STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525452	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elroy Health Services	307 Royall Ave Elroy, WI 53929

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that 1 of 3 residents (R3) reviewed for receiving a psychotropic medication were free from unnecessary drugs. R3 receives Olanzapine, an antipsychotic medication, for Alzheimer's disease with late onset. This is evidenced by: The facility policy titled, Use of Psychotropic Medications, reviewed 4/27/25, includes: it is the intent of this policy to ensure that residents only receive psychotropic medications when other non-pharmacological interventions are clinically contradicted. Additionally these medications should only be used to treat residents medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. Adequate indications for use refers to the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and after any other treatments have been deemed clinically contradicted. For psychotropic medications, without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically contraindicated, the indication for use is inadequate. Also, adequate indication for use means that the medication administered is consistent with manufacturers recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence based review of articles that are published in medical and/or pharmacy journals . chemical restraint refers to any drug used for discipline or that makes it more convenient for staff to care for a resident, and not required to treat medical symptoms. This includes instances when a psychotropic medication may be approved to treat certain symptoms, however, non-pharmacological interventions should be used or attempted, unless clinically contraindicated, because they are less dangerous to the residents health and safety . A psychotropic drug is any drug that affects brain activity is associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. Psychotropic medications are to be used only when a practitioner determines that the medication is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication is beneficial to the resident as demonstrated by monitoring and documentation of the resident's response to the medication . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3 admitted to the facility on [DATE] with the following diagnoses: Alzheimer's disease, dysphagia, unsteady on feet, weakness, long term use of anticoagulants, edema, and urinary tract infection. Her most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 6/19/25 indicates R3's cognition is severely impaired with a BIMS (Brief Interview for Mental Status) score of 3 out of 15. R3's physician orders, June 2025 and July 2025, states in part: . Olanzapine Oral tablet 2.5 MG (milligrams) . Give one tablet by mouth at bedtime related to Alzheimer's disease with late onset. (It is important to note Alzheimer's disease with late onset is not an appropriate indication of use for an antipsychotic.) On 7/1/25 at 3:50 PM PA D (Physician Assistant) indicated she prescribed R3 Olanzapine due to her late onset Alzheimer's disease with behavioral disturbance. Surveyor asked PA D if R3 had behaviors that were persistent and harmful to herself or others. PA D indicated R3 is someone who has severe psychosis in her mental state, she is impulsive, and she lacks safety awareness. Surveyor asked PA D to describe R3's psychosis. PA D indicated R3 tries to stand without help, wanders, and at times thinks she needs to be somewhere else. On 7/1/25 at 5:10 PM NHA A (Nursing Home Administrator) indicated wandering, lacking safety awareness, and self-transferring are common symptoms in a person with Alzheimer's disease and does not necessarily warrant the use of an antipsychotic medication. NHA A indicated the facility has done some education with area providers on unnecessary medication use and they will continue to educate them. The facility failed to ensure residents receiving antipsychotic medications have appropriate diagnoses for medication use.

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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 0684 Level of Harm - 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 interview and record review, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for 1 of 3 sampled residents (R2). R2 had a fall on 5/29/25. PA D (Physician Assistant) ordered x-rays STAT (right away) due to complaints of pain to right wrist and right hip. X-rays did not get completed as ordered. R2 was shaking due to severe pain the next morning and was sent to the hospital. R2 was diagnosed with a fracture to the right hip and pelvis as well as avulsion (a small piece of bone pulled off the wrist bone, causing a small fracture) to right wrist. The facility's failure to get the x-rays completed STAT as ordered resulted in a delay in treatment for R2. Evidenced by: The facility policy entitled Change in Condition, dated 9/20/22, states, in part: . A facility should immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident's representative when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); or a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). Policy Explanation and Compliance Guidelines: When a resident presents with a possible change in condition, after a fall or other possible injury, trauma, or noted changes in mental or physical functioning: 1. Assess the resident's need for immediate care/medical attention. Provide emergency care as needed . 2. Notify resident's physician-Use INTERACT Change in Condition: When to report to the MD (medical doctor), NP (nurse practitioner), PA as a guideline . R2 admitted to the facility on [DATE] and has diagnoses that include unilateral, primary osteoarthritis, left hip (type of arthritis that occurs when flexible tissue at the ends of bones wears down), personal history of (healed) traumatic fracture, and unspecified dementia. R2's Quarterly Minimum Data Set (MDS) Assessment, dated 5/10/25, shows R2 has a Brief Interview for Mental Status (BIMS) score of 8 indicating R2 has moderate cognitive impairment. R2's Care Plan, dated 7/10/23, states in part: . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Focus: ADL (activities of daily living) self-care deficit as evidenced by need for staff assist r/t (related to) dementia. Date Initiated: 7/10/23. Revision on: 5/13/25 . Interventions/Tasks: *Ambulation/Locomotion: non-ambulatory at this time may stand/pivot transfer. Requires extensive assist of 1 staff for locomotion with w/c (wheelchair) at this time with wrist and hip fracture. Date Initiated: 7/10/23 Revision: 6/03/25 . *Transfer: Assist of 1-2 staff with CGA (contact guard assistance) to stand/pivot at this time. Date Initiated: 7/10/23 Revision on: 6/03/25 . At risk for complications due to musculosketal problems r/t fracture (R) wrist, (R) hip and T12 compression fracture. Date Initiated: 6/03/25 . *Provide assist of (specify level of assist) to transfer and reposition in bed. Date Initiated: 6/03/25 . R2's Un-Witnessed Fall Report, dated 5/29/25, at 3:40PM, states, in part: .Incident Description: . Resident found in hallway on floor, resident walked down hall holding onto side railing on wall with wheelchair down hallway in front of resident's room. Resident was seen by CNA (certified nursing assistant) fall forward hitting hand on side of railing onto floor with right arm under herself on her right side, resident fell onto right shoulder and placed right side of face on floor. Resident denied pain to right shoulder of [sic] face, c/o (complained of) pain to right wrist and right hip. PA D present during assessment. VS (vital signs) stable . ROM (range of motion) intact with some mild pain to right upper and lower extremities . Immediate Action Taken: Description: Resident assessed, VS stable, DON (director of nursing) aware of fall, PA D ordered X-ray images of Right wrist, pelvic and hip . Statements: CNA H. Relation: Ancillary Staff Date: 5/29/25 Statement: Seen resident walking down the hall holding on to side railing, went to get wheelchair (less than 50 feet away) and turned around, seen resident falling forward, hitting hand on side rail falling forward onto right shoulder and gently placing face on floor with fall . R2's Progress Notes are as follows: 5/29/25 3:40 PM Type: Clinical Follow Up Note Text: The current status is Fall due to resident self-transferring down hallway holding onto side railings. VS stable. ROM intact, mild pain with right wrist and right hip . PA D assessed resident at this time with orders for STAT x-ray of right wrist and pelvic and hip imaging . 5/29/25 3:59 PM Type: Communication-with Physician/Resident/Family/HPOA (healthcare power of attorney)/Guardian Note Text: Resident suffered from a fall. PA D here and gives orders as follows: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-X-ray right wrist 3 views-STAT -X-ray pelvis and unilateral right hip-STAT Dx (diagnosis): Fall. 5/29/25 5:00 PM Type: Communication-with Physician/Resident/Family/HPOA/Guardian Note Text: This writer discussed with PA D in regard to STAT x-ray order. The company that provides the services may not be here till the next day. PA D hoped they would be here later in the evening but if not, monitor resident for signs of pain and send to hospital if needed. Important to note: Surveyor spoke with PA D and DON B and found DON B did not notify PA D that STAT X-rays were not completed until 5/30/25 when R2 was sent to ER (emergency room). 5/30/25 7:36 AM Type: SBAR (Situation, Background, Assessment and Response)-Change in Condition Situation: Called to R2's room by therapist stating that resident trying to get out of bed and in severe pain on right hip area and moderate to maximum assist for transfer. Background: S/p (status post) fall yesterday afternoon with MD order for x-rays of hip/pelvis and right wrist. Has not been done yet and probably not until after lunch. Assessment (RN: Registered Nurse)/Appearance (LPN: Licensed Practical Nurse): Resident shaking in pain, moderate to maximum assist of 2 for transfer. Resident c/o severe pain to right hip with some shortening of RLE (right lower extremity). Bruising noted to right wrist . Response: Call placed to PA D and son informing of change and that resident needs to be seen in ER. Recommendations: Send to ER via ambulance. Son will meet at the hospital. 5/30/25 7:40 AM Type: Clinical Follow Up Note Text: The current status is Resident c/o severe right hip/pelvic pain 10/10 and requiring moderate/maximum assist of 2 for transfer as she was attempting to get out of bed. Resident also c/o severe pain while sitting in w/c. Resident was scheduled to have mobile x-ray today but due to severe pain, sending to ER for evaluation at this time with son, POA meeting at the hospital . 5/30/25 11:14 AM Type: Communication- with Physician/Resident/Family/HPOA/Guardian Note Text: This writer placed a call to ER with them reporting that resident indeed has fracture to right hip and pelvis as well as evulsion to right wrist. Resident is going to be transferred [Hospital name] for surgery . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R2's Hospital Discharge summary, dated [DATE], at 1:12 PM, states, in part: .Date of Admission 5/30/25. Date of discharge: [DATE] .Principal Diagnosis: Closed displaced fracture of right femoral neck .Major Procedures: right hip hemiarthroplasty 5/30/35 . Summary of admission Chief Complaint, History of Present Illness, Pertinent Exam, Lab & Radiology Studies: .The patient lives at a nursing home. Yesterday, she was ambulating and had a fall. There are limited details available regarding the fall itself. She was brought to the emergency department today due to worsening pain . She endorses pain, and points to her right hip when I ask if she has any pain .Hospital course: . She underwent surgical fixation of her right hip fracture with orthopedic surgery . A cock-up wrist splint was placed for her right triquetral avulsion fracture . On 7/1/25 at 11:15 AM, Surveyor interviewed PA D. PA D indicated to Surveyor she was in the facility at the time of R2's fall on 5/29/25. PA D indicated she assessed R2 with the facility staff. PA D had concerns about the right hip with the way R2 had fallen on her right side and complained of pain to right wrist. PA D indicated she had ordered x-rays to be completed STAT on the right hip, wrist, and pelvis. Surveyor asked if PA D was notified the x-rays were not completed 5/29/25 and PA D indicated she was not notified the x-rays were not completed until R2 was sent to the ER on [DATE]. PA D indicated she expected the x-rays to be completed that day on 5/29/25 since she ordered them STAT. Surveyor asked PA D if she would expect to be notified if the x-rays were not able to be completed that day and PA D indicated yes, she probably would have sent R2 to the ER if they were not able to be completed. PA D indicated she would expect all orders to be followed especially STAT orders. On 7/1/25 at 12:20 PM, Surveyor interviewed RN C (Registered Nurse) who indicated on the morning of 5/30/25, approximately 6:30 AM, RN C was called to R2's room. Therapy had been passing by R2's room and heard R2 screaming in pain and trying to get out of her bed. RN C indicated she had found out in that morning's report R2 had a fall the day before on 5/29/25 and was to get x-rays on that day (5/30/25). RN C indicated she was not going to wait for the x-rays that day, so RN C sent R2 to the ER. RN C indicated R2 was in so much pain. RN C indicated R2 had received Tylenol around 5:30AM due to so much pain that AM. Surveyor asked RN C if a STAT order for an x-ray is received and cannot be completed that day due to mobile imaging what is the process to follow. RN C indicated the facility would notify the MD and see if s/he wants the resident sent to ER or what s/he would like to do. On 7/1/25 at 3:11 PM, Surveyor interviewed CNA H who indicated she was working with R2 the day R2 had fallen. CNA H indicated at the time of the fall R2 complained of pain to her right wrist and hip. Surveyor asked CNA H if R2 was experiencing pain the rest of that evening after she had fallen. CNA H indicated R2 would not get out of her wheelchair the rest of that evening which was a big change for R2. CNA H indicated she had noticed R2 was shaking around 7:30-8:00 PM. CNA H asked R2 if she was in pain at that time but R2 just mumbled. CNA H indicated she reported it to the nurse. CNA H indicated at 9:00 PM R2 was really shaking more. Surveyor asked CNA H if R2 was in pain and CNA H indicated R2 was not getting out of wheelchair, R2 was not walking that evening, and R2 was shaking, she felt R2 was in pain. CNA H indicated R2 was not acting her baseline, and it was reported to the nurse. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 7/1/25 at 3:25 PM, Surveyor interviewed DON B and asked what the facility's process is for receiving and completing STAT imaging orders. DON B indicated they go through a mobile imaging service. Once we receive orders for imaging we notify the company's dispatch service and notify them of the order being routine or a STAT order. If it is a routine order, the company will come 1 to 2 days after we notify them. If it is a STAT order we hope the company arrives within 4 hours of us notifying them. With STAT orders the dispatch service reaches out to the technicians that come to the facility to complete the imaging. The technicians are then to call us back with an estimated time frame. If we do not hear back within 2 - 4 hours it is expected we call them back. If the company is not able to make it to the facility the day the order is expected to be completed as STAT, it is expected the provider be notified and see if the provider wants the resident sent to ER for the imaging or if he wants the facility to monitor the resident. DON B indicated he found out the next morning around 7:00-7:30 AM when he arrived at the facility the x-rays had not been completed. It was reported R2 was in pain, and they sent her out to the ER. Surveyor asked DON B if the provider had been notified on 5/29/25 that the imaging STAT orders would not be completed. DON B indicated he had gone over to the clinic the afternoon of 5/30/25 and informed PA D that the x-rays were not completed as ordered on 5/29/25 and R2 was sent to the ER that morning due to pain. Surveyor asked DON B what PA D's expectation was for the STAT imaging orders and DON B indicated PA D felt the STAT orders should have been completed within 4 hours of receiving the order. DON B indicated his expectations were the STAT imaging orders should have been completed the evening of 5/29/25. DON B indicated the MD and his self should have been notified the evening of 5/29/25 that the orders would not be completed by the charge nurse. Surveyor asked DON B with R2 not wanting to get up out of wheelchair or ambulating that evening and shaking episodes, would that be considered a change in condition for R2. DON B indicated yes, and the MD should have been notified and R2 should have been sent to ER that evening. Surveyor asked if MD was notified that evening and DON B indicated no. On 7/1/25 at 3:55 PM, Surveyor interviewed LPN J who indicated on 5/29/25 she had come in to work at 6pm. LPN J had received in report that R2 had a fall that afternoon and the facility was monitoring R2, and imaging was coming that evening. Surveyor asked if she received a call from the imaging company saying they were coming or not coming. LPN J indicated it would be in her progress notes. LPN J looked and said there is no note, so no call was received. LPN indicated that by 8 or 9 pm if no call is received from the imaging company, it generally means the company will not be coming until the next day. Surveyor asked LPN J if the order is for STAT and at 8-9pm the company still has not shown up what is the expectation. LPN J indicated if she was at another facility she would send resident to ER, but this facility does not do it that way. We go through the imaging company. Surveyor asked LPN J if MD should have been notified and LPN J indicated we were monitoring R2 and if change in condition we would send her out. Surveyor asked if R2 not getting up out of wheelchair or wanting to ambulate would that be a change for R2. LPN J indicated a change in level, and she would put that on the 24-hour report. R2 experienced a delay in treatment due to STAT X-rays not getting completed as ordered and this was not communicated to R2's provider. R2 was shaking due to severe pain the next morning and was sent to the hospital. R2 was diagnosed with a fracture to the right hip and pelvis as well as evulsion to right wrist.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure a resident's environment remained free of accidents and hazards for 1 of 3 residents (R3) reviewed for falls. R3's family provided information related to R3's familiar routine and preferences. The facility failed to get this information on R3's baseline care plan, on R3's comprehensive care plan, or get it to the front line staff to use for fall prevention. R3's alarm did not sound when she self transferred. R3 fell and sustained a hip fracture. The facility's management staff reported to Surveyor that R3 has behaviors of deactivating her alarm system. R3's medical record does not contain goals, monitoring, or interventions related to this behavior in regard to fall prevention. Facility staff used education with R3 as an intervention for fall prevention when R3 was only oriented to self, noted to be confused at baseline, was assessed to have severe cognitive impairment, and have a diagnosis of Alzheimer's. Evidenced by: Facility policy, titled Fall Prevention and Management Guidelines, revised 7/18/24, includes: Policy-Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls or reduce the possibility/severity of injury . upon admission the nurse will complete a fall risk assessment . the nurse will initiate interventions to help prevent falls on the resident's baseline care plan. Suggested standard interventions may include: implement universal environmental interventions that decrease the risk of resident falling . suggested interventions for residents determined to be at higher risk for falls may include: provide interventions that address unique risk factors measured by the risk assessment tool, medications, psychological, cognitive status, or recent changes in functional status. Provide additional interventions as directed by the resident's assessment and based on input from the resident or family members . Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care . the plan of care will be revised as needed and should be communicated to the staff, the resident, and the residents family are responsible party . R3 admitted to the facility on [DATE] with the following diagnoses: Alzheimer's disease, dysphagia, unsteady on feet, weakness, long term use of anticoagulants, edema, and urinary tract infection. Her most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 6/19/25 indicates R3's cognition is severely impaired with a BIMS (Brief Interview for Mental Status) score of 3 out of 15. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's Hospital Discharge, dated 6/13/25, includes: . female with history of Alzheimer's disease with significant cognitive deficits, chronic kidney disease, hypothyroidism, hypertension, chronic lower extremity edema who presents to hospital with recurrent falls, generalized weakness, worsening, lower extremity edema, and worsening confusion. The patient has had progressive memory issues and has been cared for in her home with family members and other caregivers in the past several years, but does continue to have some time at home alone. Family has noted her to be more confused and has had several falls over the past week or more. It is difficult to get a coherent history from the patient . She has been ambulating sometimes with the walker and sometimes without . In the emergency room, she was noted to be generally weak and confused with some agitation. Work up, including left neck, knee x-ray without acute findings, but underlying degenerative arthritis. Chest x-ray and rib films without acute fracture or acute process. Lab work significant for urine analysis consistent with Urinary Tract Infection. Lactate and white blood cell count normal . D [NAME] elevated with lower extremity ultrasound negative for DVT . The patient was treated with a dose of rosechin [sic] and intravenous fluids. She was monitored in the emergency room with the hope that she would be able to discharge to a skilled nursing facility, however, she had significant agitation which required one on one monitoring . Discharge diagnoses: primary-late onset Alzheimer's disease without behavioral disturbance, psychotic disturbance, mood disturbance or anxiety . Discharge to a skilled nursing home . R3's Fall Risk Assessment, dated 6/13/25, indicates R3 is at risk for falls with a score of 17. R3's Fall Risk Assessment includes: walk in room-limited assist of 1 staff . walk in corridor-limited assistance of 1 staff . locomotion on unit-limited assist of 1 staff . mobility device-wheelchair . ambulation/locomotion-wheelchair/ambulation with gait belt and assist of 1 . Balance-postural hypotensive, impulsivity or poor safety awareness . Fall history- 1 month- 1 to 2 falls . 2 months- 1 to 2 falls . 6 months- 1 to 2 falls . Additional risk factors: diuretics, antihypertensive, cathartics/laxatives . Continence in last 14 days-occasional incontinence . Resident is at risk for falls . R3's Nurse Notes, dated 6/13/25 at 2:54 PM, includes: . admitted from (hospital) . with the following diagnoses: urinary tract infection .late onset Alzheimer's dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety . Resident vitals- weight:170.6 pounds, height: 60 inches, temperature: 97.7 degrees F, pulse: 78, respirations: 18, blood pressure: 89/38, oxygen saturation: 98% on room air . Resident is assist of 1 with personal hygiene, transfers, dressing, toileting, and ambulation. Resident does ambulate with gait belt. Resident is at risk for falls due to impulsive and poor safety awareness and so has bed and wheelchair sensor alarms on. Resident is both continent and incontinent of bowel and bladder and does wear a pull up. Resident likes to sleep in recliner in her clothes. R3's Nurse Notes, dated 6/13/25 at 10:50 PM, includes: Resident is a . admitted from hospital . Resident is alert to self only. She is confused and wants to call her parents. She was given a house phone to use. Lungs clear and oxygen saturation is 94% on room air. Bowel sounds active . Resident is hard of hearing with no hearing aids. She is both continent and incontinent of urine and is wearing a pull up. She is in her recliner with her regular clothes on. Per family this is how she sleeps. Her favorite TV station is on the TV and she is watching it. She is a risk for falls due to confusion and willfulness. Many sticky notes from family are on wall directing staff to familiar [sic] cares for R3. She requires one assist with transfers, dressing, toileting, ambulation, personal hygiene. Recliner has pressure alarm in place, and it is working. Will continue to monitor safety of resident. (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 0689 Level of Harm - Actual harm Residents Affected - Few	R3's Baseline Care Plan and Comprehensive Care Plan, dated 6/13/25, includes: At risk for falls due to: increased confusion, Urinary Tract Infection, Alzheimer's disease . Encourage to transfer and change positions slowly. Have commonly used articles within easy reach . Effective date 6/13/25 . (It is important to note the person centered interventions noted in R3's Nurse Note dated 6/13/25, were not added to R3's Baseline Care Plan or R3's Comprehensive Care Plan.) R3's Nurse Note, dated 6/14/25 at 6:50 AM, includes: .Resident is alert to self only. She is confused and wants to call her parents. She was given a house phone to use . Resident sleeps in her recliner with her regular clothes on per family this is how she sleeps. Residents has a favorite TV station, will have on at all times. Risk for falls due to confusion and willfulness. Many sticky notes from family are on wall directing staff to familiar cares for (R3). Resident requires one assist with transfers, dressing, toileting, ambulation, personal hygiene. Recliner has pressure alarm in place, and it is working. Will continue to monitor safety of resident . (It is important to note the person-centered interventions noted of keeping R3's television on at all times, sleeping in her recliner, use of alarms, and sleeping with regular clothes on are noted in a nurses note, but were not put on R3's care plan.) R3's Nurse Note, dated 6/14/25 at 9:48 AM, includes: . Resident will not remain seated in her wheelchair. We have alarm on the seat of chair. She wants to stand and to go home. We explain that she could have a fall if not careful. Resident still wants to leave her wheelchair, Notified Director of Nursing, informed to call physician as needed. (It is important to note R3 has an alarm on her chair. R3's BIMS score of 3 out of 15 indicating severe cognitive impairment, her diagnosis of Alzheimer's disease, and staff are educating her as an intervention for fall prevention.) R3's Nurse Note, dated 6/14/25, at 12:51 PM, includes: Resident will not remain seated in her wheelchair. We have alarm on the seat of chair. She wants to stand and to go home. We explain that she could have a fall if not careful. Resident still wants to leave her wheelchair. (It is important to note R3's BIMS score of 3 out of 15 indicating severe cognitive impairment, her diagnosis of Alzheimer's disease, and staff are educating her as an intervention for fall prevention.) R3's Physician Communication Note, dated 6/14/25 at 2:01 PM, includes: Notified . physician of resident continued restlessness and unable to stop her from self-transferring, chair alarm intact and functioning, offered her activities and have her sitting with staff as much as possible but once left alone she continues to get up out of chair and is high fall risk, request for an order for as needed lorazepam for restlessness. R3's Physician Communication Note, dated 6/14/25 at 2:09 PM, includes: Medical Doctor ordered Lorazepam 0.5mg (milligrams) as needed twice daily for restlessness. R3's Nurse Note, dated 6/14/25 at 2:17 PM, includes: informed power of attorney of new medication ordered, okay with lorazepam ordered for resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's Nurse Note, dated 6/14/25 at 2:50 PM, includes: . Resident is alert to self only. She is confused and wants to call her parents; she has been very restless, continues to try and self transfer or walker [sic] hallways, had staff sit one-on-one with her and still continues, notified (named) physician who ordered PRN lorazepam 0.5mg for 2x day awaiting E-script to be sent to pharmacy. Power of Attorney consented to medication . Resident sleeps in her recliner with her regular clothes on per family this is how she sleeps. Resident has a favorite TV station, will have on at all times. Risk for falls due to confusion and willfulness. Many sticky notes from family are on wall directing staff to familiar cares for resident. Resident requires one assist with transfers, dressing, toileting, ambulation, personal hygiene. Recliner has pressure alarm in place, and it is working. Daughter visited her today and sat with her outside for awhile. Chair alarm intact and functioning while in wheelchair, does not stop resident from standing up and transferring self. Will continue to monitor safety of resident. R3's Nurse Note, dated 6/14/25 at 8:57 PM, includes: . Resident at this time is in wheelchair going up and down hallways. She is very quiet. R3's Nurse Note, dated 6/14/25 at 10:50 PM, includes: . Resident is alert to self only. She is confused and very impulsive. Resident is hard of hearing with no hearing aids. She is both continent and incontinent of urine and is wearing a pull up. Resident sleeps in her recliner with her regular clothes on per family this is how she sleeps. Residents has a favorite TV station, will have on at all times. Risk for falls due to confusion and willfulness. Many sticky notes from family are on wall directing staff to familiar cares for (R3). Resident requires one assist with transfers, dressing, toileting, ambulation, personal hygiene. Recliner has pressure alarm in place, and it is working. Staff is doing frequent checks and 1:1 with her as needed. Will continue to monitor safety of resident . R3's Nurse Note, dated 6/15/25 at 6:50 AM, includes: . Resident is alert to self only. She is confused and restless . Resident sleeps in her recliner with her regular clothes on per family this is how she sleeps. Residents has a favorite TV station, will have on at all times. High risk for falls due to confusion and willfullness, chair alarm intact and functioning. Many sticky notes from family are on wall directing staff to familiar cares for R3. Recliner has pressure alarm in place, and it is working . Will continue to monitor for safety of resident. R3's Nurse Note, dated 6/15/25 at 10:50 PM, includes: . Resident is alert to self only. She is confused at baseline. Resident has slept most of the day in the recliner chair . resident sleeps in her recliner with her regular clothes on per family this is how she sleeps. Resident has a favorite TV station will have on at all times. High risk for falls due to confusion and willfulness, chair alarm intact and functioning. Many sticky notes from family are on wall directing staff to familiar cares for R3 . recliner has pressure alarm in place and it is working. No pain or discomfort noted. Will continue to monitor safety of resident. R3's SBAR Change of Condition Form, dated 6/20/25 at 7:23 PM, includes: Called to resident's room by Licensed Practical Nursing (LPN) and another resident who saw resident sit on the floor in her room and then scooting on her buttock out into the hallway. Other resident states that she did not hit her head. Resident herself unable to tell staff what she was trying to do. Resident was assisted into her w/c (wheelchair) and allowed to propel in hallway with staff observing her whereabouts. Vitals: temperature- 98. 4; pulse- 93; respirations- 20; blood pressure- 139/45; oxygen saturation level- 96% on room air. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Background: Alzheimer's dementia with sundowning. Assessment (Registered Nurse)/Appearance (Licensed Practical Nurse): Resident was found to have no internal/external rotation or shortening of lower extremity. No new skin issues noted. Vitals stable. No complaints of pain. Resident was placed in her wheelchair with sensor alarm in wheelchair and allowed to roam to help tire her out. Assessment: Recommendations: Allow resident to roam to help tire her out, offer her snacks and see if will watch TV. Response: Power of Attorney updated, Nurse on call notified. Physician updated . who saw resident and stated neuros not needed. Monitor per facility protocol. R3's Fall Report, dated 6/20/25, includes: witnessed fall . Incident Description: Called to resident's room by Licensed Practical Nursing and another resident who saw resident sit on the floor in her room and then scooting on her buttock out into the hallway. Other resident states that she did not hit her head. Resident herself unable to tell staff what she was trying to do. Resident was assisted into her w/c and allowed to propel in hallway with staff observing her whereabouts. Vitals: temperature- 98.4; pulse- 93; respirations- 20; blood pressure- 139/45; oxygen saturation level- 96% on room air . Alzheimer's dementia with sundowning . Resident Description: Resident unable to give description . Immediate Action Taken: Try to keep resident in line of sight when up wandering . Mental status- oriented to person . Predisposing Environmental Factors: Fall alarm sounding, fall alarm on and properly positioned . Predisposing Physiological Factors: confused, gait imbalance, impaired memory . Predisposing Situation Factors: ambulating without assistance . Other resident interview/witness to fall: I saw resident walking in room, then lost balance and sat down on the floor and then started scooting on her buttock towards the hallway. She did not hit her head. R3's Comprehensive Care Plan, updated 6/20/25 with the following: Pressure alarm on at all times to be transferred from bed to wheelchair to recliner. R3's Nurse Note, dated 6/21/25 at 4:23 AM, includes: No new complaints of pain. No signs or symptoms of any new injury from fall. Will continue to monitor resident more closely when more restless and maybe even try one on one (if able). Otherwise monitor resident safety. R3's Therapy Note, dated 6/21/25 at 12:23 PM, includes: Cognitive status: Never/rarely made decisions . confused . Resident has been alert but confused, is occasionally participating in therapy. Resident and staff educated to elevate her lower extremities when sitting in her recliner. Resident requires assist of one with transfers with gait belt, assist of one for personal hygiene, dressing and tray set up for meals. Pain is monitored every shift and resident given prn Tylenol. Resident taking her medications as ordered. Nursing monitoring oral intake and encourage. Nursing monitoring for any signs of anxiety/restlessness . Resident displayed the following: Wandering Exit seek behaviors. Resident exit seeking, wandering and confused. Chair alarm intact and functioning, wanderguard intact . R3's Nurse Note, dated 6/21/25 at 8:30 PM, includes: The current status is no new complaints of pain. No signs of any new injury from fall. Will continue to monitor resident closely. Chair alarm intact and functioning. Continue to educate resident to transfer with staff assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(It is important to note R3's BIMS score is 3 out of 15 indicating her cognition is severely impaired, R3's assessments and nurse notes indicate R3 is only oriented to herself, R3's diagnosis of Alzheimer's disease, and nurse notes indicating R3 is confused at baseline. It is also important to note the intervention being used is educating R3 to transfer with staff assistance.) R3's Interdisciplinary Team Meeting Note, dated 6/23/25, includes: Resident had a witnessed fall Resident is a new admit within the last week and a half, resident has an Alzheimer's diagnosis, resident is an assist of 1, resident is alert to self only. Care Plan review/update: Resident has Alzheimer's diagnosis, resident is difficult to direct, resident has had poor intake, resident is not aware of safety hazards, resident is impulsive, resident was sitting in recliner, resident had just spilled her med plus 2.0, resident to ambulate when resident is showing signs of restlessness . R3's Comprehensive Care Plan, updated 6/23/25 with the following: When noted to be restless offer to ambulate in hallway with contact gait assistance of 1 staff and walker . Tab alarm on when up in wheelchair. R3's SBAR Change of Condition Form, dated 6/24/25 at 10:55 PM, includes: Unwitnessed fall with pain to left leg and external rotation . CNA (Certified Nursing Assistant) responded to resident yelling for help. Resident was sitting in recliner prior to fall in gown. Assessment (RN)/Appearance (LPN): Resident was found on the floor with head against bathroom door lying curled on left side. Complained of pain to left leg. Vitals: Blood Pressure: 162/75 Pulse: 8 [sic] Respirations:18 Oxygen saturation: 94% on room air. Temperature: 97.7degrees F . Assessment: Resident noted to have old scabbed abrasion to left knee and raised red area to knee. Lift to bed via hoyer and noted that resident was unable to lift leg without using hands. Resident stated that pain was in left groin area. Recommendations: (blank) Response: Assistant Director of Nursing informed of fall and agreed that resident should be sent to emergency room stat. Daughter informed of transfer to hospital report called to emergency room nurse and ambulance called. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's Fall Report, dated 6/24/25 at 11:45 PM, including: Unwitnessed fall . in resident's room . Nursing description: CNA responded to resident yelling for help. Resident was sitting in recliner prior to fall in gown. Resident description: Resident unable to give description. Immediate action taken: Resident was found on the floor with head against bathroom door lying curled on left side. Complained of pain to left leg. Brief was pulled down and floor in front of chair was wet. Resident noted to have old scabbed abrasion to left knee and raised red area to knee. Lift to bed via hoyer and noted that resident was unable to lift leg without using hands. Resident stated pain was in left groin area. Taken to hospital: yes. Level of pain: occasional labored breathing. Short periods of hyperventilation. Negative vocalization: occasional moan or groan. Low level of speech with negative quality. Facial Expression: facial grimacing. Body language: rigid, fists clenched, knees pulled up, pulling or pushing away. Striking out. Consolability: distracted or reassured by voice or touch . Oriented to person . Predisposing Environmental Factors: Fall alarm improperly placed/not functioning. Predisposing Physiological Factors: Confused, impaired memory, incontinent. Predisposing Situation Factors: Ambulating without assist. Other info: Alarm was in chair not alarming, floor wet, and brief down . Statements: CNA F: I am not sure if it was water or urine on the floor. I last toileted her at 9:00 PM, she voided quite a bit and had some on the toilet seat. I had toileted her a couple times throughout PM shift, she had a medium bowel movement and was incontinent as well during the shift earlier. CNA G said he saw her last at 10:30 PM and she was asleep in her chair. CNA I: The last time I can confirm the alarm working was at the end of PM shift, so I guess 10:00 PM. Not sure the last time she was toileted, she was sleeping in her recliner the last time I saw her, I could not tell you the exact time. The floor was wet from water, but that was in front of her recliner, not where she fell, where she fell was dry. The alarm was in place in the chair, when I entered the room after the fall it was turned off. I checked it and it worked at that time. CNA F says it was on prior to the fall but when I entered after I turned it on and it worked fine. Resident had some agitation as she did not like the night gown and wanted to be in regular clothes. When I walked in after the fall she was incontinent of bladder. CNA G: I believe she was getting up to go look for clothes to go home. Last time I saw her was 10:30 PM. She was sitting on her alarm pad and it appeared to be on. I didn't get her up to check if it would sound or anything but she was sleeping and seemed to be all good. Last time I know of that she was toileted was 9:00 PM by CNA F. I am not sure what the liquid was but when she fell her brief was by her knees and I didn't see any water in sight so I am guessing it was urine. The alarm was on but it wasn't beeping. CNA I turned it off and back on after the fall and it worked fine. I can't think of anything else at this time. R3's Nurse Note, dated 6/24/25 at 11:57 PM, includes: Emergency Services arrived and transferred to hospital emergency room . Bones: . impacted fracture left proximal femur . Impression: Subcapital (fracture extends through the head and neck of the femur) fracture left hip. R3's emergency room Note, dated 6/25/25 at 12:21 AM, includes: Disposition: transfer to other facility . History of present illness: . presenting with left hip pain after an unwitnessed fall this evening at the nursing home where the patient resides . While at the nursing home this evening, the patient had an unwitnessed fall with left hip pain after the fall. Uncertain whether the patient hit her head. No loss of consciousness was witnessed. The patient is not anticoagulated. The patient herself is unable to give a history due to dementia. Physical exam: In pain with any hip movement. Suspect posterior cervical spine tenderness, without obvious step-off . Dentition appears unaffected from the fall, though patient's dentition is poor. Pelvis appears stable with left hip tenderness at the pelvis. No obvious distal left femur or distal extremity deformity, nor obvious deformity of joints . No tenderness with right leg motion at hip . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's Interdisciplinary Team Meeting Note, dated 6/25/25 at 9:14 AM, includes: Reason for Review: Resident had an unwitnessed . Resident is impulsive, resident has Alzheimer's dx, resident will sundown, resident can be difficult to redirect, resident recent admission comes independent from home, resident wanders throughout facility in wheelchair. Resident is not aware of safety hazards. Care Plan Review/Updates: RCA (Root cause analysis)- Resident was sleeping in recliner, resident was in gown and brief, resident attempted to self-transfer and ambulate without assistance to the bathroom, resident did not call for assistance, resident is not aware of safety hazards, resident took brief off on way to bathroom, resident lost balance and fell to the floor. Resident cannot always verbalize her needs. Intervention - Staff to offer assist with routine toileting at routine times for example upon arising, and before and after meals, therapy, activates and at bed time. Resident to be checked on noc shift rounds. R3's Comprehensive Care Plan, updated 6/25/25, to include: Offer toileting more frequently as does not alert staff to needs and check on rounds at night for toileting needs. (Of note: R3 was placed in a gown instead of her own clothes (per family R3 prefers to sleep in her clothes). R3's alarm did not function properly when R3 was attempting to self transfer as it was noted to be turned off.) R3's Orthopedic Pre-operative Note, dated 6/25/25 at 10:00 AM, includes: R3 arrives to surgery from emergency room with left hip fracture. Patient is disoriented to person, place, time, situation, and at baseline . presents with left hip fracture following an unwitnessed fall at her skilled nursing facility. Chief complaint: left hip fracture. History: . Per chart review, patient recently hospitalized [DATE]-[DATE] . for recurrent falls, worsening confusion and generalized weakness. Given Rocephin and Fosfomycin for urinary tract infection with urine culture growing pan sensitive E.Coli. Appears family was interested in more of a comfort care approach . She was started on Zyprexa and ultimately discharged to skilled nursing facility. Last night she was brought to the emergency room from her facility for left hip pain after an unwitnessed fall. She arrived afebrile, vitally stable, non-hypoxic on room air . CT pelvis showed subcapital fracture of the left hip . On interview with the patient, she reports being in pain, but otherwise not oriented to situation and unable to provide further meaningful history. (It is important to note R3's fall resulted in harm when she was diagnosed with a fracture of the left hip.) R3's Orthopedic Consultation, dated 6/25/25 at 10:22 AM, includes: reason for consult: left hip fracture . Plan to take patient to operating room for left hip hemiarthroplasty . R3's Orthopedic Pre-operative Note, dated 6/25/25 at 1:40 PM, includes: pre-operative diagnosis: left femoral neck fracture, pathological due to osteoporosis with minimal trauma . Procedure: cemented hemiarthroplasty of the hip . Findings: displaced fracture of the femoral neck with general poor bone quality . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's X-ray, dated 6/25/25 at 2:29 PM, includes: X-ray pelvis and lateral hip: final result . closed fracture of left hip, initial . Narrative and Impression: x-ray of pelvis and lateral hip obtained on 6/25/25 at 2:29 PM . Reason for exam: post op . Impression: Left hip hemiarthroplasty without immediate postoperative complication. The sacroiliac joints, right hip joint and symphysis pubis remain grossly aligned. Soft tissue gas overlies the operative site. R3's Kardex, dated 7/1/25, includes: bed mobility- assist of 1, at times able to reposition self . dressing- assist of 1 set up and encourage her to do what she is able, assist with lower body dressing . Safety- alert bracelet to left ankle for safety, FYI (for your information) Fall Risk, Pressure alarm on at all times to be transferred from bed to recliner. Have commonly used articles within easy reach, offer toileting more frequently as does not alert staff to needs and check on rounds at night for toileting needs, provide assistance in locating own room, tab alarm on when up in wheelchair, when noted to be restless offer to ambulate in hallway with . assist of one staff and walker . On 7/1/25 at 12:39 PM, DON B (Director of Nursing) indicated at the time of R3's unwitnessed fall her alarm was turned off. DON B stated, We concluded that we think she shut it off herself, before transferring. DON B and Surveyor reviewed R3's current Comprehensive Care Plan and Kardex. DON B indicated R3's comprehensive care plan and Kardex do not contain goals or interventions related to R3's behavior of shutting off her own pressure alarm. On 7/1/25 at 12:56 PM, LPN E (Licensed Practical Nurse) indicated R3's family leaves sticky notes on the wall behind her bed with information related to R3's preferences and familiar routine. LPN E indicated family reported to the facility staff that R3 prefers to sleep in her recliner wearing her street clothes. LPN E indicated the night of R3's fall she was dressed in a hospital gown. LPN E and Surveyor reviewed R3's Baseline Care Plan/Comprehensive Care Plan and Kardex. LPN E indicated R3's preferences should be on the Kardex and Comprehensive Care Plan, but they aren't. LPN E indicated she was unaware R3 likes to have a certain channel on her TV and her TV on at all times. On 7/1/25 at 1:13 PM, RN C (Registered Nurse) stated, She liked to sleep in her recliner fully dressed. I did her admission. I put it in a nurses note. RN C indicated Certified Nursing Assistants who dress R3 do not look at nurse notes often, because they get their information from the Kardex. Surveyor and RN C reviewed R3's Comprehensive Care Plan and Kardex. RN C indicated she did not add this entry on R3's care plan, but she did get a recliner for R3's room. RN C and Surveyor reviewed R3's fall from 6/24/25 noting R3 was wearing a hospital gown. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/1/25 at 2:46 PM, CNA F (Certified Nursing Assistant) indicated she was working on 6/24/25 when CNA G heard a scream and when she went to look she found R3 on the floor. CNA F indicated R3's alarm was placed, but it was not sounding when R3 fell. CNA F indicated R3 does not shut her own alarm off. CNA F stated, I helped her last. I put alarm on. I think it did not function properly. CNA F indicated she was not aware of R3's preference to sleep in street clothes and that is why she put a hospital gown on R3. CNA F stated, I didn't know she liked personal clothes on. It was my fault. I apologize about that. I just did what I know and put her in our gowns. I would find that information in the care plan or the Kardex. CNA F indicated the family writes on Sticky notes and posts them on wall behind her bed with information related to R3's familiar routine and preferences. CNA F indicated that one of the sticky notes stated R3 likes to sleep in recliner. CNA F stated, That was not in the care plan. Surveyor asked about her personal clothing preference, CNA F stated, I do not see this on her care plan. We have different nurses too at times and they wouldn't maybe know her clothing preference or her preference of sleeping in a recliner. It should be in the care plan. CNA F indicated the alarm has since been exchanged for one that is functioning all the time. On 7/1/25 at 2:50 PM, DON B, CNA F, and Surveyor observed sticky notes on wall behind R3's bed. DON B indicated sticky notes are not part of R3's medical record or care plan. DON B indicated it is his expectation that CNAs would use the residents' Kardex and Care Plan for information on how to care for residents. On 7/1/25 at 3:14 PM, DON B indicated if family provides information about preferences it should be added to the resident's care plan. DON B stated, We found out now she likes to be in a gown with a sweatshirt and pants on. Surveyor and DON B reviewed R3's care plan. DON B stated, It could be added in there. DON B indicated person-centered care information should get to front