STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525447	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Manor	803 S University Ave Beaver Dam, WI 53916

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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 - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not implement professional standards of practice to prevent pressure injuries (PIs) from developing and/or worsening or to promote healing of PIs for 1 (R9) of 2 residents reviewed for PIs out of a sample of 15 residents.R9 had a care plan intervention to use a Roho cushion in R9's wheelchair and recliner. The facility staff failed to ensure the Roho was properly inflated and functioned according to manufacturer's recommendations and failed to ensure weekly skin assessments were completed once R9 developed a full thickness. Findings include:The National Pressure Injury Advisory Panel (NPIAP) classifies a PI as follows: Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.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.The facility policy, Long Term Care Wound Care Prevention and Treatment Policy, dated 12/31/24, states, in part: . 3.2 Skin breakdown risk will be performed on admission and weekly for the first 4 weeks of admission to the facility, followed by quarterly or with significant change in resident condition. The Braden Skin Assessment tool will be used to determine skin breakdown risk.3.4 The Wound Care Certified (WCC) nurse or long-term care staff will collaborate with the practitioner to oversee management of skin impairments in Long Term Care .3.7 Documentation and Communication a. Skin assessments and interventions to prevent skin breakdown will be documented in the medical record. b. Abnormal skin findings will be reported to the practitioner. c. Handoff communication will include information related to skin assessments and interventions in place to prevent skin breakdown d. If there is no evidence of wound healing within 2 weeks of treatment, the plan of care should be reassessed and reviewed with the patient's practitioner3.8 Open Wounds a. Weekly wound healing assessment will include . -Pressure Injury -Anatomical location of wound -Wound dimensions including length, width, and depth -Undermining depth and location -Extent of tissue loss/staging -Tissue type including percentage of granulation, slough, and necrotic tissue -Amount, color, consistency, and odor of drainage -Presence of epithelialization at wound edges.R9 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (stroke causing weakness or paralysis to the left side of the body), other specified disorders of bone, unspecified site, chronic kidney disease, stage 3, and atherosclerotic heart disease of native coronary artery without angina pectoris (plaque buildup in arteries that provide blood to the heart without causing chest pain).R9's Significant Change Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/9/26 indicates R9 has a Brief Interview for Mental Status (BIMS) score of 11 out of 15 indicating R9 is moderately cognitively impaired. The MDS indicates R9 has upper and lower extremity impairments on both sides, uses a wheelchair for mobility, requires substantial/maximal assistance for rolling left and right and has 1 stage 3 PI.On 12/4/23, R9's Comprehensive Care Plan is (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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F 0686 Level of Harm - Actual harm Residents Affected - Few	updated to include the intervention to turn R9 on the day, evening, and night shifts.On 12/3/23, R9's Comprehensive Care Plan is updated to include Rx (prescriptions) as ordered.On 12/23/23, R9's Comprehensive Care Plan is updated to include the problem I have the potential for impaired skin integrity.On 7/8/24, R9's Comprehensive Care Plan is updated to include Roho cushion to wheelchair and Roho cushion to recliner.On 11/13/25 at 8:43 AM, a Braden Scale (a measure of pressure injury risk) was completed for R9. This assessment scored 14, indicating moderate PI risk. Preventative measures are listed as: low pressure mattress, gel cushion, turn/repositioning schedule, and toileting schedule. On 12/2/25, an Occupational Therapy (OT) & Plan of Treatment document was completed. Plan of treatment includes patient will tolerate sitting in Broda chair (tilt-in-space positioning chairs) consistently for 2 hours with good trunk position to decrease risk for further contractures and skin impairment. Baseline for this goal is listed as increased left lean noted with insertable lateral support less effective. Another goal is listed as patient will demonstrate comfort and close to midline positioning with use of Broda chair or alternative seating system to decrease risk for contractures and skin impairment.The Initial Assessment section indicates the reason for referral due to a decline in wheelchair positioning impacting safety and skin integrity.The Results section indicate R9 was currently using a high back wheelchair reclining with mosaic Roho cushion. Per nurse, excoriation to buttock crease and skin between scrotum and rectum.On 12/3/25, R9's Comprehensive Care Plan was updated to include the intervention w/ (with) Sof-Care (pressure-relieving bed overlay).On 12/23/25, R9's Comprehensive Care Plan is updated to include the problem: I have a history of impairment to the right hip. I prefer to only sleep on my right side. I decline an air mattress as it limits my independence with bed mobility and impairs my comfort.On 12/26/25, an OT Treatment Encounter Note indicates OT assessed R9's position and comfort in Broda chair throughout the day. Good midline trunk position was noted as well as no forward migration of hips.During the month of December 2025, R9's repositioning documentation indicates he was repositioned 0-7 times a day. Per the facility policy, R9 should be repositioned every 2 hours while awake and to consider repositioning every 3-4 hours while sleeping.On 1/2/26 the facility completed R9's Skin Assessment. Two areas of skin impairment were noted on the left tuberosity. The first measures 0.5 cm (centimeters) x 0.5 cm with 100% slough tissue (dead or non-viable tissue). The second area is noted to be 0.1 cm x 0.1 cm with 100% slough tissue. No drainage or odor noted to either area. The surrounding skin was reddened, and the possible cause of impairment was documented as Pressure/shearing. The treatment was for mepilex lite (thin, flexible absorbent pad of foam) placed to the area for protection. Actions taken are listed as MD (Medical Doctor) notified, care plan updated, and OT screen sent. The assessment did not include a stage for the PIs however these areas per NPAIP would be consistent with an unstageable PI.On 1/2/26 at 3:48 PM, a Nurses Note is written that indicates NP R (Nurse Practitioner) ordered a Mepilex lite dressing to the left ischial tuberosity and change every 3 days and PRN (as needed).On 1/2/26, an OT Treatment Encounter Note indicates OT assessed R9's wheelchair positioning throughout the day. Midline trunk position achieved with use of padded lateral insert on left side. Patient reports comfort with high profile Roho cushion. No forward migration of hips noted.On 1/2/26, R9's Comprehensive Care Plan is updated to include the intervention pillow between knees/legs in bed.On 1/7/26, a Skin Assessment was completed. The assessment only indicated 1 PI on the left ischial tuberosity PI measures 5 cm x 3 cm x 0.1 cm. The initial wound stage is listed as Stage 3. Moderate, serosanguinous (combination of serious fluid and blood that appears thin, pink, and watery) drainage present. Granulation tissue (newly formed connective tissue that develops during healing) makes up 75%-100% of the wound. Epithelialization (regenerative process for skin following injury) present for 5% to less than 100% of the wound. Wound is currently stage 2. According to the NPIAP, wounds should not be backstaged. This wound should be considered a Stage 3. No undermining or necrotic tissue (dead, non-viable tissue that results from cell death) present. Interventions: wound consultant, turning and proper positioning, turning schedule, resident teaching to redistribute pressure & off-loading, risks and benefits of repositioning, monitor protein and calorie (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	intake, vitamin and mineral supplements, minimize risk for shear and friction, air cushion for the wheelchair, pressure redistribution mattress, air fluidized surface mattress, and OT consult. The comments section states, .Appears to be trauma from adhesive of Mepilex border dressing in place. TAR (Treatment Administration Record) updated to reflect application of regular Mepilex with Medipore tape (soft, cloth surgical tape). OT screen resubmitted for further evaluation of skin impairment given development timeline in relation to recently issued Broda chair. Treatment: Foam Dressing. Treatment Change: No. On 1/8/26, an OT Treatment Encounter Note indicates education was provided to night shift nursing staff on bed positioning recommendations with bilateral offloading boots, turning side to side, and pillow between legs to ensure no contact between bony prominence and feet/ankles with bed. Additionally, OT assessed the inflation of the high profile Roho cushion and noted it to be low. OT inflated the cushion to the proper fill, however it continued to leak air. Roho cushion was replaced by OT.On 1/9/26 at 1:51 PM, a Skin Assessment was conducted. Type of Skin Impairment is listed as healing pressure stage 2 for both the right heel and left ischial tuberosity wounds. The possible cause is pressure/shearing over bony prominence. Resident medical diagnosis of presumed PVD (peripheral vascular disease) due to previous abnormal ABI (Ankle-Brachial Index-test to assess blood flow in peripheral arteries). Toileting schedule was revised 12/3/25. Wound healing potential listed as fair. Current protective devices in place include repositioning schedule, Roho cushion, specialty boots, air mattress, Broda chair issued 12/22, OT revaluation of chair and cushion on 1/8/26 reveals suspected air leak on Roho cushion and cushion replaced, further education to resident and staff.for need for repositioning throughout the day.On 1/9/26, an OT Treatment Encounter Note is written that indicates education was provided to nursing on bed positioning recommendations: change position side to side to offload buttocks and decrease risk for skin impairment to hip. OT also assessed position in Broda chair throughout the morning. Roho cushion properly inflated and patient reports comfort. Education to nursing on recommendations to ensure Roho cushion is flat and properly inflated prior to each transfer. Education to ensure cushion cover is not too small as this impairs cushion from lying flat. Education on frequently changing positions in Broda chair, standing in EZ stand (mechanical transfer device), lying down, and sitting in recliner to optimize pressure relief to buttocks to promote tissue healing. Education to not place means pad over Roho cushion as this decreases effectiveness for pressure relief.According to Roho Mosaic Cushion Operations Manual copyrighted 2017, Skin/soft tissue breakdown can occur due to a number of factors, which vary by individual. Check skin daily. Redness, bruising, or darker areas (when compared to normal skin) may indicate the beginning of soft tissue breakdown and needs to be addressed. If any discoloration does NOT disappear within 30 minutes of discovery, consult a healthcare professional immediately. Check inflation frequently, at least once a day! DO NOT use an under-inflated or an over-inflated product because the product benefits will be reduced or eliminated, resulting in an increased risk to skin and other soft tissue. If your product does not appear to be holding air, see TROUBLESHOOTING. If your product is still not holding air, contact your clinical caregiver, distributor, or ROHO, Inc. immediately. DO NOT use the product on top of, or in conjunction with, any other products or materials, unless otherwise indicated in this manual. Doing so may cause the individual to become unstable and vulnerable to falling. If your cushion feels unstable, see TROUBLESHOOTING or consult with a clinician for proper usage. DO NOT place any obstructions (except for a ROHO-provided cushion cover) between the individual and the cushion. Doing so will reduce product effectiveness. Consult with your clinician for proper usage. The cushion and the cover MUST be correctly oriented and sized. If they are NOT, the benefits provided by the cushion may be reduced or eliminated, increasing the risk to the skin or other soft tissue.An amendment to this note indicates nursing staff reported a new incidence of skin impairment on the left ischial tuberosity region from 1/2/26. Patient continues to prefer Broda chair over high-backed wheelchair. Broda chair offers more offloading options, R9 has improved upright posture which corresponds to improved unsupported sitting at EOB (edge of bed) and upright standing in EZ stand. Broda chair has improved (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	patient comfort and has lessened risk for falls and contractures.On 1/9/26, an OT Discharge summary indicates a recommendation for frequent changes in angle of seating or changes of location of sitting to offload buttocks for optimal pressure relief.On 1/14/26, a Nursing Facility Routine Visit Note is written by NP R (Nurse Practitioner). This note indicates R9 was seen for a routine visit and follow up of multiple medical problems. The note also indicates staff deny any concerns for R9. Under the section titled, Assessment multiple conditions for R9 are listed; however, the pressure injury is not mentioned, nor is it mentioned throughout the rest of the note.On 1/16/26 at 12:25 PM, a Skin Assessment was completed. R9's left ischial tuberosity wound measured 3 cm x 2.5 cm x 0.1 cm. Moderate, serosanguineous drainage is present. Granulation tissue makes up 25% to 75% of the wound. Epithelialization is 5% to less than 100% of the wound. Necrotic tissue is present described as adherent, soft, black eschar (necrotic dried, dead tissue) and makes up less than 25% of the wound. PI is currently stage 3. No undermining present. Interventions added or changed: redistribution footboard for the Broda chair, dietician consult, and maintain/improve nutrition and hydration status.The last measurement recorded for this wound was 9 days prior on 1/7/26.On 1/22/26 at 2:19 PM, a Nurse Practitioner's Treatment Order is placed that states Apply narrow bordered Mepilex dressing to the buttock crease every three days PM (evening shift). First date: 1/24/26 (until resolved).On 1/23/26 at 11:11 AM, a Skin Assessment was completed. R9's left ischial tuberosity wound measured 3 cm x 3 cm x 0.1 cm. (Previous measurement was 3 cm x 2.5 cm x 0.1 cm). Moderate, serosanguinous drainage present. Granulation tissue makes up 75-100% of the wound. Epithelialization is present in 5% to less than 100% of the wound. No necrotic tissue is present. PI is currently a stage 3. No undermining is present. No interventions were added or changed.On 1/27/26 at 3:34 PM, a Braden Scale was completed for R9 and scored 13, indicating moderate PI risk.On 1/28/26, a Progress Note by NP R states NP R was updated by the dietitian regarding R9's significant weight loss. A new order was placed for mirtazapine (medication that helps increase appetite). The note does not address the PI.On 1/30/26 at 9:53 AM, a Skin Assessment documented R9's left ischial tuberosity wound measured 3 cm x 3 cm x 0.2 cm. (The wound is 0.1 cm deeper than previous measurements). Small, serosanguinous drainage present. Granulation tissue makes up 25% to 75% of the wound. No epithelialization is present. Necrotic tissue, described as adherent, soft, black eschar makes up 50% to 75% of the wound. PI is currently unstageable. No undermining present. No interventions were added or changed. The comments section states, in part: .Source of pressure appears internal - over bony prominence with known compromised nutritional and mobility status. Will change treatment to built up foam dressing to peri wound to further assist in offloading to area.During the month of January 2026, R9's repositioning documentation indicates he was repositioned between 4-7 times a day, every day.On 2/6/26 at 1:32 PM, a Skin Assessment is completed. R9's left ischial tuberosity wound now measures 3 cm x 3 cm x 0.5 cm. (0.3 cm deeper than on 1/28/26). Moderate, serosanguinous drainage present. Granulation tissue is now pink and/or dull, dusk red and/or fills 25% or less of the wound. No epithelialization is present. Necrotic tissue, described as adherent, soft, black eschar makes up 50% to 75% of the wound. PI is documented as Stage 3. Undermining is now present with 2-4 cm involving less than 50% of wound margins. Length of undermining is 0.8 cm at a direction of 0600-1000 (6:00 to 10:00). Intervention added: nutritional supplement. The comments section states: CURRENT STAGE: UNSTAGEABLE. [sic] Resident denies pain. Increase in wound size anticipated [sic] with breakdown of slough tissue. Provider updated completed 2/4- recommends POC (Plan of Care) discussion towards comfort at family meeting next week.On 2/11/26, a Nursing Facility Acute Visit Note is written by NP R and indicates R9 was seen for a chief complaint of continued decline in status, weight loss, and failure to thrive as reported by a facility nurse. This note does state, in part: . Now has wound to buttocks/hip. Additionally, regarding R9's goals of care, the note states, . Patient's goals of care include focus on comfort. Skin comfort. Low air loss mattress PRN (as needed). Moisture barrier cream: every shift to peri area as tolerated with cares. On 2/12/26 at 2:03 PM, a Skin Assessment is completed. R9's left ischial tuberosity wound (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	now measures 3.5 cm x 3.5 cm, and depth is unable to be determined. Moderate, purulent drainage (thick, pus-like fluid) is present. Granulation tissue is pink and/or dull, dusk red and/or fills 25% or less of the wound. No epithelialization is present. Necrotic tissue, described as adherent, soft, black eschar makes up 75%-100% of the wound. PI is currently Unstageable. Undermining present with 2-4 cm involving less than 50% of the wound margins. Length of undermining is 1.0 cm at a direction of 0600-1000 (6:00 to 10:00). No interventions were added or changed. The comments section states, in part: . Wound presentation and POC discussed with provider and resident/family during family meeting 2/11- discussed poor healing potential and risks vs benefits of continuing with Broda chair for quality of life. Will continue with chair and transition to comfort with Hospice referral due to underlying cancer diagnosis. Goal is comfort and infection prevention with wound treatment. On 2/18/26, a Nursing Facility Routine Visit Note is written by NP R (Nurse Practitioner). This note indicates R9 was seen for a routine visit and medication review. The note also indicates staff deny any concerns for R9. Under the section titled, Assessment multiple conditions for R9 are listed, however the pressure injury is not mentioned, nor is it mentioned throughout the rest of the note.On 2/18/26, R9's Comprehensive Care Plan is updated to include the problem: I have a history of impaired skin integrity to my right heel and current impaired skin integrity to my left ischial tuberosity. I have transitioned to hospice due to overall decline and compromised nutritional status.On 2/19/26 at 2:26 PM, a Skin Assessment is completed. R9's left ischial tuberosity wound now measures 4.5 cm x 4.5 cm, and depth is unable to be determined. Moderate, purulent drainage is present. No granulation tissue or epithelialization is present. Necrotic tissue, described as adherent, soft, black eschar makes up 75%-100% of the wound. PI is currently Unstageable. Undermining present with 2-4 cm involving less than 50% of the wound margins. Length of undermining is 3.0 cm at a direction of 0600-1000 (6:00 to 10:00). No interventions were added or changed. The comments section states, . Hospice admit 2/18- new mattress provided. Large amount of slough tissue removed with dressing removal this date without trauma. Diet downgrade due to overall further decline. Wound healing potential is poor. Goal is comfort and infection prevention. No pain with today's assessment. On 2/27/26 at 12:59 PM, a Skin Assessment is completed. R9's left ischial tuberosity wound now measures 4.5 cm x 4.5 cm x 2 cm. Moderate, purulent drainage is present. Granulation tissue is pink and/or dull, dusk red and/or fills 25% or less of the wound. No epithelialization is present. Necrotic tissue, described as adherent, soft, black eschar makes up 25%-50% of the wound. PI is documented as Stage 3. Undermining present with 2-4 cm involving less than 50% of the wound margins. Length of undermining is 3.0 cm at a direction of 0600-1000 (6:00 to 10:00). Interventions added or changed: hospice consultation. On 2/28/26 at 2:51 PM, a Nurse Practitioner's Treatment Order is placed that states: [NAME] Mepilex Foam with hole cut in center (intent to offload pressure to area)- place over wound with hole exposing wound. Place second intact white foam over first foam and secure it with Medipore tape. Apply to the right greater trochanter (hip). Do not use Mepilex Border-only white thicker mepilex foam.On 3/2/26 at 10:34 AM, a Nurse Practitioner's Treatment Order is placed that states Flush wound using [NAME] syringe (syringe designed for precise irrigation), 30-60 cc (cubic centimeters) of Normal Saline (sterile mixture of sodium chloride and water). Dry gently with gauze. [NAME] Mepilex Foam with hole cut in center (intent to offload pressure to area)- place over wound with hole exposing wound. Place second intact white foam over first foam and secure it with Medipore tape. Apply to the left ischial tuberosity (hip). Do not use Mepilex Border-only white thicker mepilex foam. Once a day on the morning shift. On 3/6/26 at 12:16 PM, a Skin Assessment is completed. R9's left ischial tuberosity wound now measures 4.5 cm x 4.5 cm x 3.0 cm. Moderate, purulent drainage is present. Granulation tissue is pink and/or dull, dusk red and/or fills 25% or less of the wound. No epithelialization is present. Necrotic tissue, described as loosely adherent yellow slough, and makes up 25%-50% of the wound. PI is currently documented as Stage 3. Undermining present with 2-4 cm involving less than 50% of the wound margins. Length of undermining is 3.0 cm at a direction of 0600-1000 (6:00 to 10:00). No interventions were added or changed.On 3/10/26 at 10:31 AM, Surveyor interviewed R9. Surveyor (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	asks R9 if he has any concerns with his skin. R9 indicates he has lots of skin wounds, and that he currently has one on his butt. During this interview, Surveyor observed R9's Hoyer sling to still be underneath him as he was sitting in his Broda chair.On 3/10/26 at 2:45 PM, Surveyor observed R9 sitting in his Broda chair with his hoyer sling underneath him.On 3/12/26 at 1:54 PM, Surveyor interviewed CNA P (Certified Nursing Assistant). CNA P indicated she has worked at the facility for 16 years, and she works on all the units. Surveyor asked CNA P how R9 transfers. CNA P indicates R9 transfers with a Medilift (Hoyer lift). Surveyor asked CNA P if R9's Hoyer sling should be removed from underneath him. CNA P stated, yes. Surveyor asks CNA P why it is important to remove the hoyer sling from underneath the resident. CNA P indicated the sling should be removed to reduce skin breakdown. CNA P indicated that R9 is repositioned at night every 2 hours, and he lays down after breakfast and lunch. Surveyor asked CNA P who is responsible for weekly skin checks. CNA P indicated the nurses complete the weekly skin checks.On 3/12/26 at 2:00 PM, Surveyor interviewed MT O (Medication Tech). Surveyor asked MT O if R9's Hoyer sling should be removed from underneath him. MT O indicated staff leave R9's Hoyer sling underneath him because they are full body slings and since R9 sits in a Broda chair, the slings are left in place because it is harder to get the sling back underneath the resident. Surveyor asks MT O if staff reposition or turn R9. MT O indicates R9 is repositioned every 2 hours night and day. Surveyor asked MT O who is responsible for weekly skin checks. MT O indicates the CNAs usually do the weekly skin checks during showers. There are forms to fill out and staff put the completed sheets in the binder.On 3/12/26 at 2:13 PM, Surveyor interviewed CNA L and asked if staff leave Hoyer slings underneath residents after transferring them. CNA L indicated staff do leave slings under residents if they are putting them in a Broda chair but not a bed. CNA L indicated when residents are in a Broda chair, staff can't get the sling back underneath the resident if they were to remove it. Surveyor asks CNA L which staff members are responsible for weekly skin checks. CNA L indicates CNAs fill out shower sheets and mark any new skin issues. These sheets are then given to the nurse.On 3/12/26 at 2:18 PM, Surveyor interviews CNA Q. Surveyor asks CNA Q how long she has been working at the facility. CNA Q indicates she is agency staff but has worked at the facility for around 4 years. Surveyor asks CNA Q if there is a floor or unit she usually works. CNA Q indicates she works on both floors. Surveyor asked CNA Q if R9's Hoyer sling is supposed to be left underneath him or be taken out. CNA Q indicates his Hoyer sling should be removed from underneath him. Surveyor asks CNA Q why it is important for staff to remove Hoyer slings from underneath residents. CNA Q indicates the sling is removed to relieve pressure. Surveyor asks CNA Q how often R9 is turned or repositioned. CNA Q states every 2 hours or as needed.On 3/12/26 at 3:00 PM, Surveyor interviewed IC F (Infection Control Nurse), who is also employed by the facility as the nurse educator, DON B (Director of Nursing), and CM S (Clinical Manager). Surveyor asks IC F if staff are expected to leave the Hoyer sling underneath the residents after transferring the resident. IC F states, yes. Surveyor asks IC F to help them understand the reasoning behind this practice. DON B indicated this is done for safety, because it is very difficult to get a Hoyer sling underneath someone sitting in a chair and use the lift safely. Surveyor asked DON B what the standard or policy is for turning and repositioning residents. DON B states every 2 hours unless it is individualized per the resident's care plan. Surveyor asks DON B how often R9 is turned or repositioned. Surveyor asked IC F, DON B, and CM S how often weekly skin checks are completed. DON B indicates through the completion of the shower sheets, which are a new practice. Surveyor asked DON B when this practice started. DON B stated since she started at the facility but before 1/1/26. Surveyor asked DON B if she was the one who discovered the pressure injury and DON B stated yes. Surveyor asks DON B if a root cause was determined for the pressure injury. DON B indicated she believes the pressure injury was internal prior to identification. Surveyor asked DON B how the pressure injury was discovered. DON B indicates CNAs found the wound while repositioning R9. Surveyor asks DON B if there is any documentation of the wound prior to 1/2/26. DON B and CM S review the electronic medical record and state, no. Surveyor asks CM S, who is a Wound Care (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Certified Nurse, if a provider was updated on 1/16/26 following the development of necrotic tissue within the wound bed. CM S indicated, no because the wound stagging was the same from the previous assessment and in her professional opinion, the change did not meet criteria that would require provider notification. Surveyor asks CM S if a provider was updated on 1/23/26 when the wound increased in size from 3 cm x 2.5 cm x 0.1 cm the previous week to 3 cm x 3 cm x 0.1. CM S indicates, no because the wound stagging was the same from the previous assessment and in her professional opinion, the change did not meet criteria that would require provider notification. CM S also indicates provider notification did occur on 1/14/26 per the provider's note. Surveyor asks CM S if there was an alternative note as the one Surveyor reviewed did not state anything regarding a pressure injury. CM S indicates the facility uses provider sheets which contain all information staff need to update the provider on that day. Surveyor requested to review copies of the provider sheets for the past 3 months. CM S indicates they do not retain those records. Surveyor asks CM S if OT evaluated the resident regarding the potential for the PI to be related to his Broda chair. CM S indicates OT evaluated R9 on 1/8/26 and found a potential air leak in the cushion, which was replaced, and a need for repositioning throughout the day. Surveyor asks IC F, DON B and CM S if they know when R9 received the Broda chair. CM S reviews the electronic medical record and indicates R9 received his Broda chair on 12/22/25. Surveyor asks CM S if she saw any signs or symptoms of infection on 2/12/26 with the drainage change from serosanguineous to purulent drainage. CM S indicates no, and she suspects the drainage change is related to the presence of slough tissue and not an infectious source.Surveyor requested to review a standard of practice or equipment manual that recommends leaving the Hoyer sling underneath residents after transfers; however, none was provided.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Manor	803 S University Ave Beaver Dam, WI 53916

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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 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 store and prepare food in accordance with professional standards for food service safety. This has the potential to affect all 58 residents. Surveyor observed dried food drips on the outside of the oven doors. Surveyor observed personal, unmarked food in the beverage cooler. Surveyor observed a half loaf of bread undated and with visible freezer burn in the freezer. Surveyor observed burger patties improperly sealed in the freezer. Surveyor observed dessert bars not dated or marked and not properly closed in the bakery freezer. Surveyor observed trash cans in the food prep area to not have lids. Surveyor observed that the test strips to test the parts per million for the sanitizing buckets and three compartment sink were damaged and unusable. Surveyor observed dietary staff not cleaning the thermometer probe between each food during meal service. Surveyor observed a tray with uncovered food being taken down the hall. Evidenced by: The facility policy, titled Refrigerate Storage and Monitoring/Food Storage Procedures, dated 4/10/24, states, in part: . Purpose Statement: Establish guidelines for storage of. food and items necessitation cold storage. 3.6 Perishable employee food must be stored in a refrigerator designated especially for that purpose and clearly labeled Employee Use Only. On 3/10/26 at 8:39 AM, during initial tour of the kitchen with DM C (Dietary Manager), Surveyor observed dried food drips on the outside of the oven doors, personal, unmarked food in beverage cooler, a half loaf of bread undated and with visible freezer burn in freezer, burger patties not properly sealed in the freezer, dessert bars not dated or marked and not properly closed in the bakery freezer, trash cans in the food prep area to not have lids, and observed that the test strips to test the parts per million for the sanitizing buckets and three- compartment sink were damaged and unusable. DM C stated that the test strips must have gotten dropped in the water and been damaged. DM C stated that she checked in her office for more test strips, but the ones she had were expired. DM C indicated that there were no other test strips in the facility for testing parts per million of the sanitizing buckets. On 3/10/26 at 11:02 AM, Surveyor observed [NAME] D during meal tray service. Surveyor observed [NAME] D take a pan of garlic bread from the oven and test it, then set the thermometer temperature probe on the counter. A few minutes later, Surveyor observed [NAME] D take tomato sauce out of the microwave and test it using the same thermometer temperature probe. Surveyor asked [NAME] D when it is appropriate to clean the thermometer temperature probe. [NAME] D stated that normally he cleans it every time before inserting it into a new food but that a couple times he forgot to do that during the meal service. Surveyor asked [NAME] D what his process was for cleaning the thermometer temperature probe. [NAME] D stated that he would clean the thermometer temperature probe with an alcohol wipe for 3 seconds and then let it dry for 3 seconds before inserting the probe into the next food item. (Please note: the thermometer temperature probe should be allowed to dry at least 10 seconds before re-inserting the probe into the next food item to reduce the risk of cross-contamination). On 3/11/26 at 12:06 PM, Surveyor interviewed DM C who stated that she ordered new test strips for the parts per million sanitizer, but that she had not received them yet. DM C confirmed that she did not have any way of testing the chemical parts per million in the sanitizing bucket. On 3/12/26 at 9:23 AM, Surveyor observed a tray with uncovered food being taken down the hall and delivered to a resident's room. On 3/12/26 at 10:16 AM, Surveyor observed DA E (Dietary Aide) using the facility's industrial dishwasher. DA E indicated that they use a high temp dishwasher, and that they take the temperature off the readout and enter it on the temperature log sheet. Surveyor asked about testing the three-compartment sink. DA E stated that usually it was DW J (Dishwasher) that would do that. On 3/12/2026 at 10:48 AM, Surveyor interviewed IC F (Infection Control) nurse and shared the observation of food being carried down the hallway uncovered. IC F stated that the fruit and dessert cups are uncovered on the tray when they are received from the kitchen. Surveyor asked IC F if there could be a risk of airborne contamination if the trays are carried down the hallway (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with uncovered food. IC F stated that yes, perhaps they should be covered. IC F indicated that she covers her own food when she carries it down the hallway, so the resident's food should probably be covered as well. On 3/12/26 at 12:08 PM, Surveyor observed DW J (Dishwasher) using the facility's industrial dishwasher and three-compartment sink. DW J indicated that he washes the bigger items in the sink. Surveyor reviewed the dishwasher temperature logs with DW J, who stated that the dishwasher readout on the display should be double checked with the attached thermometer gauge on the dishwasher. Surveyor asked DW J how the parts per million (PPM) were tested in the three-compartment sink. DW J showed Surveyor the PPM log, which indicated blanks on 3/8/26 and 3/9/26, but a reading of 600 ppm on 3/10/26 with DA E's initials. On 3/12/26 at 12:17 PM, Surveyor interviewed DM C. Surveyor shared with DM C her observations of food that was open, not labeled, and improperly stored during the kitchen tour. DM C indicated that she had immediately discarded the personal food as well as the half loaf of bread and dessert bars. Surveyor asked DM C about the cleaning of the oven. DM C indicated that all the ovens get a monthly deep clean. Surveyor asked DM C about the test strips for the sanitizing buckets and three-compartment sink and reviewed the PPM log with her. DM C stated that DA E must have used the damaged test strips when he recorded 600 ppm on the log on 3/10/26. DM C stated that she should be receiving new test strips today. Surveyor asked DM C about the trash cans remaining uncovered in the food prep areas. DM C stated that she had the trash can lids ordered. Surveyor shared with DM C the observations of cross-contamination with food temping during meals service and the uncovered fruit and dessert cups observed being carried down the hall. DM C indicated that it was her expectation that the food be prepared, stored, and transferred in a safe and sanitary manner.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Number of residents sampled: 6Number of residents cited: 4Based on observation, interview, and record review, the facility did not ensure that it was free of medication error rates of 5% or greater. There were 11 errors out of 37 opportunities that affected 4 (R3, R8, R15, & R4) out of 6 residents included in the medication pass task, which resulted in an error rate of 29.73%. RN N (Registered Nurse) did not follow facility policy or current standard of practice for the administration of R3's Daptomycin (Antibiotic) through a PICC (Peripherally Inserted Central Catheter) line. MT (Medication Tech) O did not administer the correct dose for R8's ipratropium bromide 0.06% inhalation solution (Nasal spray used to relieve runny nose). Instead of the ordered 2 sprays in each nostril, R8 was only administered 1 spray in each nostril. MT O did not follow facility policy or current standard of practice when administering R15's Artificial Tears eye drops. MT O did not hold R15's eyelids open when administering the eye drops. Surveyor observed LPN I (Licensed Practical Nurse) administer R4's medication late. This is evidenced by: The facility policy titled, Basic Medication Administration Policy, dated 12/18/24, states, in part: . 3.9. Eye Medication . d. Tilt head back slightly. e. Draw lower lid down gently by pressure on maxillary prominence and instruct patient to look upward. f. Drop medication into the mid lower eye area . (Of note: Surveyor requested a policy regarding intranasal medications, however none was provided). The facility policy, Basic Medication Administration, revised 12/18/24, states in part, as follows: Purpose: To provide for safe and appropriate administration of only medications to residents(s) at facility. General Medication Administration: All medications must be given within 1 hour before or 1 hour after scheduled time. If the medication is given before or after the 1-hour time allotment, a medication error will be noted per policy. Example 1 R3's Physician Orders: Daptomycin 100 MG (milligrams) injection to run over 30 minutes via PICC line. 0800 (8:00 AM). On 3/11/26 at 08:59 AM, Surveyor observes RN N (Registered Nurse) administer an injection of Daptomycin to run over 30 minutes. When assessing for patency of the PICC line, RN N failed to aspirate for blood return. Upon RN N programming the pump, Surveyor asked RN N to state her settings. RN N states she set the pump to 100 MG in 50 mL (milliliters) to run over 30 minutes, at a rate of 100 mL/hour (milliliters per hour). After RN N started the infusion, Surveyor reviewed the medication label on the 50 mL bag of IV fluid. Surveyor noted that the total volume of the bag is listed as 70 mL (milliliters). (Of note: This means that 20 mL would not be infused within the 30-minute timeframe for (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration. The added bag volume is due to the addition of the antibiotic medication into the already existing 50 mL of IV solution). On 3/11/26 at 1:11 PM, Surveyor interviewed RN N. Surveyor asked RN N what the process is for administering intravenous medication through a PICC line. RN N indicates she starts by priming the line (allowing medication to flow through IV tubing to remove air before connecting the tubing to the patient), check the medication administration record for the dose, rate, and medication orders, review the 5 rights of medication administration, set up the pump, flush the PICC line, then administer the medication. Surveyor asked RN N if she should aspirate for blood return prior to administering the medication. RN N indicates she did not because she drew labs from the PICC line 30 minutes to 1 hour prior to administering the medication, but you should. Surveyor asked RN N what volume she set the pump. RN N states 50 mL. Surveyor asked RN N if she knows the total volume that was in the bag. RN N states 70 mL. Surveyor asked RN N if the total volume in the bag should have been administered. RN N indicates she sets the pump to 50 mL then goes back to check the bag to make sure all the medication was administered. Surveyor asked why is that important to set the pump for the total volume. RN N indicates because the medication needs to be given within 30 minutes. RN N also indicates she has never had the issue of medication left in the bag when setting the pump to the 50 mL volume. On 3/11/26 at 2:50 PM, Surveyor interviewed IC F (Infection Control Nurse), who also works as the facility's nurse educator. Surveyor asked IC F what education she provides to staff regarding PICC lines. IC F indicates she conducts in-person training with staff utilizing training arms that allow staff to practice accessing lines and setting pumps. IC F also indicates when a resident is admitted with a PICC line she does on the spot training with staff to refamiliarize them with the process and is available almost 24/7 for any staff who have questions. Surveyor asked IC F if competency checks are completed for staff. IC F states yes. Surveyor asked IC F if she would aspirate for blood return prior to administering medication through a PICC line. IC F indicates if it was her, she would have but does note RN N advised her she drew blood for labs 30 minutes before medication administration and has not had time to look up the standard of practice. On 3/11/26 at 1:44 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what the process is for administering IV medications through a PICC line. DON B indicates to follow the SASH (Saline-flush with saline, A-administer medication, S-flush with saline again, H-heparin in the line to prevent clots) method, prepare the medication, check the medication administration record, prime the tubing, clean port with an alcohol wipe, connect tubing, set up pump, review the 5 rights of medication administration, administer the medication, flush the line and administer heparin to prevent clots. Surveyor asked DON B if staff should aspirate for blood return prior to administering medication. DON B states, yes. Surveyor asked DON B if the pump should be set to the bag volume or total volume. DON B indicates, initially it can be set to bag volume, then staff can go back to reset the pump to receive all the medication. Surveyor asked DON B if the pump should be set so the medication is administered according to order, as in over the 30-minute timeframe. DON B indicates, yes. Example 2 R15's Physician Orders: Artificial Tears Solution to eye(s) (both) 1 drop three times daily 0800 (8:00 AM) 1400 (2:00 PM) 2000 (8:00 PM) (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/26 at 8:02 AM, Surveyor observes MT O (Medication technician) administer medications to R15. When administering the Artificial Tears, MT O held the dropper above R15's eyes and administered a drop without holding open R15's eyelids or requesting R15 to hold open his eyelids. Surveyor observed R15's eyes to be almost completely closed when the medication was administered. On 3/11/26 at 8:20 AM, Surveyor interviewed MT O. Surveyor asked MT O if she should hold open the resident's eyelids when administering eye drops. MT O indicates she should unless the resident can keep their eye open without someone holding the eyelids. On 3/11/26 at 1:44 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B to describe the process for administering eye drops. DON B indicates staff should perform hand hygiene, check the medication administration record, review the 5 rights of medication administration, don gloves, provide tissue to the resident, press on the inner part of the eye, and administer the medication. Surveyor asked DON B if staff should hold residents' eyelids open when administering eye drops. DON B states, yes. Surveyor asked DON B if it is acceptable to have residents hold their own eyelids open while receiving eyedrops. DON B indicates she would not as it is standard of practice to have the staff member hold the eyelids open. Surveyor asked DON B if medications should be administered according to physician order. DON B states yes. Example 3: R8's Physician Orders: Ipratropium Bromide 0.06% Solution. Nasal (both) (2 sprays) three times daily. 0800 (8:00 AM) 1100 (11:00 AM) 1700 (5:00 PM) On 3/11/26 at 8:13 AM, Surveyor observes MT O (Medication technician) administer medications to R8. When administering the ipratropium bromide nasal spray, MT O only administered 1 spray into each nostril, when the order states 2 sprays in each nostril. On 3/11/26 at 8:20 AM, Surveyor interviewed MT O. Surveyor asked MT O how many sprays of ipratropium bromide nasal spray she administered to R8. MT O indicates 1 in each nostril. Surveyor asked MT O how many sprays she should administer. MT O indicates she wants to wait until after R15 eats breakfast to administer the second spray. On 3/11/26 at 1:44 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if two nasal sprays per nostril are ordered, should they be administered at the same time. DON B states yes. Surveyor asked DON B if medications should be administered according to physician order. DON B states yes. Example 4: R4's Physician Orders, signed 3/3/26, include, in part, the following medications: 1. Ascorbic Acid 500mg (milligram) tablet by mouth two times daily 8:00 AM and 5:00 PM to prevent nutritional deficiency 2. MiraLAX (Polyethylene Glycol 3350 17g (grams)/scoop Powder by mouth daily 8:00 AM for (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	constipation 3. Allopurinol 100mg (milligram) tablet by mouth (2) (tabs) daily 8:00 AM for gout 4. Aspirin 81mg (milligrams) tablet delayed release by mouth daily 8:00 AM 5. (Plavix) Clopidogrel Bisulfate 75mg (milligrams) by mouth daily at 8:00 AM 6. Acetaminophen 500mg (milligrams) by mouth (2) (tabs) three times daily with meals 8:00 AM, 12:00 (Noon) 5:00 PM 7. Lisinopril 20mg (milligrams) tablet by mouth by mouth daily 8:00 AM for hypertension (high blood pressure) 8. Sertraline 50mg (milligram) tablet by mouth ***75mg dose***daily 8:00 AM for depression On 3/10/26 at 9:30 AM, Surveyor observed LPN I (Licensed Practical Nurse) administer the eight (8) medications above to R4. R4's medication administration was outside the hour before and hour after window, this resulted in 8 medication timing errors. On 3/12/26 at 2:10 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor shared the medication error rate with DON B. Surveyor asked DON B, do you expect staff to follow physician orders. DON B stated, yes. Surveyor asked DON B, when a medication is ordered to be administered at 8:00 AM, what time would you expect the medication to be administered. DON B stated an hour before or an hour after the order time. Surveyor asked DON B, when a medication that is ordered for 8:00 AM is administered at 9:30 AM, is this considered a medication error. DON B stated, yes, correct. Surveyor shared the medication errors for R4 with DON B. Surveyor asked DON, would you expect staff to administer the R4's medications within an hour before or an hour after the ordered time of 8:00 AM. DON B stated, yes.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately consult with 1 of 3 residents (R61) physicians when there was a significant change in the resident's physical status.The facility did not immediately contact a physician after R61 experienced decreased peripheral capillary oxygen saturation (SPO2) on two (2) consecutive days.This is evidenced by:The facility policy titled Resident Change in Condition Policy with a review date of 9/29/25 states in part; an Registered Nurse (RN) will assess residents exhibiting a change in condition and will inform resident, their physician, and responsible party. 3.1 The Nursing staff will update the residents attending physician or designee when: b. There is a significant change in the residents' physical, mental, or psychosocial status.R61 was admitted to the facility on [DATE] with diagnoses that include chronic diastolic heart failure (long term condition where the heart muscles become too stiff to relax and fill properly with blood between beats.) and atherosclerotic heart disease of native coronary artery (resident has plaque buildup narrowing the natural arteries supplying your heart.)R61's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/17/2025 states that R61 has a Brief Interview of Mental Status (BIMS) of 13 out of 15, indicating that R61 is cognitively intact.On 2/13/26 at 12:22, R61 had orders to administer oxygen via oxygen concentrator 1L-2L/min (liters per minute) continuous to keep O2 sat (oxygen saturation) greater than or equal to 90% or for clinical signs and symptoms (S/Sx) of shortness of breath (SOB)/dyspnea.On 2/18/26, R61 was seen by MD (Medical Doctor) with no new orders.On 2/18/26 AM (morning) charting in EMAR (electronic medication administration record) stated SPO2 83% on 3L. PM (evening) charting in EMAR stated 87% on 3L.No progress note with signs or symptoms was documented. No documentation that the physician had been notified.On 2/19/26 In AM R61's SPO2 was 87% on 2L, charted in EMAR. PM EMAR stated SPO2 at 87% on 2L. No other documentation in EMR regarding signs and symptoms or notification to the physician.On 2/20/26 a progress note was written as bed hold issued and appeal rights outlined.On 2/20/26 at 5:24 PM progress note states, CALL PLACED TO: Son and daughter in law REGARDING: Call placed shortly after resident was transferred to the ED (emergency department) to the family reporting resident condition and that transfer to the ED via 911 occurred. Questions answered, Support provided.CALL PLACED TO: FMP H (Family Medicine Physician) SPOKE WITH: nurse at the clinic. REGARDING: Resident transfer to the ED and updated on resident admission to [Hospital Name].On 3/12/26 at 2:45 PM, Surveyor asked RN G (Registered Nurse) when a resident has an SPO2 below the range in their O2 order, should the Provider be updated on the reading. RN G stated yes. Surveyor asked RN G Was R61's provider updated about her low readings on 2/18/26 and 2/19/26. RN G stated that it doesn't look like it. Surveyor asked RN G if R61 had any other signs or symptoms besides low SPO2. RN G stated nothing is documented in the chart about the incident.On 3/12/26 at 3:20 PM, Surveyor asked DON B (Director of Nursing) would you expect the resident's provider to be updated if SPO2 is below the range given in the oxygen order. DON B replied yes.On 3/12/26 at 4:10 PM, Surveyor asked FMP H would you expect the resident's provider to be undated when R61's SPO2 was below 90%. FMP H stated yes.The facility did not immediately contact a physician after R61 experienced decreased peripheral capillary oxygen saturation (SPO2) on two (2) consecutive days.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not provide nail care assistance for 1 of 1 (R19) dependent resident reviewed for Activities of Daily Living (ADLs) assistance.Staff did not assist R19 with nail care assistance even after Surveyor informed staff that the nails were digging into the palm of R19's contracted hand.Evidenced by:Facility policy, titled Foot and Nail Care for Long Term Care Residents, dated 11/28/22 with last review date of 12/31/24, states, . Purpose: To provide a consistent and safe method for the provision of foot and nail care for all adult residents. nail and foot care can be performed by Registered Nurses, Physicians, and appropriately trained assistive personnel .R19 was most recently admitted to the facility on [DATE] with diagnoses that include, Anxiety disorder, Depression unspecified, Ischemic Stroke (blood clot that blocks blood flow to the brain), and Contracture of muscle of right forearm. R19's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/30/25 documented that R19 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R19 has is cognitively intact. R19's Care Plan, includes, in part:Problem: I need assistance with my ADLs due to recent fall with fractures. Date Initiated:9/30/24.Intervention: Weekly nail care Wednesday AM. Date Initiated: 3/21/16.Problem: I have impaired physical mobility related to right sided weakness r/t (related to) previous CVA (cerebrovascular accident, i.e. stroke). Date Initiated: 3/21/16.On 3/11/26 at 10:06 AM, Surveyor interviewed R19 and observed moderately long fingernails on her right contracted hand, such that the thumb nail was poking up between the forefinger and middle finger on her right hand. R19 stated she needs staffs' assistance with clipping her fingernails. R19 stated staff tell her they will get to it when they have time; however, staff never seem to have the time. R19 stated the nails on her right hand are digging into her palm.On 3/11/26 at 3:42 PM, Surveyor accompanied CNA K (Certified Nursing Assistant) to R19's room to view R19's hand. With the assistance of CNA K, R19 was able to open her contracted right hand. Surveyor observed that the skin of R19's palm was intact. Surveyor and R19 pointed out to CNA K that R19 needed to have her nails trimmed. CNA K stated that a day shift nurse normally trims R19's nails.On 3/12/26 at 9:34 AM, Surveyor spoke with R19 in the hallway and asked if her nails had been trimmed. R19 indicated her nails still had not been trimmed. R19 stated that she was sure that the staff would get to it when they had time.On 3/12/26 at 1:16 PM, Surveyor interviewed CNA L and asked her how often R19 had her nails trimmed. CNA L stated that R19's nails were trimmed every week on her shower day.On 3/12/26 at 2:48 PM, Surveyor interviewed DON B (Director of Nursing) and asked how often R19 had her nails trimmed. DON B indicated that R19's nails were trimmed weekly by staff on her bath day or as needed. DON B stated R19 would let staff know. Surveyor shared with DON B that R19 had let staff know yesterday that her nails were digging into her palm and needed her nails trimmed; however, staff had still not trimmed R19's nails per her request. Surveyor asked DON B if staff should be assisting R19 with having her nails trimmed and per her need and/or request. DON B stated yes, staff should be assisting R19 with her nail care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525447	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Manor	803 S University Ave Beaver Dam, WI 53916

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for 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 observation, interview, and record review, the facility did not ensure adequate interventions were in place for safety to prevent accidents from occurring for 1 of 3 residents (R4) reviewed for falls. R4 was admitted with a known history of falls. The facility did not ensure adequate fall interventions were in place upon admission, resulting in R4 having a fall with a distal fibular (lower end of the calf bone near the ankle) fracture.Evidenced by: The facility's policy titled, Fall Prevention and Management Procedure, dated 12/19/24, indicates, in part: Purpose Statement: To establish procedure for residents at risk for falls; to systemically assess fall risk factors; provide guidelines following a fall and resident specific fall preventive interventions. 3.1 Fall Risk - Individual Resident: a. Upon admission. a registered nurse will assess each resident for risk of falls using the Morse Fall Scale. b. If determined to be at risk for falling, the resident's interdisciplinary care plan will identify him/her as at risk, along with providing interventions to provide safety for the resident. 3.2 Prevention Interventions/Strategies: . d. Interdisciplinary care plans will provide interventions for each resident to assist with keeping resident safe.R4 admitted to the facility on [DATE] with diagnoses that include, in part: Vascular dementia, mild, with anxiety, adult failure to thrive, Pain in left hip, Other chronic pain, Strain of muscle, fascia and tendon of the posterior muscle group at thigh level left thigh, Depression unspecified, and Other Alzheimer's disease.R4's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/9/26 documents R4's Brief Interview of Mental Status (BIMS) score of 8 out of 15, indicating R4 has moderate cognitive impairment. R4's fall care plan upon admission, dated 2/4/26, states, in part: Problem: I have impaired physical mobility due to dementia. I have a history of falls.Goal: I will be free from falls.Intervention: Refer me to PT (physical therapy).Intervention: Administer my pain meds.Intervention: Praise my progress.R4's Comprehensive Care Plan, dated 2/4/26, states, in part: . Turn me AM shift. Turn me PM shift. Turn me NOC (overnight) shift.R4's Morse fall risk assessment score on 2/4/26 at admission was 90, indicating high fall risk.On 3/10/26 at 9:50 AM, Surveyor observed R4 in her room with a walking boot on left foot. R4 stated she fell and broke her foot a few weeks ago and went to the emergency room (ER).On 2/21/26 R4's fall summary report, provided by the facility, indicated the following: Fall Summary: .Resident was laying on her right side with her knees bent and her feet under the register. She was leaning on her right elbow with head elevated leaning on the side of the bed. She denies hitting head. States that she has no pain except to her left hip (chronic pain). Resident was assisted off the floor with 3 people and Medi-lift. No complaints of pain to the right side and ROM (range of motion) intact. C/o (complaints of) pain to left hip. Difficulties assessing pain as resident gives very non-specific answers regarding her pain to her left hip and she already has known limitations. Limited ROM to left hip/knee. With subsequent follow-ups resident complained of pain to left hip and then when asked to move her left leg could not move it and states it hurts.R4's ER note, dated 2/21/26, provided by the facility, states the following, in part: . female with history of dementia presenting. after a fall. Staff found her on the ground next to her bed. She does not appear to have any new injury. However, she is. unable to report what happened. She was reportedly complaining of left leg pain. However, staff state that it looked like she landed on her right side. She reportedly has been having left hip pain for weeks, and a recent MRI from a few days ago showed a possible left sacral insufficiency fracture. She also seems to have a lot of ankle pain. No prior ankle x-rays on file. reviewed the x-rays. She is a distal fibular fracture. short leg post mold splint. was applied.On 2/21/26 a progress noted entered into R4's electronic medical record states, in part: Received report from ER nurse stating that resident has a fibula fracture of the left foot and a splint was applied and is to be left in place until follow-up with ortho. Resident should be non-weight bearing on the left leg.R4's Morse fall risk assessment score on 2/21/26 at re-admission was 75, indicating high fall (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risk.On 2/21/26 R4's Comprehensive Care Plan was updated to include the following:Problem: I have impaired physical mobility due to dementia.Goal: I will be free from falls.Intervention: Posey alarm to bed.Intervention: Low bed.Intervention: Transfer me AM shift with 2 assist with Medi-lift.Intervention: Transfer me PM shift with 2 assist with Medi-lift. On 2/23/26 R4's Comprehensive Care Plan was updated to include the following: Problem: I need assistance due to progression of dementia - my husband was no longer able to care for me at home.Intervention: Last round toileting at 2 pm.Intervention: Last round toileting at 10 pm.Intervention: Last round toileting 5 am.Problem: Left distal fibula fracture.Intervention: Left ankle splint at all times.Problem: I have the potential for falls related to cognitive impairment, lack of safety awareness, history of falls.Intervention: TDWB (touch down weight bearing) left lower extremity. R4's Incident SBAR, provided by the facility, indicated the following, in part: Situation: [Resident Name] was noted to be laying in bed resting prior to fall. [Resident Name] started yelling for help. Resident said the pillow at her back made her feel stuck and tried to get up. She attempted to exit the bed, and slid down to the floor, landing on her right side with knees bent and feet were under the register. Pain was noted to the left hip. Resident complained of pain during ROM and stated it hurt.Background: Resident. admitted on [DATE], from hospital, following a fall at home. Husband was no longer able to care for her at home. admitted for rehabilitation and long-term care. [Resident Name] admitted with transfer status from bed to chair as non-weight bearing due to medical condition.Assessment: Review of resident BIMS indicates she has scored a 7 and 8 recently, indicating moderate memory impairment. Review of care plan indicates facility had a fall care plan in place and had identified that she was identified as a high fall risk and was undergoing physical therapy to help identify and mitigate her risks. Interview with resident indicates she remembers attempting to stand up, although could not recall details in depth. She did remember trying to get up on the bed after falling.Recommendation: Posey alarm added to bed and care plan to assist in notification of staff to resident's need of assistance. Low bed added to bed and care plan for safety.On 3/11/26 at 2:58 PM, Surveyor interviewed DON B (Director of Nursing) about R4's fall. DON B stated that she was working as a floor nurse at the time of the fall. DON B indicated that R4 had multiple things going on at home prior to her admission, including a lot of pain in her hips and thighs and inability to bear weight. DON B stated that R4 had multiple falls at home, and the husband would pick her up. Surveyor asked DON B what fall interventions had been in place prior to R4's fall on 2/21/26. DON B stated that prior to the fall R4 had turn and reposition schedule, so staff were checking on her often and last round toileting on the ends of the shifts to make sure that incontinence was not a factor in trying to get out of bed. DON B stated that R4 is very immobile, so they were surprised to see that she got out of bed on her own. Surveyor asked DON B if a full assessment including ROM (Range of Motion) had been completed on R4 after the fall. DON B stated that the issue with R4 is that she had no complaints of pain on the right side which was the side she landed on. DON B indicated that R4 had complained of pain on her left side which is the side that she has chronic pain. DON B stated that she asked R4 to move her leg and she would not move it for her. DON B stated that she always does a full assessment before getting any resident off the floor, and that she did ROM with R4 the best that she could with the position that R4 was in. DON B stated that R4 had complained of no ankle pain, in either leg, both prior to getting her off the floor and afterwards. DON B indicated that after R4 was in bed she continued to assess her, but that it was difficult to assess if there was anything new happening. DON B indicated that R4 returned from the ER with a splint, but that it was changed to a pneumatic boot (medical or recovery device that uses inflatable air chambers to provide support, compression, and adjustable stability to the lower leg and foot.) at her follow-up appointment with orthopedics on 3/2/26. DON B stated that R4 is non weight bearing to that leg, but that she can toe touch for transfers.On 3/12/26 at 1:14 PM, Surveyor interviewed CNA L (Certified Nursing Assistant) about R4's fall interventions before and after the fall. CNA L stated that R4 had just been transferred to her floor, so she wasn't sure about her fall interventions, but they would be on her care plan.On 3/12/26 at 2:51 PM, Surveyor interviewed DON B about R4's fall (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions before and after the fall. DON B stated that the admissions coordinator had indicated that R4's falls at home were due to weakness and transferring with her husband so there was no need for an alarm or anything upon admission. DON B stated that R4 doesn't get out of bed by herself, so they were surprised when that happened. DON B indicated that because R4 does not move by herself or try to climb out of bed, there had been no need for a low bed intervention. Both of these interventions were added to R4's care plan after the fall.The facility failed to ensure that adequate fall interventions were established upon admission for a resident with a known history of falls at home, thereby failing to keep R4 safe from a fall.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure nursing staff followed professional standards of practice when flushing a peripherally inserted central catheter (PICC) for 1 of 1 resident (R3) reviewed for intravenous medication administration.RN N (Registered Nurse) did not follow facility policy or current standard of practice for the administration of R3's Daptomycin (Antibiotic) through a PICC (Peripherally Inserted Central Catheter) line. RN N failed to check for blood return prior to administering the intravenous medication. RN N also failed to set the pump to administer the medication according to physician order. Evidenced By: The facility policy titled, Peripherally inserted central catheter (PICC) drug administration, dated 9/14/25, states, in part: . Implementation . While maintaining sterility of the syringe tip, attach a prefilled 10-mL syringe or a syringe specifically designed to generate lower injection pressure containing preservative-free normal saline solution to the needless connector. Unclamp the catheter and, if not contraindicated, aspirate slowly for a blood return that's the color and consistency of whole blood. If you don't obtain a blood return, take steps to locate an external cause of obstruction . According to the National Institutes of Health (NIH), before flushing the lumen with 0.9% sodium chloride, aspiration of blood should be attempted to ensure patency. The volume of fluid used for flushing should be twice the volume of the lumen.Source: https://www.ncbi.nlm.nih.gov/books/NBK594495/R3 was admitted to the facility on [DATE] with diagnoses including infection and inflammatory reaction due to internal right knee prosthesis (infection of his artificial right knee joint), urinary tract infection, and malignant neoplasm of prostate (prostate cancer).R3's admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) 2/18/26 indicates R3 has a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating he is cognitively intact. Section O indicates R3 is receiving IV (intravenous) medication and has Central access (example: PICC).R3's Physician Orders:Daptomycin 100 MG (milligrams) injection to run over 30 minutes via PICC line. 0800 (8:00 AM).On 3/11/26 at 8:59 AM, Surveyor observes RN N administer an injection of Daptomycin to run over 30 minutes. When assessing for patency of the PICC line, RN N failed to aspirate for blood return. Upon RN N programming the pump, Surveyor asked RN N to state her settings. RN N stated she set the pump to 100 MG in 50 mL (milliliters) to run over 30 minutes, at a rate of 100 mL/hour (milliliters per hour). After RN N starts the infusion, Surveyor reviewed the medication label on the 50 mL bag of IV fluid. Surveyor notes that the total volume of the bag is listed as 70 mL (milliliters).(Of note: This means that 20 mL would not be infused within the 30-minute timeframe for administration. The added bag volume is due to the addition of the antibiotic medication into the already existing 50 mL of IV solution). On 3/11/26 at 1:11 PM, Surveyor interviewed RN N. Surveyor asked RN N what the process is for administering intravenous medication through a PICC line. RN N indicates she starts by priming the line (allowing medication to flow through IV tubing to remove air before connecting the tubing to the patient), check the medication administration record for the dose, rate, and medication orders, review the 5 rights of medication administration, set up the pump, flush the PICC line, then administer the medication. Surveyor asked RN N if she should aspirate for blood return prior to administering the medication. RN N indicates she did not because she drew labs from the PICC line 30 minutes to 1 hour prior to administering the medication, but you should. Surveyor asked RN N what volume she set the pump. RN N stated 50 mL. Surveyor asked RN N if she knows the total volume that was in the bag. RN N stated 70 mL. Surveyor asked RN N if the total volume in the bag should have been administered. RN N indicates she sets the pump to 50 mL then goes back to check the bag to make sure all the medication was administered. Surveyor asked why is that important to set the pump for the total volume. RN N indicates because the medication needs to be given within 30 minutes. RN N also indicates she has never had the issue of medication left in the bag when setting the pump to the 50 mL volume. On 3/11/26 at 2:50 PM, Surveyor interviewed IC F (Infection Control Nurse), who also works as the facility's nurse educator. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked IC F what education she provides to staff regarding PICC lines. IC F indicates she conducts in-person training with staff utilizing training arms that allow staff to practice accessing lines and setting pumps. IC F also indicates when a resident is admitted with a PICC line she does on the spot training with staff to refamiliarize them with the process and is available almost 24/7 for any staff who have questions. Surveyor asked IC F if competency checks are completed for staff. IC F stated yes. Surveyor asked IC F if she would aspirate for blood return prior to administering medication through a PICC line. IC F indicates if it was her, she would have but does note RN N advised her she drew blood for labs 30 minutes before medication administration and has not had time to look up the standard of practice. Surveyor requested RN F's most recent competency assessment.IC F provided Surveyor with a blank competency assessment she uses to assess all staff, including new hires and agency staff. This document is titled, Flushing of PICC and Medication Administration Competency Assessment and is dated 10/2022. This document stated, in part: . Flushing of Catheter with Normal Saline. 6. The RN demonstrates the steps in flushing PICC. Aspirate for blood flow/catheter patency. If no blood flow, reposition the arm. IC F indicates she is unable to locate RN N's competency assessment, however she is positive one was conducted when RN N was hired.On 3/11/26 at 1:44 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what the process is for administering IV medications through a PICC line. DON B indicates to follow the SASH (Saline-flush with saline, A-administer medication, S-flush with saline again, H-heparin in the line to prevent clots) method, prepare the medication, check the medication administration record, prime the tubing, clean port with an alcohol wipe, connect tubing, set up pump, review the 5 rights of medication administration, administer the medication, flush the line and administer heparin to prevent clots. Surveyor asked DON B if staff should aspirate for blood return prior to administering medication. DON B stated, yes. Surveyor asked DON B if the pump should be set to the bag volume or total volume. DON B indicates, initially it can be set to bag volume, then staff can go back to reset the pump to receive all the medication. Surveyor asked DON B if the pump should be set so the medication is administered according to order, as in over the 30-minute timeframe. Surveyor asked DON B if medications should be administered according to physician order. DON B stated yes.RN N was observed not following the policy and procedure for IV medications.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility did not ensure that each resident receives food and drink that is palatable and at a safe and appetizing temperature for 1 of 15 sampled Residents (R19) R19 stated they were served cold food at meals. 1 of 1 test trays were observed to have food being served at undesirable temperatures. Evidenced by: The facility policy, titled Food and Nutrition - Tray Line Taste and Temperature Log Procedures, dated 10/15/24, includes in part: .3.1 Meals Served at Set Time. food is served at the appropriate temperature. to monitor taste and temperature on the service line for patient/resident food service. standard temperatures.Hot Entrees >= 140 degrees FahrenheitHot Vegetables >= 140 degrees FahrenheitHot Soup, Sauces, Gravies, Hot Beverage & Cereal >= 140 degreesCold Items <= 41 degrees Fahrenheit (or less)Frozen <= 0 degrees Fahrenheit (or less). Example 1: On 3/11/26 at 10:06 AM, Surveyor interviewed R19 who stated that the food at the facility tastes terrible. R19 indicated that she eats her meals in the dining room, and that the food is not served hot. R19 clarified that it is not every meal, but that a lot of the time the food is not served hot, and that lately the meals have been served very late. On 3/12/26 at 11:35 AM, Surveyor received a test tray after all the dining room and hall trays had been served. Surveyor took the temperatures of the food that was served, which included the following:Pork loin 118.9 degrees FahrenheitRice with tomatoes and spinach 148.8 degrees FahrenheitPeas 128.5 degrees FahrenheitMixed fruit cup 52 degrees FahrenheitPeach cobbler 53.8 degrees FahrenheitMilk 52 degrees FahrenheitCoffee 119.5 degrees FahrenheitSurveyor noted that many of the food items served were in the temperature danger zone, and that the hot foods were not served hot enough nor the cold foods cold enough. On 3/12/26 at 12:17 PM, Surveyor interviewed DM C (Dietary Manager) and asked what the safe temperature was for serving hot and cold foods. DM C stated that the serving temp of the pork should be at least 145 degrees Fahrenheit. Surveyor shared with DM C the temperatures taken of the test tray and asked if she would expect the food to be served at a safe and palatable temperature. DM C stated yes, that would be her expectation.

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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 provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 Residents (R41) reviewed for catheters.R41 has a history of bladder disorders and MRSA (methicillin-resistant Staphylococcus aureus, a bacteria that is resistant to many antibiotics) in the urine. CNA M (Certified Nursing Assistant) did not utilize aseptic technique to minimize the risk of cross contamination from microorganisms in the environment.Evidenced by:The facility's policy, Perineal Care/Catheter Care, dated 1/3/22 with last review date of 12/31/24, states, in part: Purpose:. Residents with indwelling catheters will receive catheter care with morning and evening cares, or as indicated in the plan of care. 3.1 Steps for Perineal Care:. b. Assemble equipment as needed for perineal care on bedside table providing barrier on table with paper/cloth towels. 3.4 Catheter Care: a. Complete perineal care prior to completing catheter care.R41 was admitted to the facility on [DATE] with diagnosis that include, in part: Other specified disorders of the bladder, unspecified dementia, Major depressive disorder, anxiety disorder, and repeated falls. R41's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 3/10/26 documents that R41 has a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating that R41 is severely cognitively impaired.R41's Comprehensive Care Plan states, in part: . Problem: I have indwelling catheter due to decreased mobility due to traumatic acetabular fracture. Imaging during fracture work up noted urinary retention. Catheter placed and provider indicates desire to continue due to obstructive uropathy and neurogenic component due to nature of fracture. Intervention: Catheter care with morning and evening care. Date Initiated: 11/19/25. Problem: I have a history of MRSA - urine. Goal: EBP (Enhanced Barrier Precautions) will reduce transmission of resistant organism to others. Date Initiated: 6/30/26.On 3/12/26 at 9:31 AM, Surveyor observed CNA M (Certified Nursing Assistant) and CNA L perform perineal and catheter care with R41. Surveyor observed CNA M place a basin of soapy water directly on R41's bedside table right next to several open drinks with straws in them. CNA M proceeded to use this basin on the bedside table to complete R41's perineal care. On 3/12/26 at 10:02 AM, Surveyor interviewed CNA M about R41's perineal and catheter cares. Surveyor asked CNA M if she should use a clean barrier on the bedside table when performing R41's cares. CNA M states yes, sometimes she puts a paper towel on the bedside table under the water basin to prevent water from splashing everywhere. Surveyor asked CNA M if placing a paper towel on the bedside table would also prevent contamination from microorganisms in the environment. CNA M stated yes, she could see where that would be beneficial.On 3/12/26 at 10:46 AM, Surveyor interviewed IC F (Infection Control Nurse) and shared with her the observation of R41's perineal and catheter care. Surveyor asked IC F if CNA M should have placed a barrier down on the bedside table before performing perineal cares. IC F states yes, it would not be a bad idea to do that, and she would have to check to see if it was part of the facility policy. On 3/12/26 at 2:55 PM, Surveyor interviewed DON B (Director of Nursing) and shared with her the observation of R41's perineal and catheter care. Surveyor asked DON B if CNA M should have placed a barrier down on the bedside table before performing perineal care. DON B stated yes, they have to put a barrier down for infection control purposes.