

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Meadowbrook at Oconto Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 100 E Highland Dr Oconto Falls, WI 54154	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible for 5 residents (R) (R1, R3, R4, R6, and R8) of 5 sampled residents in a total sample of 18 residents. R1 was admitted to the facility on [DATE]. Since admission, R1 expressed a desire to leave and attempted to leave on 7/6/26, 7/9/26, and 7/21/26. The facility did not evaluate R1 to ensure all possible safety measures were implemented to prevent harm. In addition, the facility had not begun discharge planning for R1 despite their continued desire to leave. R3, R4, R6, and R8 did not have current smoking assessments. Findings include: The facility's Elopement policy, dated November 2025, indicates: .It is the policy of the facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement. All residents so identified will have these issues addressed in their individual care plan. The facility's Safe Smoking/Tobacco use policy, dated January 2026, indicates: .A resident who smokes, uses smokeless tobacco, or uses an e-cigarette is evaluated to determine whether the resident is safe or unsafe to use tobacco products or e-cigarettes using the following forms: a. Upon admission or readmission .Quarterly, annually, with a significant change of condition, and/or an infraction of the facility's smoking policy: The safe smoking/tobacco use evaluation (UDA) is completed for residents who continue to use tobacco or e-cigarettes. 1. R1 was admitted to the facility on [DATE] and had a diagnosis of delusional disorder. An admission Minimum Data Set (MDS) assessment, dated 6/11/26, stated R1's Brief Interview for Mental Status (BIMS) score was 12 out of 15, indicating moderately impaired cognition. R1 was responsible for their own healthcare decisions. A care plan, revised 7/9/26, indicated R1 would like to return home to live with family, but was unsure if family would allow them to live there again. R1's family indicated they were not welcome back at home. R1 was aware and stated they had nowhere to go. The care plan contained an intervention to follow R1's wishes as they express them (dated 6/5/26). An Elopement Evaluation on 6/5/26 indicated R1 was not at risk for wandering or elopement. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note on 7/6/26 at 2:53 AM indicated R1 wanted to go outside and would not accept redirection. R1 attempted to run over staff with their wheelchair to get to the door. Two staff went outside with R1 who made it to the road and attempted to flag down cars. R1 screamed they would throw themselves on the ground if anyone touched their wheelchair. R1 stated staff were holding them captive and attempted to go to a van in the parking lot that they thought was the police. (R1's care plan was not updated with safety measures to prevent harm or interventions for staff redirection following the incident. In addition, R1's medical record did not contain a re-assessment of their wandering/elopement risk.) Progress notes completed by Licensed Practical Nurse (LPN)-I on 7/9/26 indicated at 12:12 AM, R1 was unhappy with multiple things in the facility and wanted to leave against medical advice (AMA). R1 was calm and resting in a chair in the lobby. Director of Nursing (DON)-B was aware. At 2:13 AM, R1 became increasingly agitated. Several staff attempted to keep R1 from leaving the facility. R1 asked to speak to management in person immediately. At 2:30 AM, R1 wanted to leave and signed AMA paperwork which was witnessed by several staff. DON-B asked LPN-I to talk to R1 about staying until morning so they had a safe environment and Social Services could assist them with a safe discharge. R1 wanted to leave and did not want to wait until morning. R1 was alert and oriented to person, place, time and situation and able to make their own medical decisions. LPN-I notified the on-call physician of R1's decision to leave AMA and was awaiting orders. At 3:06 AM, R1 barricaded themselves and their roommate in their room. Staff entered the room through the bathroom from the neighboring room. R1 was educated on the importance of allowing staff in the room. R1 stated they understood but was dissatisfied with the current situation and stated they were going to have a stern conversation with management in the morning. At 3:35 AM, the on-call physician ordered a one-time dose of Ativan (anxiety medication) 0.5 milligrams (mg) and was informed that R1 signed AMA paperwork. R1 refused to take the medication. R1 was in bed with all their belongings, resting comfortably, and chose to stay. LPN-I updated DON-B. A progress note completed by Social Services Director (SSD)-D on 7/9/26 at 8:52 AM indicated R1 stated they did not want to work with Medicaid and would be leaving with their famous significant other as soon as they arrived. On 7/21/26 at 10:49 AM, Surveyor interviewed LPN-I who stated R1 was delusional but continued to be their own decision maker. LPN-I said they had R1 sign an AMA form because R1 had the right to leave. LPN-I stated R1 constantly made statements of wanting to leave and frequently attempted to leave when LPN-I worked the night shift. (R1's care plan was not updated regarding their attempt to leave facility AMA on 7/9/26 and did not contain safety measures to prevent harm or interventions for redirection. In addition, R1's medical record did not contain a reassessment of their wandering/elopement risk.) Progress notes from 7/10/26 indicated R1 went up and down the hallway at 2:45 AM with their pants around their ankles. Staff asked R1 to pull up their pants when out of their room. R1 sat on the couch in the lounge with their pants down. R1 screamed, spit at staff, and threatened physical harm when staff asked them to get dressed. At 5:25 AM, DON-B was notified. At 10:29 AM, staff called the hospital regarding R1's increased confusion, distress, and desire to leave the facility. The hospital advised staff to send R1 to the Emergency Department (ED). At 3:06 PM, the physician agreed to send (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1 to the ED for evaluation. A progress note on 7/11/26 at 12:16 AM indicated R1 told LPN-I that SSD-D took their phone and would not give it back because SSD-D and management wanted to keep them from leaving. R1 stated their phone was locked in SSD-D's desk and they needed it to set up transportation. LPN-I called DON-B who stated SSD-D did not have R1's phone. DON-B told LPN-I they would tell Nursing Home Administrator (NHA)-A about the phone. A progress note on 7/14/26 at 2:18 PM indicated staff and R1's physician discussed their increasing delusions and attempts to leave the facility. The physician recommended ED evaluation at a hospital that had psychiatric care. R1 returned from the hospital at 6:10 PM. A physician visit note on 7/16/26 indicated the physician ordered Sertraline (antidepressant medication) 25 mg daily for 7 days and then increase to 50 mg daily. A progress note on 7/20/26 at 3:40 AM indicated R1's physician requested they be referred for a psychiatric consultation. R1 had a referral to be seen in the facility when the psychologist rounded next. A progress note on 7/21/26 at 1:46 AM indicated R1 asked staff for the bubble pack for medications because they were leaving. Staff stated they were not aware that R1 was leaving. R1 raised their voice and asked for the bubble pack again. Staff administered R1's scheduled medications and stated when R1 was ready to leave and staff were aware they would provide the bubble packs. On 7/21/26 at 1:33 PM, Surveyor interviewed LPN-C who stated R1 attempted to leave the facility through the 400 wing exit doors that morning. LPN-C stated R1 often tried to leave the facility and did not wear a WanderGuard. A progress note completed by SSD-D on 7/21/26 at 4:53 PM indicated they spoke with R1 who stated they wanted to leave. When SSD-D asked if R1 wanted assistance with discharge planning and if they had a place to go, R1 stated no and they will just want out of the facility one day. When asked if R1 wanted a referral sent anywhere, R1 stated they did not want anything from SSD-D. The note indicated SSD-D spoke with APS regarding R1 being their own decision maker. (R1's medical record did not indicate APS was notified prior to 7/21/26. In addition, R1's care plan was not updated with their continued desire or attempts to leave the facility.) On 7/21/26 at 3:56 PM, Surveyor interviewed SSD-D who was aware of R1's consistent statements of wanting to leave and attempts to leave. SSD-D stated R1 had never gotten out of the facility without a staff present. SSD-D stated when R1 attempted to leave, staff were able to redirect them. SSD-D made a referral to APS and stated R1 was on the list to be seen by the facility's psychiatric provider, however, the provider did not round until the end of the month. When asked what steps were being taken to ensure R1's safety, SSD-D stated staff manually locked the front entrance at 10:00 PM and unlocked it at 6:00 AM. SSD-D stated when the doors are pushed for 15 seconds from the inside, they release and an alarm sounds. SSD-D confirmed R1 did not wear a WanderGuard and was not asked to wear a WanderGuard. SSD-D did not know when R1's last elopement assessment was (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(See interview under example 5.) 4. R6 was admitted to the facility on [DATE] and had a diagnosis of personal history of nicotine dependence. A Quarterly MDS assessment, dated 7/10/26, stated R6 had a BIMS score of 13 out of 15, indicating intact cognition. A care plan (revised 3/13/26) indicated R6 chose to smoke but preferred to vape. The care plan contained an intervention (dated 3/13/26) to determine if R6 is safe to smoke independently (see smoking assessment). On 7/22/26, Surveyor requested R6's most recent smoking assessment which was dated 3/10/26. An updated smoking assessment was not completed following R6's Quarterly MDS assessment on 7/10/26. (See interview under example 5.) 5. R8 was admitted to the facility on [DATE] and had a diagnosis of tobacco use. A Quarterly MDS assessment, dated 6/17/26, stated R8 had a BIMS score of 12 out of 15, indicating moderate cognitive impairment. R8 had a smoking care plan that was initiated on 3/10/25. On 7/22/26, Surveyor requested R8's most recent smoking assessment which was dated 3/5/26. An updated smoking assessment was not completed following R8's Quarterly MDS assessment on 6/17/26. On 7/22/26 at 1:36 PM, Surveyor interviewed DON-B who confirmed R4 did not have a smoking assessment and R3, R6, and R8's smoking assessments were late. DON-B stated since the facility had an off-site MDS coordinator, nursing leadership should be completing quarterly smoking assessments.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 resident (R) (R1) of 6 sampled residents or their legal representative was informed in advance of the risks and benefits of prescribed medication and provided consent to receive the medication. R1 was prescribed Sertraline (antidepressant medication). R1 was not informed of the risks and benefits and did not consent to receive the medication. Findings include: The facility's Psychotropic Management policy, dated December 2025, indicates: A psychotropic medication is considered a chemical restraint when it is used as the first intervention to control behavior, mood, or mental status. Psychotropic medications can also be considered chemical restraints when they are the only intervention for the treatment of a psychiatric condition .1. Upon receipt of new orders for psychotropic medication, the licensed nurse will implement the following: .b. Complete the appropriate psychotropic medication consent form; .c. Education of the resident and/or the resident representative is conducted to communicate the risks and benefits of the medication .R1 was admitted to the facility on [DATE] and had diagnoses including nonrheumatic aortic (valve) stenosis and post transcatheter aortic valve replacement (TAVR). An admission Minimum Data Set (MDS) assessment, dated 6/11/26, stated R1's Brief Interview for Mental Status (BIMS) score was 12 out of 15, indicating moderately impaired cognition. R1 was responsible for their healthcare decisions. Visit orders from R1's provider, dated 7/16/26, recommended starting Sertraline 25 milligrams (mg) once daily for 7 days then increasing to 50 mg daily thereafter. R1's Medication Administration Record (MAR) indicated they received the first dose of Sertraline on 7/18/26 with daily doses administered through 7/21/26 for a total of 4 doses. R1's medical record did not indicate they were notified of the risks and benefits of Sertraline or consented to receive the medication. On 7/22/26 at 1:33 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-C who confirmed they administered Sertraline to R1. LPN-C stated when they give R1 their medications, R1 does not ask which medications are being administered. LPN-C stated residents should consent to medication before it is administered. LPN-C stated they did not take the initial order and did not know if R1 consented to the medication. On 7/22/26 at 9:14 AM, Surveyor interviewed interim Director of Nursing (DON)-B who confirmed the facility did not have documentation that R1 consented to the administration of Sertraline. DON-B stated R1 refused the medication on 7/21/26 when staff attempted to obtain consent. DON-B acknowledged that R1 received 4 doses of Sertraline without consent and stated consent should have been obtained before Sertraline was administered.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when they did not ensure allegations of misappropriation and neglect were reported to law enforcement and/or the State Agency (SA) for 2 residents (R) (R1 and R7) of 2 sampled residents. The facility was informed of suspected misappropriation involving R1. The allegation of misappropriation was not reported to local law enforcement or the SA. R7 required the assistance of two staff for mechanical lift transfers. R7 was transferred via sit-to-stand lift by 1 staff, fell to the floor, and sustained a head laceration. The SA wasn't notified of the allegation of neglect. Findings include: The facility's Abuse Prevention Program Policy indicates: .The purpose of this policy is to ensure the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents .External Reporting: 1. Initial reporting of allegations: When an allegation of abuse, neglect .misappropriation .has been made, the Administrator or their designee shall .notify the Division of Quality Assurance (DQA) that an occurrence of potential abuse, neglect .misappropriation .was reported to the Administrator and is being investigated .Informing Local Law Enforcement: .When there is reasonable suspicion that a crime has been committed in the facility by a person other than a resident . 1. R1 was admitted to the facility on [DATE] and had a diagnosis of delusional disorder. An admission Minimum Data Set (MDS) assessment, dated 6/11/26, stated R1's Brief Interview for Mental Status (BIMS) score was 12 out of 15, indicating moderately impaired cognition. R1 was responsible for own healthcare and financial decisions. A care plan, dated 7/9/26, indicated R1 had psychosocial well-being concerns related to a risk of being taken advantage of monetarily. The care plan stated R1 believed their significant other was a TV star and country music singer. R1 told staff they had given personal information to another person to assist them with finances. On 7/21/26 at 1:25 PM, Surveyor attempted to interview R1 who refused to speak to Surveyor. A progress note completed by Social Services Director (SSD)-D on 7/9/26 at 8:52 AM stated R1 told SSD-D that they did not want to work with Medicaid and their famous significant other was coming to get them as soon as possible. R1 showed SSD-D text messages in which the individual asked them about money and accounts. The progress note also stated R1 gave a friend personal information, including their date of birth , bank information, and social security number. R1 told SSD-D that they had not received a social security check for some time and the friend was assisting them with it. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note on 7/14/26 at 2:18 PM stated R1's physician recommended they be sent to the Emergency Department (ED) for evaluation of increasing delusions. R1 returned to the facility at 6:10 PM. On 7/21/26 at 3:56 PM, Surveyor interviewed SSD-D who stated R1's initial plan was to discharge to a family member's house, however, the family member was no longer willing to allow R1 to live with them. Shortly after learning that, SSD-D became concerned about financial abuse due to statements made by R1 and their family. SSD-D confirmed that R1 believed their significant other was a famous actor and country singer who texted them all the time. SSD-D confirmed they had seen the texts. SSD-D spoke with R1's family who stated the individual had taken between \$20,000 and \$30,000 of R1's money. SSD-D also stated R1 told them they gave personal information to another friend, however, they were not willing to give SSD-D the friend's name or contact information. SSD-D attempted to have R1 sign a Representative Payee form which would send their social security checks to the facility, however, R1 refused and stated their significant other did not want them to. SSD-D reported the concerns to Adult Protective Services (APS) who stated R1 was their own decision maker and they would not get involved unless R1 was a threat to themselves or others. SSD-D stated R1 had not been evaluated for mental capacity or competency to make their own decisions. On 7/22/26 at 8:53 AM, Surveyor completed a follow-up interview with SSD-D who could not recall the exact date they became aware of the financial abuse or when they filed the initial report with APS but thought it was the beginning of July (2026). SSD-D confirmed law enforcement was not notified. (A consultation request, dated 6/24/26, was completed and a referral was sent for psychiatric evaluation due to financial abuse and possible delusions.) On 7/22/26 at 1:08 PM, Surveyor interviewed Adult Protective Services (APS)-H who stated SSD-D called them on 7/14/26 and stated the facility was sending R1 to the ED for evaluation with a potential transfer to psychiatric care. APS-H stated they told SSD-D to let APS know if/when R1 returned to the facility. APS-H stated APS was not informed of R1's return until 7/21/26. APS-H sent an email to SSD-D on 7/21/26 at 3:03 PM to see if R1 had an activated Power of Attorney (POA) document but did not receive a response. APS-H stated APS did not have concerns working with the facility on potential guardianship for R1, but needed more information from the facility before proceeding. On 7/22/26 at 2:30 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who was not aware of suspected misappropriation for R1. NHA-A stated if there was an allegation or suspicion of misappropriation, NHA-A should have been informed and would have filed a report with local law enforcement and the SA. 2. R7 was admitted to the facility on [DATE]. R7 had an indwelling catheter and a diagnosis of a urinary tract infection (UTI). An MDS assessment, dated 4/6/26, stated R7 had a BIMS score of 15 out of 15, indicating intact cognition. A care plan indicated R7 had limited physical mobility. The care plan contained an intervention to transfer R7 with the assistance of two staff (dated 7/8/26). (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's medical record and a fall investigation report indicated R7 was standing in a sit-to-stand lift with one Certified Nursing Assistant (CNA) present on 7/12/26. R7 became weak and slid from the sling while the CNA was providing peri-care. R7 sustained a right forehead laceration with bleeding and was unconscious. Staff called 911 and R7 was transferred to the hospital. Staff did not follow R7's care plan and provide the assistance of two staff for a sit-to-stand transfer. On 7/22/26 at 4:51 PM, Surveyor interviewed NHA-A who stated the facility did not realize staff's neglect to follow R7's care plan which resulted in an injury was a reportable incident.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure an allegation of misappropriation was thoroughly investigated for 1 resident (R) (R1) of 1 sampled resident. The facility was informed of suspected misappropriation involving R1. The facility did not thoroughly investigate the allegation and implement safety measures to prevent further misappropriation. Findings include: The facility's undated Abuse Prevention Program indicates: The facility affirms the right of residents to be free from abuse, neglect, exploitation, misappropriation of property, or mistreatment. Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats or coercion. Misappropriation of resident property means the deliberate misplacement, exploitation of a resident's belongings or money without the resident's consent. Additionally, misappropriation of a resident's property means obtaining property of a client by intentionally deceiving the client with a representation which is known to be false, made with the intent to defraud, and which does defraud the person to whom it is made and/or intentionally using or attempting to use personal identifying information. The facility will take steps to prevent potential abuse while the investigation is underway. Accused individuals not employed by the facility will be denied unsupervised access to the resident during the course of the investigation. Any incident or allegation involving abuse, neglect, exploitation, mistreatment, or misappropriation of resident property will result in an investigation. R1 was admitted to the facility on [DATE] and had a diagnosis of delusional disorder. An admission Minimum Data Set (MDS) assessment, dated 6/11/26, stated R1's Brief Interview for Mental Status (BIMS) score was 12 out of 15, indicating moderately impaired cognition. R1 was responsible for their own healthcare and financial decisions. A care plan, dated 7/9/26, stated R1 had psychosocial well-being concerns related to a risk of being taken advantage of monetarily. The care plan stated R1 believed their significant other was a TV star and country music singer. R1 told staff they had given personal information to another person to assist them with finances. On 7/21/26 at 1:25 PM, Surveyor attempted to interview R1 who refused to speak to Surveyor. A progress note completed by Social Services Director (SSD)-D on 7/9/26 at 8:52 AM indicated R1 stated they did not want to work with Medicaid and their famous significant other was coming to get them as soon as possible. R1 showed SSD-D text messages in which the individual asked R1 about money and accounts. The progress note also stated R1 gave a friend personal information, including their date of birth, bank information, and social security number. R1 told SSD-D they had not received a social security check for some time and their friend was assisting them with it. A progress note on 7/14/26 at 2:18 PM stated R1's physician recommended they be sent to the Emergency Department (ED) for evaluation of increasing delusions. R1 returned to the facility at 6:10 PM. On 7/21/26 at 3:56 PM, Surveyor interviewed SSD-D who stated R1's initial plan was to discharge home with a family member, however, the family member was no longer willing to allow R1 to live with them. Shortly after learning that, SSD-D became concerned about financial abuse due to statements made by R1 and their family. SSD-D stated R1 believed their significant other was a famous actor and country singer who texted them all the time. SSD-D confirmed they saw the text messages. SSD-D stated R1's family stated the individual had taken between \$20,000 and \$30,000 of R1's money. R1 also told SSD-D they gave personal information to another friend, however, they were not willing to provide their name or contact information to SSD-D. SSD-D attempted to have R1 sign a Representative Payee form which would send their social security checks to the facility, but R1 refused and stated their significant other did not want them to. SSD-D reported the concerns to Adult Protective Services (APS) who stated R1 was their own (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Meadowbrook at Oconto Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 100 E Highland Dr Oconto Falls, WI 54154	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decision maker and they would not get involved unless R1 was a threat to themselves or others. SSD-D stated R1 had not been evaluated for mental capacity or competency to make their own decisions. On 7/22/26 at 8:53 AM, Surveyor completed a follow-up interview with SSD-D who could not recall the exact date they became aware of the allegation of misappropriation or when they requested assistance from APS to prevent further misappropriation. SSD-D confirmed safety interventions were not implemented to prevent further misappropriation and confirmed R1 was still in contact with the individual suspected of committing misappropriation. On 7/22/26 at 9:14 AM, Surveyor requested the facility's investigation, including all documentation and interventions implemented to prevent further misappropriation. On 7/22/26 at 1:08 PM, Surveyor interviewed Adult Protective Services (APS)-H who stated SSD-D notified APS on 7/14/26 that the facility was sending R1 to the ED for evaluation with a potential transfer to psychiatric care. APS-H told SSD-D to call APS if/when R1 returned to the facility. APS-H stated APS was not informed of R1's return until 7/21/26. APS-H stated they sent an email to SSD-D on 7/21/26 at 3:03 PM to check if R1 had an activated Power of Attorney (POA) document but did not receive a response. APS-H stated they had no concerns working with the facility on potential guardianship for R1, but they needed more information from the facility before proceeding. On 7/22/26 at 2:30 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who was not aware of suspected misappropriation involving R1. NHA-A stated if there was an allegation or suspicion of misappropriation, NHA-A should have been informed and would have completed an investigation.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure 1 resident (R) (R7) of 4 sampled residents received care and treatment based on their needs and medical orders. R7 had an order to wear Prevalon boots in bed to prevent skin breakdown. The order was not consistently followed. In addition R7's care plan did not contain an intervention for Prevalon boots. Findings include: The facility's Skin Management Policy, revised 7/2026, indicates: Residents receive care to aid in the prevention or worsening of wounds and/or pressure ulcers. Individuals at risk for skin compromise are identified, assessed, and provided treatment to promote healing, prevent infection, and prevent new ulcers from developing .4. Residents admitted with skin impairments will have: a. Interventions implemented to promote healing; b. A physician's order for treatment .5. A care plan is developed upon admission, and reviewed upon readmission, identifying the contributing risks for breakdown, including history of skin impairment or actual impairment, and the interventions implemented to promote healing and prevent further breakdown . R7 was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes, chronic venous insufficiency, and gout. A Minimum Data Set (MDS) assessment, dated 4/6/26, stated R7 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. R7's medical record indicated they had limited mobility and wound care orders for the left ischium and right lower extremity. R7 also had an order to wear Prevalon boots at all times while in bed and to be sure the ankle does not rest on the foot pedal of the wheelchair. R7's medical record also indicated staff may free float R7's heels by elevating legs and placing pillows laterally under calves to keep heels and right lateral ankle free from all surfaces (dated 12/12/25). R7's care plan indicated they had the potential for pressure injury development due to decreased mobility (revised 5/8/26). The goal indicated R7's pressure injury would show signs of healing and remain free from infection. (The care plan did not contain an intervention to wear Prevalon boots at all times while in bed.) On 7/22/26 at 11:15 AM, Surveyor observed R7 in bed without Prevalon boots. R7's feet/heels were in direct contact with the mattress. R7 stated staff only apply the boots at night. R7 stated they are willing to wear boots at all times in bed if that is what is ordered. On 7/22/26 at 11:19 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-F who indicated R7's Prevalon boots are for comfort and they chose when to wear them. CNA-F did not think R7 needed to wear the boots at all times when in bed. On 7/22/26 at 3:48 PM, Surveyor interviewed Director of Nursing (DON)-B who stated if there is a medical order for Prevalon boots, the boots should be on R7's care plan and staff should follow the order as written.		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure medically-related social services were provided to attain or maintain the highest practicable well-being for 1 resident (R) (R1) of 18 sampled residents. R1 was admitted to the facility on [DATE]. The facility did not ensure appropriate and safe discharge planning was implemented and R1's decision-making capacity was assessed. Findings include: R1 was admitted to the facility on [DATE] and had a diagnosis of delusional disorder. An admission Minimum Data Set (MDS) assessment, dated 6/11/26, stated R1's Brief Interview for Mental Status (BIMS) score was 12 out of 15, indicating moderately impaired cognition. R1 was responsible for their own healthcare and financial decisions. Discharge Planning: A care plan, revised 7/9/26, indicated R1 wanted to return home to live with family, but was unsure if family would allow them to live there again. R1's family indicated they were not welcome back at home. R1 was aware and stated they had nowhere to go. The care plan contained an intervention to follow R1's wishes as they express them (dated 6/5/26). An admission MDS assessment, dated 6/11/26, indicated R1's discharge plan was to return to the community. The assessment indicated there was no active discharge plan for R1 and they declined county referral for assistance with discharge planning. A care conference note on 6/9/26 indicated R1 stated they were no longer welcome to live with family which was the plan upon admission. The note indicated R1 would continue to work with therapy and the Aging and Disability Resource Center (ADRC) for housing. R1's progress notes indicated they made statements or attempted to leave the facility on the following dates: ~ On 7/6/26 at 2:53 AM, R1 stated they wanted to leave and left the facility with staff following. ~ On 7/9/26 at 2:30 AM, R1 expressed a desire to leave the facility and attempted to do so. ~ On 7/10/26 at 10:29 AM, 7/11/26 at 12:16 AM, and 7/21/26 at 1:46 AM and 4:53 PM, R1 stated they wanted to leave the facility. On 7/21/26 at 10:49 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-I who stated R1 constantly made statements of wanting to leave and frequently attempted to leave when LPN-I worked the night shift. On 7/21/26 at 1:33 PM, Surveyor interviewed LPN-C who stated R1 often made statements of wanting to leave and often attempted to leave the facility. LPN-C stated earlier that day, R1 attempted to leave through the 400 wing exit doors. On 7/21/26 at 3:56 PM, Surveyor interviewed Social Services Director (SSD)-D who stated R1's initial discharge plan was to move back in with a family member, however, the family member was no longer willing to allow R1 to live with them. SSD-D stated R1 was cut from insurance and they attempted to have R1 sign a Representative Payee form which would send their social security checks to the facility, but R1 refused to sign or apply for Medicaid. SSD-D was aware of R1's consistent statements of wanting to leave and repeated attempts to leave. SSD-D stated staff were able to redirect R1 when they attempted to leave. SSD-D stated there was no active discharge plan for R1 and no referrals had been submitted regarding discharge planning. R1's medical record included several instances in which they stated they wanted to leave the facility as well as documented attempts to leave. The facility did not have documentation to support ongoing discharge planning. Evaluation of Decision Making Capacity: A care conference note on 6/9/26 indicated R1 appeared to have delusional-type thoughts of being in a relationship with a known Hollywood star and county singer. A care plan, dated 7/9/26, indicated R1 had psychosocial well-being concerns related to a risk of being taken advantage of monetarily. The care plan indicated R1 believed their significant other was a TV star and country music singer. R1 told staff they gave personal information to another person to assist them with finances. A referral was (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	made to the facility's contracted behavioral consulting provider.A progress note on 7/9/26 at 8:52 AM indicated R1 told SSD-D their famous significant other was coming to get them as soon as possible and showed SSD-D text messages from the individual. SSD-D indicated the individual asked R1 about money and bank accounts in the text messages. The progress note also indicated R1 gave a friend personal information, including their date of birth , bank information, and social security number. R1 told SSD-D that they had not received a social security check for some time and the friend was assisting them with it.A progress note on 7/10/26 at 10:29 AM indicated the physician was notified that R1 stated they had no family support and said they were going to be a caretaker in a children's home.A progress note on 7/14/26 at 2:18 PM indicated R1's physician and staff discussed the fact that R1 was increasingly more delusional and altered over the last couple weeks and often attempted to leave the facility. The physician suspected potential underlying dementia and recommended evaluation at a hospital that had psychiatric care. R1 returned to the facility at 6:10 PM.A progress note on 7/16/26 at 11:53 AM indicated SSD-D spoke with the long-term care Ombudsman regarding concerns about financial abuse, competency, safe discharge options, representative payee, and Adult Protective Services (APS) for R1. The Ombudsman encouraged SSD-D to call APS again with an update.A progress note on 7/21/26 at 4:53 PM indicated SSD-D spoke with APS regarding R1 being their own decision maker.On 7/21/26 at 3:56 PM, Surveyor interviewed SSD-D who stated shortly after R1 was admitted to the facility, they became concerned about financial abuse due to statements made by R1 and their family. SSD-D confirmed R1 believed their significant other was a famous actor and country singer who texted them all of the time. SSD-D confirmed they had seen the texts. SSD-D stated R1's family said the individual had taken between \$20,000 and \$30,000 of R1's money. SSD-D stated R1 also stated they gave personal information to another friend, however, they were not willing to give SSD-D their name or contact information. SSD-D attempted to have R1 sign a Representative Payee form which would send their social security checks to the facility, however, R1 refused and stated their significant other did not want them to. SSD-D reported the concerns to APS who stated R1 was their own decision maker and they would not get involved unless R1 was a threat to themself or others. SSD-D stated R1 had not been evaluated for decision-making capacity and a referral was made to the facility's behavioral consulting provider who did not round until the end of the month. SSD-D confirmed they did not contact the facility's Medical Director or R1's physician to evaluate for incapacity.On 7/22/26, Surveyor reviewed R1's Power of Attorney for Healthcare (POA) document and noted R1's primary agent had signed off as unwilling to act as their agent. R1's secondary agent was a legal guardian. The document indicated the POA agents were not able to admit R1 for long-term nursing home care.On 7/22/26 at 8:53 AM, Surveyor completed a follow-up interview with SSD-D who could not recall the exact date they became aware of the allegation of misappropriation or when they requested assistance from APS to prevent further misappropriation. SSD-D confirmed additional safety interventions to prevent further misappropriation were not implemented and R1 was still in contact with the individual suspected of committing the misappropriation. SSD-D could not recall the exact date the initial report was made to APS and was aware R1's POA document indicated their agent was unwilling to act and was not allowed to admit them to a nursing home. SSD-D stated they were working with APS on getting R1 evaluated for capacity.On 7/22/26, Surveyor requested documentation of the facility's communication with APS. The facility could not provide documentation of communication with APS prior to 7/21/26.On 7/22/26 at 1:08 PM, Surveyor interviewed Adult Protective Services (APS)-H who stated SSD-D notified APS-H on 7/14/26 that R1 was being sent to the hospital. APS-H asked SSD-D to call back if/when R1 returned to the facility. APS-H stated APS was not notified of R1's return to the facility until SSD-D contacted APS again on 7/21/26. APS-H (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated they sent an email to SSD-D on 7/21/26 at 3:03 PM to check if R1 had a POA document and if their physician had evaluated them for incapacity but did not receive a response. APS-H acknowledged concerns related to financial abuse, delusions, and discharge safety. APS-H reported no concerns working with the facility on potential guardianship for R1 but stated they needed more information from the facility before they could proceed. APS-H reported previous concerns working with the facility and getting timely and consistent information. Surveyor noted R1's medical record included several incidents of potential misappropriation and delusional episodes. The facility was unable to provide documentation to support ongoing communication with APS and attempts to have R1 evaluated for incapacity.		

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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 maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 2 residents (R) (R7 and R9) of 3 sampled residents. R7 was on enhanced barrier precautions (EBP) due to an indwelling catheter and had a diagnosis of urinary tract infection (UTI). R7's Foley catheter bag was observed on the floor without a barrier to prevent infection. R9 was on EBP due to a feeding tube and indwelling catheter and had diagnoses of sepsis and UTI. Staff did not wear a gown while changing R9's feeding tube dressing. Findings include: The facility's Enhanced Barrier Precautions policy, revised 5/2026, indicates: .Initiation of Enhanced Barrier Precautions: .b. An order for EBP will be obtained for residents with any of the following: i. Wounds .Indwelling medical devices (e.g., .urinary catheters, feeding tubes .) even if the resident is not known to be infected or colonized with a multidrug-resistant organism (MDRO) .High-contact resident care activities include: .g. Device care or use: .urinary catheters, feeding tubes . 1. R7 was admitted to the facility on [DATE]. R7 had an indwelling catheter and a diagnosis of UTI. A Minimum Data Set (MDS) assessment, dated 4/6/26, stated R7 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. On 7/22/26 at 11:22 AM, Surveyor observed R7's catheter bag on the floor of their room. Medical Records (MR)-G (who was also a Certified Nursing Assistant (CNA)) was leaving the room and verified R7's catheter bag was on the floor. MR-G confirmed the bag should not be on the floor and cleansed and hung the bag from the side of R7's bed. On 7/22/26 at 11:25 AM, Surveyor interviewed CNA-F who was in R7's room just prior to MR-G. CNA-F verified the catheter bag should not be on the floor and stated the bag must have fallen when they repositioned R7. On 7/22/26 at 3:48 PM, Surveyor interviewed Director of Nursing (DON)-B who verified catheter bags should not be on the floor due to infection control concerns. 2. R9 was admitted to the facility on [DATE]. R9 had a feeding tube, indwelling catheter, and a diagnosis of UTI. An MDS assessment, dated 6/29/26, stated R9 had a BIMS score of 14 out of 15, indicating intact cognition. On 7/22/26 at 8:05 AM, Surveyor observed Licensed Practical Nurse (LPN)-E change R9's feeding tube dressing. LPN-E wore gloves but not a gown. Surveyor interviewed LPN-E who verified they should have worn a gown during the dressing change. On 7/22/26 at 3:48 PM, Surveyor interviewed DON-B who stated staff should wear a gown and gloves during high-contact cares for a resident on EBP.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility did not ensure the nurse staffing was posted daily. This practice had the potential to affect all of the 71 residents residing in the facility. The facility did not consistently post the required daily nurse staffing. Findings include: On 7/21/26 at 11:39 AM, Surveyor observed the nursing staff posting outside Nursing Home Administrator (NHA)-A's office which was dated 7/2/26. On 7/21/26 at 1:22 PM, Surveyor showed NHA-A the posting that was dated 7/2/26. NHA-A verified the posting had not been updated and confirmed it should be updated daily to reflect the total number of licensed and unlicensed nursing staff directly responsible for resident care per shift and the actual hours worked. NHA-A stated the Human Resources Department was responsible for updating the posting.		