident does have staples to posterior scalp laceration. No bleeding noted. VSS. Neuro checks WDL. IDT (Interdisciplinary Team) review of fall on 5/19/2026: Resident unable to voice what she was trying to attempt when fall occurred. Laundry aide did observe resident standing, go for walker, and then fall backwards. Resident noted to have bleeding from back of head. Resident was not moved and provider updated with orders to send to ER for eval. Resident returned with staples to back of head. Resident offered no complaints of pain discomfort noted r/t fall. Resident has a hx of self transferring despite staff reminders and education. Neuros (Neurological) and vitals were within normal limits. Immediate intervention was to keep walker next to resident when in recliner. (Injury Scalp injury posteriorly on the left - 2 staples) Intervention: Resident has a history of self transferring despite staff reminders and education. Immediate intervention was to keep walker next to resident when in recliner. On 6/1/26 at approximately 9:00 AM, Surveyor spoke with R21. R21 stated she receives help when she needs it. Surveyor asked R21 if she has fallen over the last couple of months. R21 responded no, staff will not let me fall. On 6/3/26 at 2:37 PM, Surveyor spoke with DON B (Director of Nursing) with RDOCS L (Regional Director of Clinical Services) and NHA A (Nursing Home Administrator) also present. Surveyor asked DON B what interventions are in place for R21. DON B stated, staff keep R21's walker next to her recliner and close to her when she's in the recliner, we toilet between 2:00-4:00 PM, have a colored call don't fall sign in her room, and she wears slippers with grippers or gripper socks. DON B added, staff are to make sure the grippers are not worn down, offer toileting every 2-3 hours and PRN (as needed.) Surveyor asked, does R21 self-transfer. DON B stated, yes. Surveyor asked DON B, what is the facility doing to prevent R21 from falling. DON B stated, we put falls interventions in place, R21 can use the call light but does not always remember so we try to anticipate her needs as we can. Surveyor asked DON B, what is the facility doing to prevent R21 from falling? Surveyor asked DON B (continued on next page)

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	525438	A. Building B. Wing	06/18/2026

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F 0689 Level of Harm - Actual harm Residents Affected - Few	when R21 is found self-transferring what are staff to do. DON B stated, staff will ask her what her needs are and if she's able to tell them they will assist her with what she was trying to do. Surveyor asked DON B, when staff observe R21 self-ambulating do they increase monitoring. DON B stated, no. DON B stated, therapy is in place, neuros are in place following falls, she is on a busy hall and we monitor her for 3 days following a fall. Surveyor shared concerns regarding R21 self-ambulating with further follow-up needed. On 6/4/26 at 1:08 PM, Surveyor spoke with CNA K (Certified Nursing Assistant) who has worked at the facility for two years. Surveyor asked CNA K, according to R21's care plan, does she need assistance for ambulating. CNA K stated, yes, R21 needs 1 assist for ambulation in her room and hallway. Surveyor asked CNA K, does R21 ambulate independently. CNA K stated, Yes, all the time, it's terrible. Surveyor asked CNA K how often does R21 self-ambulate. CNA K 3-4 times per shift. Surveyor asked CNA K, what do you do when you see R21 self-ambulating. CNA K stated she tells her nurse. Surveyor asked CNA K, do you and other staff do anything different when you observe R21 self-ambulating. CNA K stated, no, we're trying our best. CNA K added, we keep R21's walker and call light near her. CNA K stated, I'm not sure if there's another way to stop her. Surveyor asked CNA K, has R21 had any injuries with falls. CNA K stated, yes, she had a fall 1-2 weeks ago and needed staples to her head. CNA K added, R21 doesn't remember she needs assistance. CNA K added, R21 will say she can do it by herself and should be helping (staff.) CNA K stated, we remind R21 we're here to help her. On 6/4/2026 at 1:50 PM, Surveyor spoke to DON B again. Surveyor asked DON B if the facility has had a conversation with R21 and her APOAHC regarding risks and benefits associated with self-ambulating. DON B stated that the facility does not have a formal risk and benefits sheet. DON B added, we can educate R21. DON B stated, the facility will usually put this education in the care plan. There is no evidence that risks and benefits associated with self-ambulating have been discussed with R21's APOAHC. There is no evidence of increased monitoring (e.g., line of sight or 1:1 supervision is being put in place when R21 is self-ambulating) to prevent further self-ambulation and potential injuries.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on interview and record review the facility did not ensure the Physician or Provider, reviewed the resident's total program of care, including medications and treatments or sign and date all orders for 1 of 1 Residents Physician orders reviewed (R5). R5 was missing a provider review of R5's total program of care, including medications and treatments due to not having signed monthly orders for January, February, April and May of 2026 Evidenced by: Facility policy entitled, Physician Services, indicates the following: Procedure: .11. The physician will: a. review the resident's total program of care, including medications and treatments, at each visit; b. Write, sign and date progress notes at each visit; and c. sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility standing house orders after an assessment for contraindications. On 6/18/26 Surveyor conducted record review and was not able to locate signed monthly physician orders. Surveyor asked for R5's signed monthly physician orders for the last 6 months. Surveyor received the following documents:Physician order report dated 2/6/26 - 3/6/26 which was signed by R5's provider.Physician Assistant encounter note dated 1/5/26, which did not include all of R5's orders/total program of care (no orders for dietary supplements, wound care treatments, bladder scanning, tubi grips etc.,) On 6/18/2026 at 1:33 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and DON B (Director of Nursing) regarding R5's physician orders. DON B indicated monthly MD orders get printed out for when providers are going to see them, they review them and sign them, and they get uploaded into the EMAR (electronic medication administration record) every month. Surveyor asked how often this is done, DON B indicated every month if on the list to be seen for rounds. DON B indicated on admission residents are seen every 30 days, 60 days, 90 days then 60 days thereafter with alternating provider between. Surveyor asked DON B to review R5's visit note. Surveyor asked DON B if visit note includes all orders being reviewed when signed DON B indicated it does not have those items. Surveyor asked if provider visits addressed treatment orders, supplements, blood sugar checks, tubi grips, bladder scan etc., DON B indicated no. Surveyor asked if all orders should be included in the order review? DON B and NHA A indicated yes. Surveyor asked if the orders signed on March 9th indicate how long they are good for, DON B indicated no.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 59 residents who reside in the facility.Surveyor observed dust covering the sprinkler heads and suspended from the light fixtures in the facility's stove hood.Surveyor observed staff with facial hair and not wearing hair restraints.Surveyor observed [NAME] J use a dirty alcohol swab to sanitize a thermometer and intervened before the thermometer touched resident food. Surveyor also observed [NAME] J use a dry paper towel to manually dry the thermometer after sanitizing it and before probing food.Surveyor observed 3 mixers to be stored under a plastic covering and unclean.Surveyor observed staff placing wet dishware upside down on trays creating a seal and not allowing the dishware to airdry completely.Evidence by:Example 1Facility policy, titled Cleaning Procedures, undated, includes: Hoods and filters- Clean inside and outside of hood. Wash hood with detergent solution. the interior section of the hood that extend to the roof should be cleaned annually by a commercial hood-cleaning operator.(It is important to note the facility's policy does not include the sprinkler system or light fixtures within the unit's stove hood.On 6/1/26 at 10:50 AM, Surveyor, DM H (Dietary Manager), and [NAME] G observed dust swinging in the changing air, suspended from the light fixtures, inside of the facility's stove hood unit. Surveyor, DM H, and [NAME] G also observed the sprinkler heads inside of the facility's stove hood to be coated in a thin layer of dust. DM H and [NAME] G indicated there is potential for the dust to dislodge and fall into the food being prepared underneath.Example 2Facility policy, titled Employee Health and Personal Hygiene, dated 2019, includes: Keep beards and mustaches neat and trimmed. [NAME] covers are required.On 6/1/26 at 10:50 AM, Surveyor observed [NAME] G and [NAME] F with facial hair, working with food in the facility's kitchen without donning a beard net. DM H (Dietary Manager) indicated they need a beard net and asked [NAME] G to go grab them. [NAME] G indicated he did not know where to find the beard restraints.Example 3Facility policy, titled Cleaning Procedures, undated, includes: . Food mixer-frequency of cleaning- daily and after each use. Cover mixer in clear plastic.On 6/1/26 at 10:50 AM, Surveyor observed three mixers to be stored under plastic and to be unclean with dried food particles on the undercarriages. DM H (Dietary Manager) indicated the mixers should have been cleaned before being covered in plastic and stored.Example 4On 6/3/26 at 4:38 PM, Surveyor observed [NAME] J use an alcohol wipe to sanitize his thermometer and then he used a dry paper towel to wipe the thermometer. [NAME] J indicated he was using the paper towel to dry the alcohol solution off the thermometer. [NAME] J probed a pan of rice to get a temperature reading on it. [NAME] J used the same dirty alcohol wipe to sanitize the thermometer and the same dirty paper towel to dry the thermometer and was just about to probe another food when Surveyor intervened. [NAME] J and DM H (Dietary Manager) indicated after using an alcohol wipe to sanitize a thermometer the alcohol wipe is dirty and should not be reused. DM H educated [NAME] J to allow the thermometer to air dry before using it to probe food. DM H indicated during interview that staff should not be using paper towels to dry the thermometer off after it has been wiped with alcohol. DM H also indicated staff should use a new alcohol wipe each time they sanitize the thermometer.Example 5Facility policy, titled Dishwashing Procedures, dated 2019, includes: all items are to be air-dried.On 6/3/26 at 8:56 AM, Surveyor observed DA I (Dietary Aide) to be placing wet coffee mugs, cups, and dessert bowls upside on plastic trays. DA I, DM H, and Surveyor observed white film on the upside-down dishware. DM H indicated the wet and upside-down dishware creates a seal that does not allow the dishware to air dry trapping the chemicals and creating a white chalky film inside. DM H indicated dishware should be allowed to air dry as that is the last step in the sanitation process.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure hospice collaboration and communication processes were established to ensure continuity of care between hospice and the facility for 1 of 1 resident (R40) reviewed for hospice. R40's hospice notes are not available to facility staff. The facility did not designate a staff member to coordinate the plan of care with the hospice provider. As evidenced by: The facility policy entitled, Hospice, dated June 2021, states, in part: .Policy: The community will provide collaborative care with Hospice providers to ensure the resident's end of life preferences and choices are honored . Procedure 1. There is agreement for the provision of hospice services with one or more Medicare-certified hospices. 2. This signed agreement will include. i. A provision that the community associates are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care. 4. There is a designate member of the community's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the community associates and hospice staff. 5. The interdisciplinary team member is responsible for. b. Communicating with hospice representatives. participating in the provision of care for the terminal illness, related conditions, other conditions. R40's most recent Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/24/26 indicates R40 has a Brief Interview for Mental Status score of 0 out of 15, indicating severe cognitive impairment. Section GG indicates R40 has lower extremity impairments on both sides and is dependent on staff for rolling left and right in bed. Section M indicates R40 is at risk for developing pressure injuries and has one stage two pressure injury and one unstageable pressure injury. R40's Physician Orders include:admitted to [Agency Name] Hospice. Start Date: 4/29/26. R40's Comprehensive Care Plan indicates:Problem: Resident receives hospice services related to cerebrovascular disease from [Agency Name] hospice, 24-hour contact number is [Phone Number].Approach:Facility will coordinate with Hospice providers and reference hospice care plan located in resident's chart. Start Date: 1/20/26.See hospice care plan for resident choices and preferences related to resident's comfort, cognition, pain, and functional status. R40's Physician Orders indicate:admission to [Hospice Agency Name]. Start Date: 1/7/26. On 6/2/26. Surveyor reviewed R40's hospice binder and electronic medical record. Surveyor was unable to locate any hospice nurse notes in either location. On 6/3/26, Surveyor notified DON B (Director of Nursing) and RDOCS L (Regional Director of Clinical Operations). of the investigation into R40's pressure injuries and requested all pertinent documentation. At that time, Surveyor was provided with some of R40's hospice notes that were written by registered nurses. The print date for all of the notes was indicated to be 6/3/26. On 6/3/26 at 3:59 PM, Surveyor interviewed WCN V (Wound Care Nurse). Surveyor asked WCN V who completes R40's wound dressing changes. WCN V indicates hospice completes wound dressing changes when they are in the facility, and facility staff complete the dressing changes when hospice is not in the facility. On 6/4/26 at 9:00 AM, Surveyor interviewed DON B and RDOCS L. Surveyor asks DON B what the process is when the facility receives notes or physician orders from hospice. DON B indicates the floor nurse gets a carbon copy, the HUC (Health Unit Coordinator) scans in the order and the nurse reviews the orders to make sure they are transcribed into the facility's electronic medical record. Surveyor asks DON B who is responsible for reviewing hospice notes for care updates. DON B indicates that there is no one individual staff member, but the floor nurses review the notes and will share the information with managers if something changes. Surveyor asks DON B who is responsible for updating care plans. DON B indicates the managers. R40's hospice visit notes were not available to the facility's direct care or licensed nursing staff.

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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 observation, interview, 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 2 of 21 residents (R65 and R1) reviewed for infection control. R65 was not tested for COVID-19 after he was showing signs and symptoms of COVID-19. RN M (Registered Nurse) did not complete hand hygiene during R1's wound care. This is evidenced by: The facility's COVID-19 manual, dated 9/29/22, includes Symptom-and Contact-Based Testing: Test vaccinated and unvaccinated residents and associates (1) who develop COVID-19 symptoms. For symptom-based testing, anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible. R65 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (a progressive lung disease that restricts airflow and makes breathing difficult) and heart failure. R65's nurse progress notes include the following:On 2/2/26 at 3:14 PM, .admitted to [Facility Name]. Lungs CTAB (Clear to Auscultation Bilaterally), on room air. On 2/4/26 at 6:15 PM, Noted resident noted to have pursed lip breathing. O2 sat (Oxygen Saturation) completed and at 85%. Resident reported I feel short of breath. Lungs auscultated with diminished breath sounds and wheezing. Breathing rapid and shallow, respirations at 22. See previous noted [sic] for further information contacting the on call provider. Discussed situation with resident and decision made to complete respiratory treatment and start Oxygen. Also resident refused to go to the ER (Emergency Room) to be evaluated if symptoms worsened. O2 (Oxygen) started at 1840 (6:40 PM). 1L (Liter) of O2 started per order and O2 sat was ranging from 88-91. Noted resident to have easier time with breathing and still intermittent SOB (Shortness of Breath). Resident refused to go to the ER. On 2/6/26 at 4:06 AM, .O2 remains at 2L and O2 sat was 91%. Denies SOB, respirations non-labored and lungs auscultated with diminished breath sounds and rales and rhonchi. On 2/6/25 at 6:24 PM, Resident reported dyspnea (difficulty breathing) when CNA (Certified Nursing Assistant) collected supper tray. As writer entered room resident was breathing with pursed lips, sitting upright in bed. Writer asked if resident was doing anything strenuous, resident denies. O2 read 87% on RA (Room Air) via pulse oximeter (device used to measure oxygen saturation). Occasional coughs noted. On 2/16/26 at 11:00 AM, .talked to the resident about having him sent in and agreed after the discussion. Was sent to [Hospital Name] via non emergent transport. R65's 2/16/26 Infection Tracker with McGeer's Criteria indicates R65 tested positive in the emergency room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/26 at 11:31 AM, Surveyor interviewed RN C (Registered Nurse). RN C indicated she is the infection prevention nurse. RN C indicated residents and staff are tested for COVID-19 if they are symptomatic. RN C indicated some symptoms of COVID-19 would include a change in respiratory status, cough, abnormal lung sounds, and new onset of decreased oxygen saturation. RN C indicated if a resident exhibited any symptoms of COVID-19 a test should be done right away. On 6/3/26 at 12:11 PM, Surveyor interviewed DON B (Director of Nursing). DON B indicated she would expect the facility staff to follow the facility's COVID-19 testing policies. DON B indicated the staff should have tested R65 for COVID-19 the day he started having symptoms but did not. Example 2 The facility policy, Hand Hygiene, reviewed 6/2026, indicates, in part, as follows: Purpose: Infection Prevention begins with the basic hand hygiene. By following proper hand hygiene practices, associates will reduce the spread of potentially deadly germs, as well as reduce the risk of healthcare provider colonization by germs acquired from the residents. Policy: It is the policy of the facility that all associates will be trained and competent in following proper hand hygiene practices. Procedure: Hand hygiene means cleaning hands using either handwashing (washing hands with soap and water), or antiseptic hand rub (i.e., alcohol-based hand sanitizer, including foam or gel). Times to Perform Hand Hygiene are but not limited to: Before and after direct resident contact, after removing gloves, and before and after changing a dressing. R1 was admitted to the facility 9/6/23. During R1's stay, R1 developed pressure injuries (localized damage to skin and underlying tissue) to her bilateral buttocks. On 6/4/26 at 10:15 AM, Surveyor observed RN M (Registered Nurse) and LPN N (Licensed Practical Nurse) complete dressing changes to R1's bilateral buttocks. Surveyor observed LPN N set treatment supplies in R1's wheelchair. Surveyor observed RN M put one glove on her right hand, pick up the garbage can with her right hand and move it next to her. RN M then removed the glove to her right hand and put on clean gloves. Surveyor observed RN M did not sanitize or perform hand hygiene in between glove changes. On 6/4/26 at 10:18 AM, Surveyor spoke with RN M. (Registered Nurse). Surveyor asked RN M, when should you wash or sanitize your hands. RN M stated, wash at the beginning (of a treatment), in between glove changes, dirty to clean, and at the end of the treatment. Surveyor asked RN M, should you have sanitized your hands after moving the garbage can with your gloved right hand and removing your right glove. RN M stated, yes. Surveyor asked RN M, should you set treatment supplies in a resident's wheelchair. RN M stated, no, she should have used a barrier. Surveyor asked RN M, is there a better place to set up treatment supplies. RN M stated, she should have cleaned the tray table, used a barrier, and set up supplies on the tray table. On 6/4/26 at 1:50 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B, when should staff wash or sanitize their hands. DON B stated, before they enter the room, before putting on gloves, between any dirty and clean, when they exit the room, and in between working with residents. Surveyor asked DON B, when RN M put a glove on her right hand, move the trash can, removed the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525438	A. Building B. Wing	06/18/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	glove to her right hand and put on clean gloves should RN M have sanitized her hands after removing the glove to her right hand. DON B stated, yes. Surveyor asked DON B where staff should set up supplies when doing wound care. DON B stated staff should disinfect the tray table, put on a barrier, set supplies on the barrier, and disinfect the tray table when done. Survey asked DON B, is it acceptable for RN M to set treatment supplies in a resident's wheelchair. DON B stated, she does not think this is acceptable as we do not know what is on the wheelchair.