STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525466	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Valley Health and Rehab Center	S830 - Westland Dr Spring Valley, WI 54767

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility did not designate a person to serve as the director of food and nutrition services who had completed the minimum qualification requirements for the position. This practice could potentially affect all 35 residents residing in the facility.The facility's Dietary Manager (DM) M does not have required certifications for the Dietary Manager role, there is no full time Registered Dietician, and the facility does not have a waiver in place or on file. Findings include:On 12/2/25 at 1:01 PM, Surveyor interviewed Dietary Manager (DM) M and asked what qualifications they held that allowed them to assume the role of Dietary Manager. DM M stated she does not hold any certifications or degree. DM M stated she started this position approximately three weeks ago, around November 13. DM M stated she is qualified to be Dietary Manager because she has 3 years' experience at her last job. DM M stated she was not required to be certified or licensed at the last job but is enrolled in a class starting 12/17/25. DM M stated there is a Registered Dietician about 10 hours a week and available to contact when she needs her. DM M does not know if Nursing Home Administrator (NHA) A filed for a waiver.On 12/02/25 at 2:32 PM, Surveyor interviewed NHA A who stated the DM M just started her position at Spring Valley but is an experienced Dietary Manager. NHA A stated DM M is enrolled in a class starting 12/17/25. Surveyor went through the flow sheet on citing an F801 with NHA A. NHA A stated there is no full-time registered dietician and they do not have any waivers in place. On 12/3/25 at 3:38 PM, NHA A brought email evidence of Registered Dietician responding to facility request. Email was sent on 12/3/25 at 2:33 PM and Registered Dietician responded on 12/3/25 at 3:19 PM.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not maintain safe storage and sanitary environment in which food is prepared and distributed. This has the potential to affect all residents who reside in the facility.Facility staff did not monitor dishwasher temperatures consistently.Facility staff did not monitor refrigerator and freezer temperatures consistently. This is evidenced by:The facility policy titled, Policy and Procedure Manual [NAME] & Associates, Inc: Food Storage, dated 2021, states: 13. Refrigerator food storage: .b. Temperatures for refrigerators should be between 35 to 39F. Thermometers should be checked at least two times each day. 14. Frozen Foods: .b. Frozen foods must be maintained at a temperature to keep the food frozen solid. Freezer temperatures should be checked at least two times each day.The facility policy titled, Policy and Procedure Manual [NAME] & Associates, Inc: Dish Machine Temperature Log, dated 2021, states: The director of food and nutrition services will post a log near the dish machine for the staff to document temperatures. 1. Staff will monitor dish machine temperature throughout the dishwashing process.2. Staff will record dish machine temperatures for the wash and rinse cycles at each meal.On 12/1/25 at 9:41 AM, Surveyor started the observation of the kitchen on entrance per survey protocols. Dietary Manager (DM) M was not available for initial tour. [NAME] N walked Surveyor through the initial tour. [NAME] N stated they take the temperatures of the fridges and freezers twice a day. It is the beginning of December, and logs were posted but not started for the month. Past logs were not on clipboards. [NAME] N stated the records and policies can be found with DM M. On 12/2/25 at 1:01 PM, Surveyor asked DM M for logs for all fridges, freezer and dishwasher. DM M provided Surveyor what she had. DM M stated that when the Regional Manager came for her orientation, DM M was told they only needed to keep 3 months' worth of logs, and she tossed all logs before September 2025. DM M stated she knows tracking temperatures is a problem and it is on her list to fix. DM M is new to the position and started around 11/13/25. DM M stated she has met with staff about job descriptions and expectations. Temperature taking is a task facility has required prior to DM M starting. Some logs for September and October were provided; no logs for November were provided. What was provided was the following:Kitchen cooler 1:September 28, 30 temperatures missed.October - completedNov - nothing receivedKitchen cooler 2:September 21, 22, 25, 27, 28 temperatures missed.October complete, no dates missedNov - nothing receivedChest Freezer 1: September 30 missed temperaturesOctober 7, 19, 23, 24 missed temperatures,Nov - nothing received Chest Freezer 2:September. 21, 22, 27, 28, 30 temperatures missed.October 6, 19, 23, 24 missed.Nov - nothing receivedChest Freezer 3:September 21, 22, 25, 27, 28, 30 temperatures missed.October 24 completedNovember nothing receivedKitchen Freezer 1:September 30 temperatures missed.October 2025 completedNovember nothing receivedKitchen freezer 2:September 28, 30 temperatures missed.October - completeNovember nothing receivedKitchen Freezer 3:September 28, 30 temperatures missed.October - completedNovember nothing receivedRiver Ridge [NAME] Fridge Freezer:Only one log available - 10/27 through Nov. 2nd - Temperatures missed on 10/27, 10/28, 10/29, 10/30, 10/31, 11/2River Ridge Black Fridge:Only one log available - 10/27 through Nov. 2nd - Temperatures missed on 10/28, 10/29, 10/30, 10/31, 11/1, 11/2River Ridge Stainless Freezer:Only one log available - 10/27 through Nov. 2nd - temperatures missed 10/27, 10/28, 10/31, 11/2 Stainless [NAME] Fridge:Only one log available - 10/27 through Nov. 2nd Temperatures missed on 10/27, 10/28, 10/29, 10/31White [NAME] Freezer:Only one log available - 10/27 through [DATE]nd Temperatures missed 10/27, 10/28, 10/29, 10/31Black [NAME] Freezer:Only one log available 10/27 through [DATE]nd Temperatures missed 10/27, 10/28, 10/29 ,10/30, 10/31Black [NAME] Fridge:Only one log available - 10/27 through-[DATE]nd Temperatures missed 10/27, 10/28, 10/29, 10/31On 12/2/25 at 1:01 PM, Surveyor asked for dishwasher hot water sanitizing temperature logs. There is a hot water sanitizing (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dishwasher in the main kitchen, Ridge River Kitchenette, and [NAME] Kitchenette. The following is what was received: 1. Kitchen [DATE] - Temperatures missed 9/6, 9/7, 9/8, 9/11, 9/17, 9/21, 9/22, 9/24, 9/25, 9/28 2. No location listed - November 2025 - Temperatures missed 11/13, 11/14, 11/19/25.3. No location, undated log - Temperatures missed on 4th, 5th, 17th, 18th, 19th, 23rd, and 31st On 12/3/25 at 8:55 AM, Surveyor walked through both small kitchenettes with DM M. At end of the tour Surveyor asked DM M again for kitchenette fridge/freezer logs, how long the sanitizer put in spray bottles from wall system is stable from manufacturer, and dishwasher logs again. DM M stated we do not have logs for kitchenette dishwashers. Surveyor asked DM M one last time for all logs she has for main kitchen and kitchenette for fridge, freezers and dishwashers.On 12/3/25 at 10:10 AM, DM M stated to Surveyor she has given Surveyor all the logs DM M has for dish washing temperatures, refrigerator and freezer logs.

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview, the facility did not ensure garbage and refuse were properly disposed in the outside garbage storage receptacles. This has the potential to affect all 35 residents residing in the facility.Garbage dumpsters were open on 3 different observations.This is evidenced by:According to State Operations Manual, Appendix PP: Guidance to Surveyors for Long Term Care Facilities, revised last 4-25-25, garbage receptacles should be covered to prevent the harborage and feeding of pests.On 12/1/25 at 4:30 PM, Surveyor observed garbage dumpster and recyclable containers were uncovered. On 12/2/25 at 1:01 PM, Surveyor observed with Dietary Manager (DM) M that garbage dumpster and recyclable containers were uncovered. Surveyor interviewed DM M who stated, talk to Plant Operations Director (POD) I, he handles that. Surveyor asked if DM M's staff take garbage out to the dumpsters. DM M asked, So is that our problem? Surveyor replied yes, it is the responsibility of whoever takes garbage out to close them after using.On 12/2/25 at 1:01 PM, Surveyor interviewed POD I about garbage pickup service and dumpster management. POD I stated that GLF takes care of the garbage on Tuesday mornings and does not think there is a policy. POD I asked if the garbage cans were open. Surveyor told POD I yes.On 12/2/25 at 5:30 PM, Surveyor observed garbage dumpster still uncovered. Surveyor looked inside dumpster; 4-5 garbage bags were present. On 12/3/25 at 7:48 AM, Surveyor observed dumpsters; they remained open. On 12/3/25 at 7:56 AM, Surveyor interviewed Nursing Home Administrator (NHA) A about the dumpsters. NHA A stated in a questioning tone when asked about the dumpsters, what are they supposed to be closed. When Surveyor said yes, NHA A stated well the garbage man came last night. Surveyor explained they were open when she looked on 12/2/25 at 1:01 PM with DM M and at 5:30 PM. At 5:30 PM on 12/2/25, there were 4-5 bags of garbage in the can. Surveyor asked Administrator if there was a policy. NHA A stated he did not think so, but he would look into it. On 12/4/25 at 10:32 AM, POD I stated there is no policy for garbage.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not establish an Infection Prevention and Control Program (IPCP) to include outcome surveillance systems to prevent the transmission of disease and infection, which has the potential to affect all 33 residents in the facility and did not perform proper infection control practices for 2 out of 2 residents observed for tube feedings (R7, R19). Facility has no surveillance system to track and monitor staff illnesses/infections. Facility had incomplete and untimely illness/infection surveillance for residents. Registered Nurse (RN) O wore same gown while going in and out of R7's room and R19's room, who were on enhanced barrier precautions. RN O did not allow the syringe to dry after rinsing it following flushing R7's Peg tube. RN O placed the plunger back into the syringe and placed the wet syringe inside a wet graduate, which promoted bacterial growth. RN O did not allow the syringe to dry after rinsing it following flushing R19's's Peg tube. RN O placed the plunger back into the syringe and placed the wet syringe inside a wet graduate, which promoted bacterial growth. RN O did not allow the syringe to dry after rinsing it following administering medications via R19's's Peg tube. RN O placed the plunger back into the syringe and placed the wet syringe inside a wet graduate, which promoted bacterial growth. Facility policy titled, Infection Prevention and Control (General), dated [DATE] states, in part: . the Infection Preventionist responsibilities for infection prevention and control include, but are not limited to: Conducts surveillance for community-associated infections and/or other communicable diseases. Assures compliance with state/federal regulatory and accreditation standards as they pertain to infection and prevention/control matters within the community . Example 1 On [DATE], Surveyor interviewed Nursing Home Administrator (NHA) A and asked who the Infection Preventionist was. NHA A stated they have gone through many of them since he was hired 7 months ago, but currently it is Director of Nursing (DON) B. On [DATE] at 10:42 AM, Surveyor asked DON B for the infection control surveillance logs. DON B reported they are behind on entering the information. DON B stated he has only been employed for 3 weeks and is trying to catch up. On [DATE], Surveyor received the surveillance binder from DON B. DON B handed Surveyor the binder and a stack of papers that are to be placed in the binder that, We were behind on. I am trying to enter everything to give to you. Surveyor skimmed the binder and asked for the surveillance logs for employees. DON B stated they could not locate a binder for tracking employee illnesses. Surveyor asked what was in the resident surveillance binder from [DATE] to current. DON B stated nothing was in the binder after [DATE].Example 2 On [DATE], Surveyor reviewed the facility's Infection Prevention and Control manuals for surveillance tracking of resident infections/illness. Concerns identified were: 1. No facility map tracking by room was utilized since the last standard survey on [DATE]. 2. The facility does not have the specifics of a surveillance document, such as symptoms, tests performed with dates/results with dates, isolation, symptoms resolution date, whether resident hospitalized , or expired, unless it is specifically documented. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. [DATE]: 7 infections identified: Tracking form not completely filled out. Dates of reviews were [DATE] and [DATE] (after Surveyors entered the facility). 4. [DATE]: 2 infections identified: Tracking form not completely filled out. Date of reviews was [DATE] (after Surveyors entered the facility). 5. [DATE]: 5 infections identified: One was not reviewed at all; 4 others were reviewed after 2 months. 6. [DATE]: 4 infections identified: Reviewed [DATE] (after Surveyors entered the facility). 7. [DATE]: 3 infections. Not reviewed for over 2 weeks. On [DATE], Surveyor interviewed NHA A to discuss infection control surveillance. NHA A stated they currently do not have a qualified IPIC nurse since the last one left on [DATE]. NHA A stated they hired a new IPIC nurse that will be starting later in [DATE]. Example 3 Surveyor requested policies which included Enhanced Barrier Precautions, on [DATE] at 11:59 AM, from Nursing Home Administrator (NHA) A, and [DATE] at 11:01 AM, from Assistant Director of Nursing (ADON) C. A policy related to Enhanced Barrier Precautions was not provided. The facility policy titled Transmission-based Precautions, dated [DATE], states, Follow nationally recognized standards and guidelines for transmission based (isolation) precautions. To include standard, Contact, Droplet, and airborne precautions to prevent spready of infectious pathogens in the community. Per the CDC operations memo titled, QSO24-08-NH, dated [DATE], states in 2019, CDC introduced Enhanced Barrier Precautions (EBP). They are a strategy for high contact care in nursing home, recommending gown, and gloves for specific activities such as catheter care, wound care, and feeding tube care. Per CDC guidelines from website titled, How to Clean, Sanitize and Store Feeding Items Frequently Asked Questions, dated [DATE], states: The CDC explicitly recommends that reusable items . should be allowed to air-dry thoroughly before storing to help prevent germs and mold from growing. Once completely dry, items should be stored in a clean, protected area. On [DATE] at 9:37 AM, Surveyor observed Registered Nurse (RN) O flush R7's peg tube, cleanse site and change peg tube dressing and wound dressings with assist of ADON C distracting R7. RN O started by cleaning the peg tube. RN O did not have all the dressings she needed, took off gloves, left room, came back into room, performed hand hygiene, and with same contaminated gown continued with peg tube dressing. Talking to herself, RN O stated, I better double check. RN O took off her gloves and left room again with gown on. Surveyor observed RN O's gown touching medication cart while RN O checked what was on the computer. RN O came back into the room, performed hand hygiene, donned new gloves, and stated R7 ate her meal so does not need a bolus feeding. With contaminated gown, RN O checked placement via auscultation, flushed the Peg tube, and started administering medications. After administering meds, RN O and ADON C changed dressings bilaterally to both knees and assessed shoulder and healed wound locations for R7. Before completing the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dressing change, RN O left the room for supplies 3 more times.RN O went back to her computer to check dressing change orders/directions with gown on, did not change gown and gown was touching medication cart.RN O left for collagen dressing with gown on, came back into room and continued cares with same gown on. RN O left because a coworker knocked on door, and RN O stepped out to talk with them, again pulling her gown out of the way and getting her keys and going into medication cart. At 10:02 AM, RN O cleaned up her supplies, took the graduate cylinder and syringe back into bathroom. RN O rinsed the syringe and graduate, kept wet syringe together and put back in its wrapper, placed inside wet graduate upright cylinder and placed on towel on side of sink closest to the toilet. Wet syringe was put back together and placed in wet graduate, not allowing to air dry first, promoting bacterial growth. Example 4 On [DATE] at 11:45 AM, RN 0 started preparing to administer medications to R19 via her peg tube. RN O completed hand hygiene and put on a gown when she had all her medications ready to go at R19's side. RN O started by disconnecting the tube feeding and paused. RN O stepped back from R19 and left the room with gown and gloves on, came back in room with stethoscope, took gloves off, and completed hand hygiene. With same contaminated gown on, RN O checked placement of peg tube via auscultation. RN O proceeded to administer medication one at a time with flush in-between wearing same contaminated gown. When medications were administered, RN O reconnected the feeding tube, started the feeding, and cleaned up her work area. RN O took graduate cylinder to the bathroom, rinsed and put the wet syringe in the wet container, not allowing to air dry and promoting bacterial growth. Example 5 On [DATE] at 2:32 PM, Surveyor observed RN O administer medications to R19. Once set up, RN O disconnected the feeding and looked at Surveyor and said the order still says to check placement by listening so can I still do that. Surveyor told her to do what she thinks is right. RN O took off gloves and went out of room to medication cart with gown on. RN O pulled gown out of the way, pulled out her keys, opened cart, got a tape measure, and put keys back in her pocket. RN O let the gown fall back into place and came back into the room. RN O performed hand hygiene, put on new gloves, with same contaminated gown bent over R19, and measured placement of the peg tube. With same gloves and gown, RN O administered R19's medication. When task was completed, RN O cleaned up her supplies, took the graduate cylinder and syringe back into bathroom. RN O rinsed the syringe and graduate, kept wet syringe together, placed inside wet graduate upright cylinder and did not allow to air dry, promoting bacterial growth. On [DATE] at 12:11 PM, Surveyor interviewed RN O who stated enhanced barrier precautions (EBP) should be used any time there is a catheter, peg tube, wound care or nebulizer. Surveyor asked when do you wear a gown, gloves, or change them. RN O stated you should change gloves as needed, a lot of times. RN O stated PPE required for precautions is gloves, gown, mask if upper respiratory and goggles if splashes. Surveyor asked RN O if the gown needs changing. RN O stated it usually doesn't but would change it if I get it soiled. RN O stated the gown is worn to protect you and the resident, but mostly the resident. RN O stated she probably would not need to change her gown. Surveyor asked even if you leave the room. RN O stated, I should have changed it. RN O stated the med cart was just outside the door in the hall. I consider my med cart to be part of the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 3:36 PM, Surveyor interviewed ADON C who stated EBP should be followed with all residents with catheters, wounds, peg tubes, and things like that. A gown is like gloves and needs to be put on before you start, kept clean, changed if dirty, and taken off in the room before you leave. Hand hygiene should be performed before you enter the room, do anything with patients, if you are going from dirty to clean, or leaving the room. Surveyor asked what if you leave the room with your gown and gloves on. ADON C stated both should be changed.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interviews and record reviews, the facility did not ensure their designated Infection Control Preventionist (ICP) completed training in infection control (IC) prior to assuming the role, without oversight by another IC trained individual. This has the potential to affect all 33 residents in the facility.An ICP is an essential component of an effective infection control program and is the person designated by the facility to be responsible for infection control.The Centers for Disease Control and Prevention (CDC), CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings updated October 2022, states in part, . Adherence to infection prevention and control practices is essential to providing safe and high quality patient care across all settings where healthcare is delivered . Assign one or more qualified individuals with training in infection prevention and control to manage the facility's infection prevention program . On 12/03/2025 at 2:00 PM, Surveyor interviewed Nursing Home Administrator (NHA) A who identified Director of Nursing (DON) B as the facility's current ICP. Surveyor asked for DON B's professional credentials regarding infection control training. NHA A stated that no one in the facility has completed the infection control education since the last DON's employment terminated on 11/20/25 and confirmed there is no other staff in the building that is qualified. NHA A stated they hired an ICP that plans to start at the end of December.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 all portions of the call light system were working properly. This had the potential to affect all 35 residents. The facility's call light system is not visible in the hallways unless the corner with computer screen is in direct line of sight. Staff need to be close to screen to read who has their call light on.The call light system does not have auditory alarms. Call lights are often not answered in timely manner, resulting in injuries and interference with resident choices.Surveyor requested facility policy, and none was provided. According to Ford, Dean and [NAME], PA white paper, titled What is Average Response Time in a Nursing Home, dated 3/4/25, states: It is important for staff workers at nursing homes and assisted living centers to respond quickly when residents signal that they need assistance. They may need assistance for a variety of reasons, as extreme as a fall or a poor reaction to medication and as simple as needing help getting food or taking a shower. In general, it's important for these response times to be under five minutes. Delays can be highly detrimental to elderly individuals. Example 1 R5 was admitted to the facility on [DATE] with pertinent diagnoses of idiopathic peripheral neuropathy, atrial fibrillation, overactive bladder, localized edema, and pressure ulcer stage 4 of back, buttock, and hip. R5's most recent significant change Minimum Data Set (MDS) assessment, dated 11/07/25, noted a Brief Interview for Mental Status (BIMS) score of 15, indicating cognition is intact. R5 requires partial/moderate assist with lying to sitting; substantial/max assist with shower/bathing self, upper/lower dress, personal hygiene, rolling left to right, and sit to lying; dependent assist with toileting hygiene, chair/bed transfer, toilet transfer, and wheeling 50 feet in wheelchair. R5 is always incontinent of bowel and bladder. From November 1 through December 2nd, R5 had 33 call lights that took 20-30 minutes to be acknowledged. There were 33 call lights that took over 30 minutes to be cleared. Of the 33 call lights, 12 required a reset at 30 min and were on for a range of 33 min 18 sec to needing to reset twice and being answered at 70 min 16 sec. On 10/28/25, R5 had a fall after her air mattress started deflating. Charting of fall occurred at 6:50 PM after patient was assessed and deemed stable. R5 reported she put her call light on, and no one came. As the air mattress deflated, she rolled out of bed. According to call record log R5 put on her call light at 5:22:54. It went 30 min 3 sec without being answered so it reset and went another 10 min and 59 sec before it was answered. R5 waited for assistance for 40 min 62 sec and by that time she had an unwitnessed fall. On 12/01/25 at 2:02 PM, Surveyor interviewed R5 regarding call lights and staffing. R5 stated frequently having to wait 15-20 minutes or longer for assistance after using call light. R5 stated that on 10/28/25, R5's bed began to deflate and R5 turned on call light. For approximately 15-20 minutes, R5 waited for staff to assist, but no one answered call light. R5 stated the bed completely deflated and she began to slide down off the side of the bed and was unable to reposition self and ultimately fell out of the right side of the bed and landed on right side. R5 stated she believed she hit her head on both the bed frame and floor but did not lose consciousness. R5 stated she was still holding the call (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	light after fall and believed she pushed the button again, but that the call light should have still been calling for assist as no one came into the room to turn it off yet. R5 stated she laid on the floor for an additional 15-20 minutes before staff entered the room to assist. Surveyor reviewed facility's call light log for 10/28/25 and noted the following: On 10/28/25 at 5:23 PM, R5's call light was turned on. R5's call light remains on until 6:04 PM. No other call light recordings were noted after this time. On 12/03/25 at 10:34 AM, Surveyor interviewed Certified Nursing Assistant (CNA) F regarding call light system. CNA F stated the facility's call light system is very outdated, has no alarm or visible light attached to it. CNA F stated the only way to know if a resident has turned on their call light is to see it on the monitor at the nursing station. CNA F stated that staff are frequently unaware of call lights if they are assisting residents in rooms and the monitor is not visible from all the hallways. On 12/04/25 at 10:39 AM, Surveyor interviewed Director of Nursing (DON) B regarding call light system. Surveyor asked DON B's expectation for staff to answer call lights. DON B stated difficulty in providing a timeframe, but expressed that the desire would be for call lights to be answered within 10-15 minutes. Surveyor asked DON B if the current call light system had any audible alarm or visible light for notification that a call light is on. DON B stated no, the light being turned on is only visible from the computer monitor at the nurse's station. Surveyor asked DON B if this monitor was visible from all resident hallways. DON B stated no, it is not. Surveyor asked DON B if this could be a potential risk for safety and impaired resident care. DON B stated yes, that the inability to see or hear resident call lights is a concern and should be addressed. Example 2 On 12/01/25, Surveyor completed screening interviews with residents in the [NAME] Neighborhood of the facility. Surveyor noted no audible call light alarms and no visible lights outside of resident rooms indicating a call light was turned on. Surveyor observed a computer monitor located at the nursing station. The monitor had resident room numbers listed for the facility. Surveyor asked staff by the monitor how the call light system worked. Staff stated the monitor will display a resident room number in red when the call light is turned on. When staff turn off the call light, the resident room will return to white on the monitor. Staff stated that no audible alarm or sound is emitted from the monitor and staff do not have any portable devices to alert them when a resident turns on their call light. R12 was admitted to the facility on [DATE] with pertinent diagnoses of morbid obesity with diabetic neuropathy, Crohn's disease, diabetes mellitus type 2, chronic pain syndrome, and generalized anxiety disorder. R12's most recent annual Minimum Data Set (MDS) Assessment, dated 11/14/25, noted a Brief Interview for Mental Status (BIMS) score of 15/15, indicating cognition is intact. R12 requires substantial/max assist with shower/bathing self, upper dress, personal hygiene, and rolling left to right; Dependent assist with toileting hygiene, lower dress, sit to lying, lying to sitting, and chair/bed transfers. R12 is always incontinent with bowel and bladder. On 12/01/25 at 10:33 AM, Surveyor interviewed R12 regarding call lights and staff assistance. R12 stated frequently waiting for staff for upwards of 20 minutes on average. R12 stated she couldn't recall the exact date but recently waited for over 6 hours for staff to change soiled brief. R12 stated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that at approximately 6:30 PM, she turned on her call light and after 20-30 minutes, a staff member entered her room and told her they didn't have time to change R12's brief and to call another staff member to assist, then turned off R12's call light. R12 stated she didn't have the ability to call for a specific staff member and turned the call light back on. R12 stated after approximately 20 minutes, the same staff member came back into R12's room and turned off the call light and told R12, I told you, I don't have time right now. You are going to have to wait. R12 stated feeling upset and uncomfortable having to sit in her soiled brief. R12 stated she had to wait until the next shift came on-duty to be cleaned up, but by this time R12 was experiencing some burning from skin irritation after sitting in the soiled brief from approximately 6:30 PM – 12 AM. R12 stated that no skin breakdown occurred, but the irritation lasted for 2-3 days after incident. Surveyor asked R12 if this concern was mentioned to a nurse or the administrator. R12 stated she couldn't remember for sure but thought she had told the administrator. Of note: Surveyor reviewed R12's medical record and there was no documentation of reddened or irritated skin. Surveyor reviewed facility's grievance/complaint log and did not note any documentation of R12 reporting having to wait for staff assistance for 6 hours during the past year. Example 3 R3 was admitted to the facility on [DATE], with diagnoses that include but are not limited to: Body Mass Index (BMI) 60-69.9, edema, peripheral vascular disease, kidney disease, immobility syndrome (paraplegic), atrial fibrillation, congestive heart failure, restress legs, sleep apnea, and muscle weakens. R3's most recent significant change Minimum Data Set (MDS) assessment, dated 11/24/25, documents a Brief Interview for Mental Status (BIMS) score of 15/15, indicating cognition is intact. R3 requires assist of 2 with mechanical lift to change positions, going from lying to sitting and sitting to lying. R3 needs assistance to shower/bathe, dress, with personal hygiene and cares, with at least 1 and often 2 assist. On 12/1/25 at 10:01 AM, Surveyor interviewed R3, who stated he had just put his call light on to get up. Surveyor continued with the screening interview while waiting for staff to respond to reported call light. Confirmed by the call light log report, R3 did put his call light on at 9:57:42 AM. At 10:27:42 AM, the call light reached the 30 minute mark and reset. At 10:35:33 AM (37 min 51 sec), Certified Nursing Assistant (CNA) R came in and acknowledged R3's call light, telling R3 that they would be back. By 11:01 AM, no one had come back to get R3 up for the morning. Surveyor suggested that R3 put his call light back on. At 11:23:51 AM, CNA R came in to get R3 up for the day. R3 waited for 116 minutes to get up for the morning. During the interview with Surveyor, R3 mentioned 3 times that he was supposed to go down to therapy before lunch. Surveyor heard R3 during cares tell CNAs that he had missed going to therapy. R3 was up and dressed just in time to go to lunch; therapy exercises were missed. From November 1 through December 2nd, R3 was out of the facility in the hospital. For the remainder of the period, R3 had 9 call lights that took between 20-30 minutes to be cleared by staff and 33 call lights that took over 30 minutes or more to be cleared by staff. Of the 33 call lights, 12 required a reset at 30 min and were on for a range of 34 min 23 sec to needing to reset twice and being answered at 104 min 30 sec.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on staff interview and record review, the facility did not provide appropriate notices for residents (R) whose Medicare Part A coverage was discontinued for 2 of 3 residents reviewed. (R5, R4) -Did not provide Advanced Beneficiary Notice (ABN) for 2 of 3 residents. (R4, R5) -Did not provide the required 2-day notice that Medicare coverage will end for 1 of 3 residents reviewed. (R5) Findings: R4 had a skilled Medicare A Service Episode with a start date of 07/15/25 and last covered date of 07/30/25. The facility/provider initiated the discharge from Medicare A Services when benefit days were not exhausted. The facility checked the box on the SNF Beneficiary Protection Notification Review form that asked the question Was a Skilled Nursing Facility (SNF) Advanced Beneficiary Notice (ABN), Form CMS-10055 provided to the resident? The facility checked the box Yes with a date of 12/02/25 after the survey was in process.R5 had a skilled Medicare A Service Episode with a start date of 06/17/25 and last covered date of 009/24/25. The facility/provider initiated the discharge from Medicare A Services when benefit days were not exhausted. The facility checked the box on the SNF Beneficiary Protection Notification Review form that asked the question Was a Skilled Nursing Facility (SNF) Advanced Beneficiary Notice (ABN), Form CMS-10055 provided to the resident? The facility checked the box Yes with a date of 12/02/25 after the survey was in process. On the box on the SNF Beneficiary Protection Notification Review form that asked the question Was a Notice of Medicare of Non-Coverage (NOMNC) provided to the resident? The box labeled YES. R5 received and dated the NOMNC on 09/23/25, which was only 1 day notice instead of the required 2-day notice. Surveyor reviewed R5's electronic health record (EHR) and did not find notes explaining reason only a one-day notice of benefits ending was given. Surveyor could not interview the social worker because s/he was unavailable. On 12/04/25 at 12:12 PM, Surveyor interviewed Assistant Executive Director (AED) L who stated she does not know why only a one-day notice was given to R5 but will check on it. On 12/04/25 at 12:56 PM, AED L returned and stated there was only a one-day notice given. They could not find any notes as to why. Surveyor asked AED L if she would expect that residents receive a two-day notice which she replied yes.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure residents/representatives were notified of the rate to reserve the resident's bed and was not documented in the Wisconsin Bed Hold and Notice of Transfer for 2 of 3 residents (R) (R5, R3) reviewed.R5 was transferred to the hospital on [DATE] and 11/04/25. A bed hold notice with daily rate to reserve bed and a written notice of transfer were not documented.R3 was transferred to the hospital on 3/11/25, 4/20/25, and 10/25/25. A bed hold notice with daily rate to reserve bed and a written notice transfer were not documented.R3 was transferred to the hospital on [DATE]. A notice of transfer discharge was given but did not specify reason for transfer or daily rate to reserve bed. This is evidenced by: Facility policy titled, Bed Hold and Re-Admission, with a review date of 12/2025, states in part: Before a resident is transferred to a hospital or placed on therapeutic leave, written notification is provided to the resident and/or resident representative that specifies: Bed hold: the duration of the bed hold period.Bed hold transfer: At the time of transfer for hospitalization or leave, written notice that specifies the duration of the facility bed hold period is provided to the the resident and/or resident representative. A copy and/or documentation of the notice is placed in the resident's medical record. Facility policy titled, Transferring a Resident to Another Facility or Hospital, with a review date of 12/2025, states in part: Procedure: 2. In an acute change of condition/emergency situations: d. Notify the resident's representative of the pending transfer to include appeal notification. F. Complete the transfer form and bed hold information to be sent with resident. Example 1 On 06/07/25, R5 had a change in mentation and began experiencing chest pain. R5 was transferred to the hospital via ambulance and admitted to the hospital. R5's family and provider were notified. No written notice of transfer indicating reason for transfer and destination was documented. A bed hold indicating the daily rate to reserve bed and appeal rights was not documented. On 11/04/25, R5 experienced increased weakness and dizziness and was transferred to the emergency room for evaluation. R5 returned to the facility on the same day. No written notice of transfer indicating reason for transfer and destination was documented. A bed hold indicating the daily rate to reserve bed and appeal rights was not documented. On 12/04/25 at 10:06 AM, Surveyor interviewed Health Information Clerk (HIC) D regarding bed holds and written notice of transfer. HIC D provided Surveyor with a nurse progress note, dated 06/07/25, stating family approved bed hold until resident is strong enough to return to facility. Surveyor asked HIC D if there was any documentation of the bed hold being completed by R5 when R5 returned to facility on 06/17/25. HIC D stated no. HIC D stated not having any documentation of a bed hold or written notice of transfer completed for R5 for the transfer that occurred on 06/07/25 and 11/04/25. Example 2 On 3/11/25, R3 had hypertension (high blood pressure) and tachycardia (fast heartbeat). R3 was feeling nervous, confused, and light-headed. R3's pulse was erratic ranging between 116 and 146 (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	beats per minute (BPM). Facility called emergency medical services (EMS) and R3 was sent to the emergency room (ER). R3 was hospitalized . R3's physician was notified, and a voicemail was left with R3's family. No written notice of transfer indicating reason for transfer and destination was documented. A bed hold indicating the daily rate to reserve bed and appeal rights was not documented. On 11/04/25, R3 was very lethargic and off baseline per documentation. R3's face was flushed and pulse elevated at 116. Per the documentation R3 stated, something is wrong, and requested to go to the ER. R3 was hospitalized . No documentation that family or physician were notified. No written notice of transfer indicating reason for transfer and destination was documented. A bed hold indicating the daily rate to reserve bed and appeal rights was not documented. On 10/25/25, R3 appeared very pale and complained of feeling light-headed and dizzy. Per documentation, R3 stated, doesn't feel right, and wanted to go to the ER. R3 had 4+ pitting (significant) and taut edema in his lower extremities. Facility notified the on-call physician. It is documented that R3 did not want family notified and verbal bed hold obtained. No required written notice of transfer indicating reason for transfer and destination was documented. A bed hold indicating the daily rate to reserve bed and appeal rights not documented. On 11/7/25, 5 days post hospital discharge, R3 returned to hospital due to rectal bleeding. Document for Notice of Transfer/Discharge available but does not document specific reason for hospitalization or daily rate for bed hold. No documentation of physician or family notified, or R3 refusing family notification. On 12/3/25 at 11:34 AM, Assistant Director of Nursing (ADON) C provided Surveyor with one bed hold notice for the four hospitalizations. ADON C stated there are no other bed hold/transfer notices she can find. ADON C stated she usually fills them out but if they are not hospitalized , they are not kept. R3 was hospitalized for all of these, and bed hold and written transfer notice required.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure a resident who entered the facility as an exception (an exempted hospital discharge) that was later found to require more than 30 days care, received a Level II resident review within 40 calendar days of admission, for one of one resident (R1). State of Wisconsin regulation 42 CFR 483.106(b)(2)(ii), If an individual who enters a nursing facility as an exception (an exempted hospital discharge) is later found to require more than 30 days of care, the State mental health or intellectual disability authority must conduct a Level II resident review within 40 calendar days of admission. R1 was admitted to the facility on [DATE] with diagnoses that include anxiety, depression, and PTSD. R1 has intact cognition and makes own decisions. On 12/02/25 at 3:43 PM, Surveyor requested a Level II PASARR screening from Social Worker (SW) J after Surveyor was unable to locate it in R1's electronic health record (EHR). On 12/02/25 at 4:11 PM, SW J provided R1's level 1 PASARR screen that identifies R1 had a major mental disorder and was discharged from a hospital with a 30-day exemption. SW J stated that she is late completing the level II PASARR screen. On this day, R1 has been in the facility 68 days; 28 of those days the facility has not been in compliance.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, facility did not implement professional standards of practice to ensure that a resident does not develop pressure injuries (PIs), receives necessary treatment and services to promote healing and prevent new PIs from developing for 1 of 3 residents (R)(R5) reviewed.R5 developed a stage 3 Pressure Injury (PI) on right buttock and a stage 3 PI on left buttock. The facility did not completely weekly assessments and update care plan with PI interventions.This is evidenced by:Facility policy titled, Pressure Injury/Skin Integrity, with a reviewed date of 12/2025, states in part: It is the policy of this facility to enable nursing staff to manage wounds and select appropriate interventions according to National Pressure Injury Advisory Panel (NPUAP). Based on the comprehensive assessment of a resident, Health Dimensions Group Communities will ensure: Routine ongoing documentation should be conducted related to the resident's skin condition and the resident's response to the care and treatment of the skin. Wound documentation is more detailed than routine skin documentation and shall include information related to the wound based on a clinical assessment. Documentation: 1) Routine ongoing documentation should be conducted related to the resident's skin condition and the resident's response to the care and treatment of the skin. The frequency of documentation shall be determined based on the resident's individual needs in accordance with accepted standards of practice, at least weekly. 3) Wound Documentation Guidelines (documentation may include): a. Document size. b. Document any undermining/tunneling/sinus tract.c. Describe any exudates - type, amount, and/or odor.d. Describe the various types/characteristics of tissue in wound bed.e. Wound edges may be described.f. Describe any indicators of infection.g. Document pain.Care Planning: 1) Upon admission, a baseline plan of care will be developed to identify areas of concern, risk factors, or existing wounds, measurable goals of care, and to specify interventions to preserve and/or treat skin integrity issues. A. Pressure Injury (Prevention) - Reduce pressure/shearing intervention examples but not limited to: i. Pressure reducing devices such as an air mattress or chair cushion.R5 was admitted to the facility on [DATE] with pertinent diagnoses of idiopathic peripheral neuropathy, atrial fibrillation, overactive bladder, localized edema, and pressure ulcer stage 4 of back, buttock, and hip.R5's most recent significant change Minimum Data Set (MDS) assessment, dated 11/07/25, noted a Brief Interview for Mental Status (BIMS) score of 15, indicating cognition is intact. R5 requires partial/moderate assist with lying to sitting; substantial/max assist with shower/bathing self, upper/lower dress, personal hygiene, rolling left to right, and sit to lying; dependent assist with toileting hygiene, chair/bed transfer, toilet transfer, and wheeling 50 feet in wheelchair. R5 is always incontinent of bowel and bladder.R5's care plan, dated 07/31/25, with a target date of 01/28/26, states: At risk for complications related to pressure ulcers and skin integrity due to noncompliance and refusing repositioning and pressure relief interventions with interventions of educate/remind as needed about potential negative outcomes r/t choice (07/31/25), check for comfort levels - pain, thirst, hunger, temperature - offering comfort as able/accepted (07/31/25), involve family/friends as available/able (07/31/25), seek residents reasons for non-compliance (07/31/25), SS to intervene as needed/requested (07/31/25).R5's care plan, dated 10/17/24, with a target date of 01/28/26, states: Actual impaired skin integrity, stage 4 pressure ulcer to right and left buttocks with risk for further impaired skin integrity including skin tears, pressure ulcers r/t resident is non-compliant with interventions for skin breakdown prevention and pressure ulcer prevention strategies, decreased mobility, bowel and bladder incontinence, non-ambulatory status. Interventions include: Keep HOB less than 30 degrees (10/06/25), low air loss mattress (08/21/25), resident is to be in bed at all times other than toileting, daily weight and breakfast only (08/21/25), Roho Quadtrol Select Cushion in wheelchair (06/24/25), staff encourage and assist res to off-load pressure to buttocks (07/21/25), supplements as ordered for wound healing (06/25/25), wound care per MD orders, observe for (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	healing, s/sx infection including increased redness, warmth, swelling, drainage, odor, pain, fever - consult with provider if concerns arise (06/25/25), Wound Clinic to Eval and Treat per WWH Providers (08/04/25), assist/encourage pressure relief as needed/accepted (10/02/25), follow community skin protocol (10/02/25), observe skin with AM/PM cares and with toileting.weekly skin check.(10/17/24), pressure reduction mattress on bed (10/02/25).-Of note: no specification for settings of air mattress or monitoring of function noted.R5's physician orders:08/21/25 Low Air Loss mattress-Of note: no setting parameters for air mattress noted.10/04/25 Ensure wound vac is ON, charged (or charging) & functioning at 125 mmHg every shift for wound care11/07/25 WOUND CARE: Left Buttocks - Ensure Santyl is being placed to wound bed in the afternoon every Tue, Fri for wound care.11/14/25 WOUND CARE: Right Buttocks Wound 1.) Cleanse with VASHE; soak for 5 mins. 2.) Apply skin prep to surround skin. 3.) Cover with Mepilex. In the morning every Fri for wound care. R5's BRADEN Score assessments:05/05/25 - 18 low risk05/26/25 - 19 no risk-Of note: This assessment was completed after initial assessment of PI on right buttock06/17/25 - 14 moderate risk08/06/25 - 16 mild/low risk10/15/25 - 13 moderate risk11/07/25 - 15 mild/low riskR5's facility wound assessments:05/14/25 - INITIAL ASSESSMENT - Right buttocks, stage 3 - 2.3 cm x 1.3 cm x 0.2 cm - provider notified and seen; documented assessments; interventions implemented.-Of note: prior skin assessments completed weekly noted no areas of redness or impairment.05/19/25 - initial Wound Care Clinic visit; stage 3 PU right upper buttocks; debridement completed. New wound care orders implemented.Weekly wound assessments completed by facility and wound care clinic. Treatments completed per order.On 06/07/25, R5 was hospitalized with Non-ST elevation myocardial infarction. R5 returned to facility on 06/17/25.06/23/25 - Wound assessment completed. Right buttock 2.6 cm x 2.5 cm x 1.9 cm with new undermining at 10 to 1 - 2.5 cm. Wound clinic assessed and implemented new orders.-Of note: Facility did not complete skin assessment on readmission to facility on 06/17/25. R5 did not have documented wound assessment noted for 6 days following readmission.Weekly wound assessments completed by facility. Treatments completed per order.07/21/25 - NEW Left Buttock stage 1 - 2.5 cm x 3.5 cm x 0 cm. Wound clinic assessed and implemented treatment.07/28/25 - Left buttock measured 3 cm x 4 cm x 0.1 cm and noted as stage 2. Provider notified. No new orders noted. No new interventions implemented.-Of note: no wound clinic visit or assessment noted.08/04/25 - Right buttock: 0.7 cm x 0.7 cm x 1.5 cm; Left buttock: 3.5 cm x 6.7 cm x 0.2 cm and noted as stage 3. Both wounds have worsened. Provider notified. New treatment orders received, and new wound clinic consult ordered. Administrator notified to order new low air loss mattress.08/06/25, R5 was seen by a new wound care clinic provider for more advanced care and to take over wound treatment. Right buttock: 1.0 cm x 0.5 cm x 8.5 cm; Left buttock: 3.2 cm x 4.6 cm x 0.1 cm. New treatment plan implemented. New orders include: measure and document wound condition per facility policy and to contact wound care clinic with any deterioration.Weekly wound assessments completed by facility. Treatments completed per order.09/11/25 - Wound clinic visit. New orders obtained: turn and reposition every 2 hours: right/left runs, avoid back.-Of note: no documentation of this intervention being implemented or resident refusal noted.09/18/25 - Right buttock: 0.7 cm x 0.5 cm x 8.5 cm; Left buttock: 2.5 cm x 3.5 cm x 3 cm.09/25/25 - Wound clinic documentation: no wound measurements noted. Surgical consult for debridement scheduled for 09/26/25.-Of note: no wound clinic or surgical consult documentation noted for 09/26/25 appointment.No wound clinic visits/assessments or facility assessments noted for R5's left buttock or right buttock PI noted between 09/26/25 - 10/16/25.10/16/25 - Wound clinic documentation: Left buttock: 8.8 cm x 3.5 cm with depth and undermining. No documentation of right buttock documented. Documentation noted black granufoam was not inside the left buttock wound very far. Order sent to facility to be sure to gently pack dead space with black granufoam and apply wound vac at continuous low suction 125 mmHg and change twice a week. Continuous order noted to reposition every 2 hours.-Of note: no order or care plan intervention to reposition every 2 hours noted. No documentation of resident refusal of repositioning every 2 hours was noted.No facility assessments noted for R5's (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	left buttock or right buttock PI noted between 10/17/25 - 10/28/25.10/28/25 - Wound clinic documentation: Right buttock: 1 cm x 0.7 cm x 1.1 cm with undermining; Left buttock: 7.5 cm x 3 cm x 6 cm. Continuous order noted to reposition every 2 hours.-Of note: no order or care plan intervention to reposition every 2 hours noted. No documentation of resident refusal of repositioning every 2 hours was noted.No facility assessment of R5's left and right buttock PI was documented after 09/18/25.On 12/04/25 at 12:48 PM, Surveyor interviewed Assistant Director of Nursing (ADON) C regarding R5's PIs. Surveyor asked ADON C if nurses are expected to document wound assessments weekly. ADON C stated yes. Surveyor asked for R5's facility wound assessments after 09/18/25. ADON C looked through R5's medical record and stated not being able to find any. ADON C stated that the prior DON was completing weekly wound assessments and thought that the floor nurse completing wound care was documenting this. ADON C stated that this is a concern and at minimum, should have been documented weekly to monitor for changes.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure the resident environment remains free of accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents for 1 of 1 resident (R)(R5) reviewed.R5 had a fall; the facility did not initiate immediate intervention to prevent future falls, complete staff education and review and revise care plan fall interventions.This is evidenced by:Facility policy titled, Accidents/Falls - HDGR, with a review date of 12/2024, states in part: The facility strives to promote safety, dignity, and overall quality of life for its residents by providing an environment that is free from any hazards for which the facility has control and by providing appropriate supervision and interventions to prevent avoidable accidents. Procedure: 5. Resident care plans should be evaluated and updated with each fall with a new and applicable intervention based on root cause. The focus is to be on prevention and maintaining a safe environment.R5 was admitted to the facility on [DATE] with pertinent diagnoses of idiopathic peripheral neuropathy, age-related osteoporosis, sensorineural hearing loss bilateral, atrial fibrillation, overactive bladder, localized edema, and pressure ulcer stage 4 of back, buttock, and hip.R5's most recent significant change Minimum Data Set (MDS) assessment, dated 11/07/25, noted a Brief Interview for Mental Status (BIMS) score of 15/15, indicating cognition is intact. R5 requires partial/moderate assist with lying to sitting; substantial/max assist with shower/bathing self, upper/lower dress, personal hygiene, rolling left to right, and sit to lying; dependent assist with toileting hygiene, chair/bed transfer, toilet transfer, and wheeling 50 feet in wheelchair. R5 is incontinent of bowel and bladder. R5 has had one fall with injury (except major) since admission.R5's care plan, dated 10/17/24, with a target date of 01/28/25, states: At risk for falls.with interventions of call light positioned for easy access (10/24/24), check for unmet needs: pain, toileting, hunger, thirst, temperature (10/20/25), encourage/assist with non-skid shoes/socks (10/20/25), ensure environment is free of clutter (10/20/25), fall review per facility protocol (10/24/24), have commonly used articles within easy reach (10/20/25), reinforce need to use the call light to request assistance (10/24/24).Of note: R5's alternating air mattress is not noted to include settings and monitoring for functioning; no new safety interventions implemented after fall on 10/28/25.Surveyor reviewed R5's fall incidents and noted facility did not educate staff regarding air mattress settings or monitoring of the air mattress to ensure proper functioningOn 10/28/25 at 6:30 PM, R5 had an unwitnessed fall in room; R5 was found lying on floor on right side next to bed. R5 stated bed deflated and rolled out of bed. R5 reported hitting head, face and right shoulder bruised, and abrasion on left outer ankle. DON and provider were notified. Facility investigation determined root cause to be bed malfunction. Durable Medical Supply (DME) was contacted to inspect bed and air mattress was replaced. Facility implemented Performance Improvement Plan (PIP) on 11/04/25 that stated, [R5] had a fall on 10/28/25. Air mattress broke while resident was lying in bed. Interventions included complete education on provider notifications (11/05/25 and 11/11/25), obtain air mattress manufacturer's guidelines (11/05/25), audit other air mattresses to ensure we have manufacturer recommendations for all of them and ensure they are being followed and documented (11/05/25), and start maintenance air mattress tracking log of pressures in the air mattresses (no date noted).R5's fall with injury was on 10/28/25. Surveyor reviewed R5's nursing progress notes and noted:On 11/04/25, facility nurse noted R5 required more assist during transfer due to increased weakness and pain in lower extremities, dizziness, and lightheadedness. R5 stated having continued pain on right side of head where it was hit during fall on 10/28/25. Provider was notified and R5 was transferred to the hospital for further evaluation. Hospital discharge notes stated CT scan indicated no hemorrhage and no fractures; diagnoses of vertigo and hematoma of scalp. R5 returned to facility same day.On 12/01/25 at 2:02 PM, Surveyor observed R5 in bed. R5's bed was an alternating air mattress set at level 4 and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	functioning properly. Surveyor asked R5 about the fall that occurred on 10/28/25. R5 stated that she observed the bed starting to deflate and turned on call light. For approximately 15-20 minutes, R5 waited for staff to assist, but no one answered call light. R5 stated the bed completely deflated and she began to slide down off the side of the bed and was unable to reposition self and ultimately fell out of the right side of the bed and landed on right side. R5 stated she believed she hit her head on both the bed frame and floor but did not lose consciousness. R5 stated she was still holding the call light after fall and stated she pushed the button again, but the call light should have still been calling for assist as no one came into the room to turn it off yet. R5 stated she laid on the floor for an additional 15-20 minutes before staff entered the room to assist. Surveyor asked R5 if staff were monitoring the air mattress functioning appropriately. R5 stated she did not know.On 12/03/25 at 10:28 AM, Surveyor interviewed Certified Nursing Assistant (CNA) E regarding resident air mattresses. CNA E stated not receiving any education or training on monitoring air mattresses for safety or appropriate settings for use. CNA E stated the only thing she was aware of regarding air mattress operation was that if it is beeping to contact maintenance. Surveyor asked CNA E if she knew what settings a resident's air mattress should be set to. CNA E stated no.On 12/03/25 at 10:34 AM, Surveyor interviewed CNA F regarding air mattresses and R5's fall. CNA F stated being at the facility for over a year and a half and had never received training or education regarding monitoring air mattress functioning. Surveyor asked CNA F if she knew what settings R5's bed should be set at. CNA F stated no and never received any education or training regarding this.On 12/03/25 at 11:45 AM, Surveyor interviewed CNA G regarding air mattresses. CNA G stated not receiving any official education or training on resident air mattresses regarding functioning or settings. Surveyor asked CNA G if aides are expected to check if air mattresses are functioning. CNA G stated not being aware of having to check this as part of her job responsibility.On 12/03/25 at 11:46 AM, Surveyor interviewed Registered Nurse (RN) H regarding air mattresses. RN H stated no recollection of training or education regarding air mattress functioning or settings. Surveyor asked RN H how staff know if an air mattress is functioning appropriately. RN H stated using visual observation of bed being inflated and checking with touch for empty air areas, but most air mattresses are provided by hospice, and hospice usually checks for functioning. RN H stated the only inspection she makes is by checking that air mattress is on. RN H stated not knowing what other nurses do but was not aware of any responsibility to check or document air mattress functioning.On 12/03/25 at 12:07 PM, Surveyor interviewed Plant Operations Director (POD) I regarding air mattresses. POD I stated being contacted approximately 1-2 weeks ago by the Nursing Home Administrator (NHA) A via email to review air mattress manufacturer guidelines and inspect all residents with air mattresses for appropriate settings. POD I provided Surveyor with a sticky note and paper with handwritten room numbers and air mattress settings that had no date or signature. POD I stated that prior to this, no assessment of air mattress settings or functioning had been completed. Surveyor asked POD I if he was expected to check functioning on a schedule (i.e. weekly, monthly, etc.). POD I stated not being aware of a schedule and was only told to ensure all air mattresses were set according to manufacturer's settings.On 12/03/25 at 1:39 PM, Surveyor interviewed NHA A regarding R5's fall and investigation. Surveyor asked NHA A what the facility determined was the root cause of R5's fall. NHA A stated it was a bed malfunction. Surveyor asked NHA A if air mattress functioning was assessed for any resident prior to this incident. NHA A stated no. Surveyor asked NHA A why follow-up education did not include air mattress functioning and setting. NHA A did not provide an answer but stated that originally the plan was for POD I to ensure functioning and setting, but NHA A failed to follow-up to ensure weekly monitoring was being completed. NHA A stated recognition that nursing staff should have been educated on air mattress functioning and appropriate settings and would now include it on the nurse task list.Facility did not educate staff regarding air mattress settings or monitoring of the air mattress to ensure proper functioning. Facility did not have a routine maintenance/monitoring plan in place for the air mattress prior to R5's fall on 10/28/25 to ensure all resident's who have air mattresses, are functioing properly and are on the proper settings for each resident.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility did not ensure 2 of 2 residents (R) with an NG-Tube (Nasogastric) in the facility received the appropriate treatment and services to prevent complications of enteral feedings and medication administration. (R7 and R19)R19 had unlabeled/dated enteral solutions being administered.R19 and R7's Gastrostomy tube (G-tube/ feeding tube) placement was not appropriately assessed prior to medication administration. Example 1Per provided facility policy, titled Care and Treatment of Feeding Tubes, dated copyright 2024 The Compliance Store, LLC, states: Policy: It is the policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with intervention to prevent complications to the extent possible.The American Society for Parenteral and Enteral Nutrition, Enteral Nutrition Practice Recommendations (2017, Journal of Parenteral and Enteral Nutrition-Vol 41, Number 1, Jan/February 2017, 34-44) indicate that a label should be affixed to all enteral nutrition delivery systems. The label should reflect the patient's demographics (name/location), individuals responsible for hanging and preparing, and the date and time the formula is prepared and hung. The enteral nutrition label should be compared with the enteral nutrition order for accuracy and hang time or beyond-use date before administration.Per facility provided policy titled, Verifying Placement of Feeding Tube, dated copyright 2024 The Compliance Store, LLC, states: Policy: It is the practice of this facility to ensure proper placement of feeding tubes prior to beginning g a feeding, flushing the tube, or before administering medications via feeding tube.4. Procedure for verifying placement of feeding tubes:c. Verify tube placement:i. For gastrostomy tubes, check that the enteral retention device is properly approximated to the abdominal wall by gently tugging on the tube and taking note of the markings on the tube. ORii. Measure length of tube from insertion site to tip.R19 was admitted to the facility on [DATE] with the diagnoses that include but are not limited to cerebral palsy, generalized idiopathic epilepsy, dysphasia, (difficulty swallowing), aphasia (inability to speak, understand read and write), Rett's syndrome, severe intellectual disability, and gastrostomy (has a feeding tube/g-tube). R19's Minimum Data Set (MDS) assessment, dated 9/1/25, indicates that R19 is cognitively impaired, does not understand, cannot respond, and is wheelchair dependent and a full assist of 2 for all activities of daily living and cares.R19's care plan, dated 10/2/25, states. Feeding Tube: At Risk for Complications with tube feeding.Verify placement of feeding tube prior to administering any medication, flushing the tube or beginning a feeding. Tube length on admission: Black marking on tube at 6cm against skin and bumper. Measure 7 inches of length from tube insertion site to end of the tube (not entire connector piece). If measurements are incorrect, do not put anything in tube and notify MD. Date Initiated: 7/11/25.R19's Order Summary Report, dated 12/2/25, states: Verify placement of feeding tube prior to administering any medications, flushing the tube or beginning a feeding. Tube Length on admission: Black Marking on tube at cm against skin and bumper. Measure 7 inches of length from tube insertion site to end of tube (not entire connector piece.) if measure is incorrect, do not put anything in tube and notify MD. Order date 6/13/2025. Apply label to tube feeding bag. Include: Name, Room#, Date, time started, feed rate, formula and volume/day one time a day. Order started 12/2/25.On 12/2/25 at 7:40 AM, Surveyor observed R19's tube feeding bag running at 57ml/hr. per physician order. There was no label on tube feeding bag or tube identifying it was Jevity or the date and no time that the feeding was started. On 12/2/25 at 10:07 AM, Surveyor asked Registered Nurse (RN) O about tubing feeding and should it be labeled. RN O stated night shift sets up the new and they didn't label it. They should have. On 12/2/25 at 11:08 AM, Surveyor observed unlabeled feeding tube and bag with Assistant Director of Nursing (ADON) C who stated the expectation is that it should be labeled. Night shift usually does it. ADON C will get Surveyor the policies.On 12/2/25 at 12:02 PM, while Surveyor was in R19's room with ADON C and RN (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	O, it was noted that the tube feeding bag remained unlabeled, no date at minimum. ADON C stated she did not label the tube feeding back earlier when we saw it because she would have had to dump and start over, and we already saw it that way, so she didn't want to waste it.On 12/2/25 at 12:13 PM, Director of Nursing (DON) B stated tube feeding bags/tubing are usually changed on night shift and labeled when they start the next day's feeding. Surveyor asked if it is not labeled what should the next shift do. DON B stated they should put a date on it, they aren't sure the time, but they can at least date it.On 12/2/25 at 11:45 AM, RN O started preparing to administer medications to R19 via her peg tube. RN O completed hand hygiene and put on a gown when she had all her medications ready to go at R 19's side. RN O started by disconnecting the tube feeding and paused. RN O stepped back from R19, left the room with gown and gloves on, came back in room with stethoscope, took gloves off and completed hand hygiene. With same contaminated gown on, RN O checked placement of peg tube via auscultation and proceeded to administer medication one at a time with flush in-between. On 12/2/25 at 12:12 PM, RN O stated you check placement of a g-tube by listening for air in the stomach when you push about 5cc in with the syringe. If you can hear the noise, you are in the right part of stomach. On 12/2/25 at 12:14 PM, ADON C stated proper placement is with a swoosh of air and you hear it, or you can measure if you know what the length of the tube is supposed to be.On 12/2/25 at 12:13 PM, Surveyor interviewed DON B who stated you test proper placement of a g-tube with the measurement thing. There is a doctor's order that is distinct on how long the tubing should be, its placement. There should be a measuring tape in the room and before they utilize the tube, they would measure it. Example 2R7 was admitted to the facility on [DATE], with the diagnoses that include but are not limited to protein-calorie malnutrition, adult failure to thrive, dysphagia (difficulty swallowing), and unstageable pressure ulcer.R7's Minimum Data Set (MDS) assessment, dated 10/1/25, indicates that R7 is moderately cognitively impaired, she understands and is understood with behaviors of yelling out due to anxiety and hallucinations. R7 uses a wheelchair for mobility with assist of one to go 50 feet or further, is assist of 2 with mechanical lift for position changes and requires set up assistance for eating, oral hygiene and brushing her teeth.R7's Order Summary Report, dated 12/2/25, states: Verify placement of feeding tube prior to administering any medications, flushing the tube, or beginning a feeding. Tube Length on admission: Black Marking on tube at cm against skin and bumper. Measure 7 inches of length from tube insertion site to end of tube (not entire connector piece.) if measure is incorrect, do not put anything in tube and notify MD. Order date 9/23/25.On 12/2/25 at 9:37 AM, Surveyor observed Registered Nurse (RN) O flush R7's peg tube, cleanse site and change peg tube dressing and wound dressings with assist of ADON C distracting R7. RN O started by cleaning the peg tube. RN O did not have all the dressings she needed, took off gloves, left room, came back, performed hand hygiene, and with same contaminated gown continued with peg tube dressing. With contaminated gown, RN O checked placement via auscultation of g-tube and flushed the g-tube and started administering medications. On 12/2/25 at 12:12 PM, RN O stated you check placement of a g-tube by listening for air in the stomach when you push about 5cc in with the syringe. If you can hear the noise, you are in the right part of stomach. On 12/2/25 at 12:14 PM, Assistant Director of Nursing (ADON) C stated proper placement is with a swoosh of air and you hear it when using a stethoscope and listen, or you can measure if you know what the length of the tube is supposed to be.On 12/2/25 at 12:13 PM, Surveyor interviewed DON B, who stated you test proper placement of a g-tube with the measurement thing. There is a doctor's order that is distinct on how long the tubing should be, its placement. There should be a measuring tape in the room and before they utilize the tube, they would measure it.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R1) of 1 resident reviewed for post-traumatic stress disorder (PTSD) received culturally competent, trauma informed care in accordance with professional standards of practice and accounting of resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of R1.R1 does not have a person-centered care plan for triggers and interventions for R1's PTSD diagnosis. Findings:The facility policy titled Trauma Informed Care dated 12/2025 documents: This community ensures that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident . Person-centered care plan will be developed with resident's and /or family involvement to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident and will account for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.R1 was admitted to the facility on [DATE] with diagnoses that include PTSD, depression, and insomnia. R1's Minimum Data Set (MDS), dated [DATE], indicated R1 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15/15. R1 eats independently and receives moderate assistance for bed mobility, toileting, and transfers. R1 did not have an activated power of attorney and makes own decisions. Surveyor reviewed R1's care plan and found no plan was created for R1 regarding PTSD. Care plan dated 9/25/25 documents noncompliance with plan of care and mood/behavior. Interventions are: Observe for percent of time in compliance. If alternatives are appropriate review for alterations or change if ineffective. Observe / Monitor / Document behaviors/mood and notify supervisor, SW, and / or MD as needed. Surveyor reviewed R1's CNA Kardex and noted no documentation for possible triggers for R1's PTSD and no interventions to prevent possible PTSD triggers for R1. Social worker was not available for interview at the time of this investigation. On 12/03/25 at 8:35 AM, Surveyor interviewed Assistant Director of Nursing (ADON) C and asked to show the care plan that addresses R1's PTSD. ADON C stated there is not one, but R1 sees an in-house psych provider weekly. ADON C added that R1's PTSD is from childhood and states that R1 had recent suicide attempts and will get quiet. ADON C stated she will get a care plan in there right away. On 12/03/25 at 9:17 AM, Surveyor interviewed Certified Nursing Assistant (CNA) K who reported working at the facility for approximately a year. CNA K stated she is not aware of who has PTSD or what the interventions are for R1 when told R1 has PTSD.