

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on individual and group interviews, the facility does not always provide reasonable access to residents' mail. Mail that is delivered to the facility on Saturdays by the Postal Service is not delivered to the residents until the following Monday afternoon. This has the potential to affect 93 out of 93 residents in the facility. Findings include: The facility's policy document titled Resident's Rights to Privacy in Communication dated 03/04/2025 and revised 07/01/2025 documents: Definitions: Promptly means delivery of mail or other materials to the resident within 24 hours of delivery by the Postal Service (including a post office box) and delivery of outgoing mail to the Postal Service within 24 hours, except when there is no regularly scheduled postal delivery and pickup service. Explanation and compliance guidelines: 1. The facility will honor the resident's right to privacy in communications including the right to: a. Send and promptly receive mail that is unopened. During Resident Council held on 08/11/2025, at 10:30 AM, R78 and R49 informed Surveyor that mail is not delivered on Saturdays. R78 informed Surveyor Saturday's mail is delivered on Monday in the afternoon. On 08/12/2025, at 11:53 AM, Surveyor interviewed Business office assistant (BOA)-Z about how mail is delivered in the facility. BOA-Z informed Surveyor that the Activities department delivers Resident packages and mail after BOA-Z sorts the mail. BOA-Z informed Surveyor that the Resident's Saturday mail is placed into Business Office Manager (BOM)-H's office for safe keeping until activities can deliver to the Residents. BOA-Z informed Surveyor the facility receives mail on Saturday from the postal service, but Resident mail is not delivered until Monday because we don't know if a Resident's mail has sensitive information, and no one from the business office is here Saturdays to sort the Resident's mail for delivery. Surveyor asked BOA-Z to explain the mail delivery procedure on Mondays. BOA-Z informed Surveyor that BOA-Z will sort mail on Mondays and the Activities department delivers Resident mail after the mail is sorted by someone from the business office. Surveyor asked BOA-Z what the time frame on Mondays the Resident's mail is delivered. BOA-Z informed Surveyor the Resident's Saturday mail was delivered sometime after 01:30 pm on Monday. Surveyor asked BOA-Z to clarify if the residents always need to wait until Monday afternoon for Saturday's mail. BOA-Z informed Surveyor yes because I need to sort it to make sure sensitive materials are handled correctly, and we don't really have anyone from the business office on the weekends. On 08/12/2025, at 01:10 PM, Surveyor interviewed BOM-H about resident's mail delivery. BOM-H informed Surveyor Resident's mail is stored in BOM-H's office when it is received from the Postal Service on Saturday. BOM-H informed Surveyor the business office sorts the mail before it goes out to the residents on Monday. On 08/13/2025, at 9:50 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A about Surveyor's concerns with no Saturday mail delivery for the facility's Residents. Surveyor asked if NHA-A knew there was no Saturday mail delivery for the residents. NHA-A informed Surveyor there was no one from the business office on the weekends. Surveyor informed NHA-A the facility policy documents that residents should receive their mail within 24 hours and that the resident's mail was not being delivered until Monday afternoon. NHA-A informed Surveyor that the facility was working on fixing all the issues the Surveyor's presented. No other information was presented to Surveyor at this time.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility did not ensure the kitchen was storing and preparing food in a safe and clean manner. This has the ability to affect all 93 residents. The walk-in freezer had buildup of thick ice on the floor, walls and ceiling including boxes of food in the freezer. Two fans in food prep area had buildup of red substance making the fan appear dirty and in disrepair. A bag of lettuce salad was opened with a date that was faded so it made the date unreadable. The lettuce was brown. The exhaust fan over the stove area had a buildup of dust. No beard restraint used for Dietary Staff (DS)-LL and Dietary Manager (DM)-MM. Findings include: The facility policy regarding dietary staff attire dated 10/2023 documents: 1. All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. On 8/6/25, at 8:50 a.m., Surveyor toured the kitchen. Surveyor observed the walk-in cooler with a thick buildup of ice along the ceiling, walls and floor of the freezer. There were boxes in the freezer had a buildup of ice. Surveyor did not walk in the freezer due to safety issues due to ice on the floor. Surveyor walked into the walk-in cooler and observed a bag of lettuce salad that was opened and dated. The date had faded off and made it unreadable. The lettuce was observed to look brown. On 8/6/25, at 11:00 a.m., Surveyor observed a fan mounted on the wall. The front covering of the fan was off and there was a buildup of red substance on the fan, making it appear dirty. The fan was above the food prep area. Surveyor observed a box fan, on a table facing a food prep area, that had the same buildup of red substance. The exhaust fan, above the stove, was thick with dust. Surveyor observed DS-LL, who had a mustache and beard, preparing food without a beard restraint in the kitchen. On 8/6/25, at 12:00 p.m., Surveyor observed DM-MM in the kitchen, assisting with meal prep. DM-MM has facial hair and did not have a beard restraint on. On 8/6/25, at 12:00 p.m., Surveyor interviewed DM-MM. Surveyor asked DM-MM, why did the walk-in freezer have a thick coating of ice all over. DM-MM stated about a month ago they got a new freezer and the company that installed the freezer place the temperature too cold and it froze everything. DM-MM also stated the freezer door wasn't closing well but maintenance fixed it. DM-MM stated he only orders three days' worth of freezer food items because of the state of the freezer. DM-MM stated Nursing Home Administrator (NHA)-A is aware of the state of the freezer. Surveyor explained to DM-MM observations made earlier in the day regarding the brown lettuce in the cooler, the fans and the exhaust fan. DM-MM stated daily, he usually will walk around and get rid of expired or old food items. DM-MM had no further explanation regarding the dirty appearing items. On 8/7/25, at 12:39 p.m., Surveyor interviewed NHA-A. Surveyor explained the concern of the walk-in freezer, old salad, dirty fans and exhaust fan and male staff without beard restraint. NHA-A stated he understood the concerns and stated the facility ordered plastic curtains for the freezer to prevent frost build up when the door opens. NHA-A had no additional information.		

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility did not ensure it completed accurate mandatory submission of staffing information based on payroll data in a uniform electronic format to the Centers for Medicare & Medicaid Services (CMS). This had the potential to affect 93 of 93 residents residing in the facility. Staffing information for Quarter 2 (January 1 - March 31) of the Payroll Based Journal (PBJ) was not accurately submitted to CMS triggering a one-star staffing rating for Quarter 2: January 1-March 31 of 2025. Findings include: Surveyor reviewed the PBJ Staffing Data Report, CASPER Report 1705D, for Fiscal year 2025 (run on 8/4/25) which indicated the Facility had a one-star staffing rating for the 2nd Quarter (January 1-March 31). The facility document titled Facility Assessment dated 06/20/2025, documents: Overall needs per shift daily (adjust as needed) under Ratio of staff to residents or #HPRD: Night shift: RN (Registered Nurse)-1, LPN (Licensed Practical Nurse)-1, CNA (Certified Nursing Assistant)-4. Evening shift: RN 1, LPN 3, CNA 7. Day shift: RN 1, LPN 3, CNA 7. The facility guideline document titled Nursing Service and Sufficient Staff dated 12/17/2024 and revised 02/05/2025 documents: Guideline: It is the guideline of the facility to provide sufficient staff with appropriate competencies and skill sets to assure Resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and individual plans of care. The facility census acuity and diagnosis of the resident population will be considered based on the facility assessment. 7. The facility is responsible for submitting timely and accurate staffing data through the CMS payroll-based journal (PBJ) System. Surveyor reviewed the Facility's schedules from January 1, 2025, to March 31, 2025. Surveyor noted licensed nurses and certified nursing assistants present on each shift, for each unit. Surveyor noted these schedules included call ins, agency staff and staff who picked up shifts. Surveyor noted that several night shifts during the second quarter were documented as having 3 CNAs and not 4 CNAs, which could have potentially triggered the one star staffing rating from CMS. On 08/12/2025, at 8:12 AM, Surveyor interviewed Scheduler-M on staffing for the facility. Scheduler-M informed Surveyor staffing was based on acuity and census and Corporate provided a staffing ladder and daily staffing letter. Scheduler-M informed Surveyor the facility's corporate structure informed the facility of the daily staffing allowance. Surveyor asked Scheduler-M what the minimum staffing level for each day for the direct care staff was. Scheduler-M informed Surveyor it is currently 10-16 licensed staff including unit managers and 18 certified nursing assistants (CNA). Scheduler-M informed Surveyor the current daily staffing is 10 CNAs on day shift, 4 CNAs on evening shift and 4 CNAs on the night shift. Scheduler-M informed Surveyor the facility has had Registered Nurse (RN) every day and tries to have one RN every shift as direct care staff. Surveyor asked if the Director of Nursing (DON) is counted as an RN for direct care. Scheduler-M informed Surveyor no the DON is not counted as a direct care staff. Surveyor asked Scheduler-M who in the facility reports the Payroll Based Journal (PBJ) data to the Center for Medicaid and Medicare Services (CMS). Scheduler-M informed Surveyor that Scheduler-M was not sure. On 08/12/2025, at 10:30 AM, Surveyor interviewed Director of Nursing (DON)-B about the facility staffing. DON-B informed Surveyor that minimum staffing level is 7 CNAs on the day and evening shifts and 4 CNAs on the night shift. DON-B informed Surveyor that currently staffing levels are being adjusted based on census and acuity in the facility. DON-B informed Surveyor corporate reports the staffing data to CMS for the CASPER report. Surveyor informed DON-B that several night shifts during the second quarter were documented as having 3 CNAs and not 4 CNAs which could have triggered the one star staffing rating from CMS for the second quarter. DON-B informed Surveyor the facility runs staffing based on census and acuity and that 4 is the desired staffing but not the minimum and that the facility was not short staffed at that time. Surveyor asked DON-B if DON-B felt the staffing data was reported incorrectly for the CASPER report that was submitted to CMS by the facility's corporate structure. DON-B informed (continued on next page)		

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor she reviewed staffing with Scheduler-M and that the reporting to CMS was inaccurate. On 08/12/2025, at 1:15 PM, Scheduler-M provided Surveyor with schedules that documented that in January and February of 2025, on the days in question by Surveyor, the facility had at least 4 CNAs during the night shift. On 08/13/2025, at 9:50 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding the facility triggering a one-star staffing rating from CMS for quarter two on the facility [NAME] reports from 1/1/25 through 3/31/25. NHA-A informed Surveyor that Corporate reports the PBJ data to CMS for the CASPER report. NHA-A informed Surveyor that NHA-A has been working on the staffing concerns with corporate and the report for the next quarter would document an accurate number of staff and address any reporting issues. No additional information was provided as to why the facility did not ensure that the accurate mandatory submission of staffing information based on payroll data in a uniform electronic format to the Centers for Medicare & Medicaid Services (CMS) was provided to CMS from 1/1/25 through 3/31/25.		

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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 observation, interview, and record review, the facility did not ensure a sanitary environment was maintained and the Enhanced Barrier Policy was implemented to help prevent the development and transmission of communicable diseases potentially affecting 93 of 93 residents. Enhanced Barrier Precautions (EBP) were not in place throughout the facility. Two of the six units provided signs and Personal Protective Equipment (PPE) for residents that required EBP; four of the six units did not implement EBP. *R3 was in Contact Isolation and observations were made of staff entering R3's room without putting on PPE. *R1's wound care was observed with no EBP in place and staff did not put on PPE when providing the wound treatment. *R16's wound care was observed with no EBP in place and staff did not put on PPE when providing the wound treatment. *R34's wound care was observed with no EBP in place and staff did not put on PPE when providing the wound treatment. *R27 had an indwelling urinary catheter with no EBP in place. *R24 had a gastrostomy tube with no EBP in place. Medication administration was observed using the gastrostomy tube and staff did not put on PPE. *R5 had an indwelling urinary catheter with no EBP in place and staff did not put on PPE when providing cares. *R53's wound care was observed with no EBP in place and staff did not put on PPE when providing the wound treatment. *The sink in the contaminated laundry area was not functional and no other sink or hand hygiene methods were available to staff to use after sorting contaminated laundry and removing PPE. Findings include: The facility policy and procedure titled "Enhanced Barrier Precautions" dated 2/5/2025 documents: "Guideline: It is the guideline of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. . . . Explanation and Compliance Guidelines: . . . 2. Initiation of Enhanced Barrier Precautions: . . . b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. (Peripheral IVs, continuous glucose monitors, insulin pumps, or ostomies without an associated indwelling medical device are not (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	an indication for EBP.) &hellip; 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. &hellip; 4. High-contact resident care activities include: a. Dressingb. Bathingc. Transferringd. Providing hygienee. Changing linensf. Changing briefs or assisting with toiletingg. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline cathetersh. Wound care: any skin opening requiring a dressing &hellip;10. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.&rdquo; In an interview on 8/11/2025 at 3:12 PM, Surveyor asked Director of Nursing (DON)-B what would denote a resident to be in EBP. DON-B stated residents that have multi-drug resistant organisms (MDROs) present would be placed in EBP. Surveyor requested the facility EBP policy and procedure. On 8/12/2025 at 3:04 PM at the daily exit, Surveyor shared with DON-B the concern the facility was not following their own policy on EBP. Surveyor shared that any resident in the facility that met the criteria for EBP should be placed in EBP. DON-B stated there are two residents in the facility that currently have MDROs. DON-B stated any resident that meets the criteria for EBP on the units where the residents with the MDROs reside are placed in EBP. DON-B stated residents on the other four units have not been placed on EBP because they are not in close proximity to the residents with MDROs. Surveyor shared with DON-B the concern that the residents that meet the criteria for EBP and are not in EBP could be cross contaminated because PPE is not being worn to protect and prevent infections. On 8/13/2025 at 8:17 AM, DON-B stated the EBP policy and procedure was reviewed extensively and are working on getting all the residents that meet the criteria for EBP carts with PPE and signs for their rooms in place. DON-B stated DON-B now understands the reasoning behind the EBP and will be working on carrying the protocol out. 1.) R3 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (a brain disorder characterized by changes in mental and cognitive function), diabetes, chronic obstructive pulmonary disease, dementia, depression, anxiety, and coronary artery disease. R3's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R3 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13. R3's Power of Attorney (POA) was activated. Surveyor noted R3 did not have any documentation of a multi-drug resistant organism (MDRO) on R3's diagnosis list. R3's Impaired Immunity Care Plan was created on 7/17/2025 and was placed on Contact Precautions (requiring anyone entering R3's room to put on a gown and gloves) for an MDRO. The Care Plan did not document what MDRO was present. On 8/6/2025, at 9:38 AM, Surveyor observed R3's doorway to have an isolation cart with a sign documenting Contact Precautions. Surveyor asked Licensed Practical Nurse (LPN)-G passing medications in the hallway why R3 was in Contact Precautions. LPN-G was unsure but thought maybe R3 had VRE (Vancomycin-Resistant Enterococci). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/6/2025, at 10:06 AM, Surveyor observed Activity Aide (AA)-P enter R3's room. AA-P did not put on a gown or gloves prior to entering R3's room. AA-P was in R3's room for approximately three minutes and then left the room. AA-P did not perform any hand hygiene after leaving R3's room. AA-P then entered another resident room and left the room pushing the resident in a wheelchair. In an interview on 8/6/2025, at 11:01 AM, Surveyor asked AA-P what the different precaution signs on resident isolation carts meant. AA-P stated AA-P did not know what the different signs meant. AA-P stated if there is a sign on the door, AA-P does not go in. AA-P stated AA-P was new to the facility so was not really sure what the different signs meant. On 8/6/2025, at 11:05 AM, Surveyor observed Certified Nursing Assistant (CNA)-O enter R3's room. CNA-O did not put on a gown or gloves prior to entering R3's room. CNA-O was in R3's room for approximately four minutes. CNA-O did not perform any hand hygiene after leaving R3's room. At 11:09 AM, Surveyor asked CNA-O if staff needed to wear any PPE when going into R3's room. CNA-O stated you do not have to put anything on unless you are doing personal cares. CNA-O picked up the Contact Precaution sign but did not read the directions of use. As Surveyor was talking to CNA-O, DON-B walked past and told CNA-O that the sign says what should be worn. CNA-O responded to DON-B, "That's what I said, right?" Surveyor noted the Contact Precaution sign documented a gown and gloves should be worn prior to entering R3's room, which CNA-O did not do. On 8/12/2025, at 10:49 AM, Surveyor shared with DON-B the observations of AA-P and CNA-O going into R3's room without wearing any PPE as documented on the Contact Precaution sign or performing hand hygiene upon leaving the resident rooms. 2.) R1 was admitted to the facility on [DATE] with diagnoses of malignant carcinoid tumor of the stomach, malignant neoplasm of the right kidney, and hyperparathyroidism. R1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R1 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R1 did not have an activated Power of Attorney. R1 was admitted with Stage 3 pressure injuries to the left upper buttock, the left lower buttock, the left upper posterior thigh, the left lower posterior thigh, and the left ischium, and Unstageable pressure injuries to the left outer ankle, the left second toe, the right heel, and the left trochanter. On 8/6/2025, at the time of survey, eight of R1's nine pressure injuries that were present on admission had healed. R1's Stage 4 pressure injury to the left trochanter had healed on 7/1/2025 and reopened on 7/8/2025. On 8/12/2025, at 8:53 AM, Surveyor observed Unit Manager (UM)-C, UM-D, and UM-E provide wound care to R1's left trochanter Stage 4 pressure injury. R1 did not have a sign for EBP or an isolation cart outside of the room. UM-C, UM-D, and UM-E did not put on a gown while providing wound care. Surveyor asked UM-E if staff should wear PPE when providing wound care. UM-E stated PPE is only needed for residents in EBP. Surveyor asked UM-E what the criteria is for someone to be on EBP. UM-E stated on the two units where residents are that have MDROs, any resident that has a tracheostomy, a wound, an indwelling urinary catheter, or anything else that would make them compromised would be in EBP. UM-E stated since there are not any residents with MDROs on R1's unit, R1 does not need to be in EBP. Surveyor noted staff were not following the EBP policy and procedure or standards of practice. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3.) R16 had a pressure injury to the coccyx. On 8/12/2025, at 8:41 AM, Surveyor observed UM-C, UM-D, and UM-E provide wound care to R16's coccyx pressure injury. R16 did not have a sign for EBP or an isolation cart outside of the room. UM-C, UM-D, and UM-E did not put on a gown while providing wound care. Surveyor asked UM-E if staff should wear PPE when providing wound care. UM-E stated PPE is only needed for residents in EBP. Surveyor asked UM-E what the criteria is for someone to be on EBP. UM-E stated on the two units where residents are that have MDROs, any resident that has a tracheostomy, a wound, an indwelling urinary catheter, or anything else that would make them compromised would be in EBP. UM-E stated since there are not any residents with MDROs on R16's unit, R16 does not need to be in EBP. Surveyor noted staff were not following the EBP policy and procedure or standards of practice. 4) R24 was admitted to the facility on [DATE] with diagnoses of Epileptic Seizures (brain has sudden, uncontrollable surge of electrical activity), Dysphagia (difficulty swallowing foods), Gastrostomy Status (artificial opening in stomach used for feeding). R24 currently has a legal guardian. R24's Quarterly Minimum Data Set (MDS) completed 6/23/25 documents R24 demonstrates severely impaired skills for daily decision making. R24's memory was not assessed. R24 is dependent for upper/lower dressing, showers/bathing, mobility, and transfers. R24 is always incontinent of bowel and bladder. R24 currently receives feeding tube. R24's active physician order effective 4/4/25 document; Infuse feeding via pump at 65ml(milliliter)/hr (hour) with 260cc (cubic centimes) of water every 4 hours Jevity 1.5. Surveyor notes that R24's comprehensive care plan and Kardex did not contain documentation instructing nursing staff to don personal protective equipment (PPE) when providing cares to R24 or that R24 should be in EBP. On 8/7/2025, at 11:12 AM, Surveyor observed R24's door to be open. Surveyor observed Licensed Practical Nurse (LPN)-II hanging a bottle of tube feeding. Surveyor observed LPN-II maneuvering the tubing in the area of R24's stomach. Surveyor observed LPN-II with no gloves or gown on. LPN-II informed Surveyor LPN-II is looking for the correct dressing to put on the tube feeding site because the last nurse did not put the correct one on. Surveyor observed LPN-II exited R24's room and did not perform hand hygiene. LPN-II entered back into R24's room with a new dressing. LPN-II put the dressing on the tube feeding site without wearing gloves or a gown. LPN-II went into R24's bathroom and washed LPN-II's hands before exiting R24's room. 5) R27 was admitted to the facility on [DATE] with diagnoses of Cerebral Palsy (congenital disorder of movement, muscle tone, or posture), Neuromuscular Dysfunction of Bladder (nerves controlling bladder and urinary sphincter are damaged and not working correctly), Paraplegia (paralysis of lower half of body). R27 is currently his own person. R27's quarterly minimum data set (MDS) completed 5/31/25 documents R27's brief interview for mental status (BIMS) score to be 13, indicating R27 is cognitively intact for daily decision making. R27's MDS documents R27 has range of motion impairment on one side of lower extremity. R27's MDS also documents R27 requires substantial/maximum assistance for upper dressing and is dependent for lower dressing. R27 is dependent for mobility and transfers. R27 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	requires substantial/maximum assistance for showers. R27 has an indwelling catheter and is always incontinent of bowel. R27's active physician order effective 11/22/24 document: Foley Catheter cares every shift and as needed. Surveyor notes R27's comprehensive care plan and Kardex did not contain documentation instructing nursing staff to don personal protective equipment (PPE) when providing cares to R27 or that R27 should be in EBP. On 8/11/2025, at 7:39 AM, Surveyor observed no sign on the door for EBP, and no PPE cart outside of R27's room. Surveyor observed Certified Nursing Assistant (CNA)-X come out of the R27's room. CNA-X informed Surveyor when asked that CNA-X had adjusted R27 in bed. Surveyor observed CNA-X was not wearing gloves or a gown. On 8/11/2025, at 7:49 AM, Surveyor observed Medication Technician (MT)-N give medications in applesauce to R27 and raise R27's bed. MT-N was not wearing gloves or gown at this time. On 8/11/2025, at 9:39 AM, Surveyor observed CNA-X and CNA-Y exit R27's room. CNA-Y had gloves on but no gown. CNA-X had no gloves or gown on. CNA-Y informed Surveyor both CNA-X and CNA-Y emptied the foley catheter bag and provided other incontinence cares for R27. CNA-Y informed Surveyor there was no alcohol wipes so they could not clean the foley catheter. CNA-Y also informed Surveyor they would know if R27 required EBP because there would be a sign on the door. 6) R34 was admitted to the facility on [DATE] with diagnoses of Myasthenia Gravis (muscles under voluntary control to feel weak). R34 is currently his own person. R34's admission Minimum Data Set (MDS) completed 7/22/25 documents R34's Brief Interview for Mental Status (BIMS) score to be 15, indicating R34 is cognitively intact for daily decision making. R34 requires partial/moderate assistance for upper dressing and substantial/maximum assistance for transfers. R34 is dependent for lower dressing and mobility. R34 is at risk for developing a pressure ulcer and currently has one venous and arterial ulcer. R34's active physician order effective 7/23/25 document: Left Lower Extremity: cleanse with normal saline. Foam border Xeroform to wound beds foam border, Ultra Boot with zinc gauze foam border, cotton patting foam border Coban wrap. Change Monday, Wednesday, Friday and as needed for wound care. Surveyor notes that R34's comprehensive care plan and Kardex did not contain documentation instructing nursing staff to don personal protective equipment (PPE) when providing cares to R34 or that R34 should be in EBP. On 8/11/2025, at 1:55 PM, Surveyor observed R34's treatment to R34's outer leg. Unit Manager (UM)-C and (UM)-E completed the treatment. Surveyor observed UM-C did not wear gloves when cutting the foam border with scissors. During the treatment, UM-C put gloves on, but upon exiting the room for more supplies, UM-C did not perform hand hygiene. UM-C and UM-E did not wear a gown during the treatment process. On 8/11/2025, at 3:20 PM, Director of Nursing (DON)-B informed Surveyor EBP as only being for a (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident that is Multidrug-Resistant Organism (MDRO), Vancomycin-Resistant Enterocci, and Carbapenem-Resistant Enterobacteriaceae. On 8/12/2025, at 1:32 PM, Surveyor interviewed UM-E regarding EBP. UM-E stated two Residents on Unit 5 and 6 have a MDRO. Other residents on Unit 4 have wounds, tube feeding, and foley catheters do not need EBP because they are not within the vicinity of the two residents with a MDROs. UM-E stated Centers for Disease Control and Prevention (CDC) is always changing EBPs. UM-E stated typically, anyone providing cares with an Intravenous Therapy, Foley Catheter, Tube Feeding should have PPE for EBPs but UM-E explained the Residents on Unit 4 do not require PPE because they are not in the vicinity of the two residents on Unit 5 and 6. UM-E stated the facility determined housekeeping should gown up when cleaning the rooms. UM-E provided Surveyor with a sign that reads:EBPEveryone Must:Clean their hands, including before entering and when leaving the room.Providers and Staff Must Also:Wear gloves and a gown for the following High-Contact Resident Care Activities.DressingBathing/ShoweringTransferringChanging LinensProviding HygieneChanging briefs or assisting with toiletingDevice care or use:Central line, urinary catheter, feeding tube, tracheostomyWound Care: any skin opening requiring a dressing On 8/12/2025, at 3:17 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and DON-B the concern R24, R27, and R34 by CDC recommendations should have been in EBP. The facility provided no further information at this time as to why R24, R27, and R34 were not in EBP during the survey process. 8) R5 was admitted to the facility on [DATE]. R5's Electronic Medical Record (EMR) documents R5 having a urinary catheter in place. On 8/7/25, at 1:23 PM, Surveyor observed no sign or indication of R5 being placed in Enhanced Barrier Precaution (EBP). Surveyor knocked on R5's room. R5 responded for Surveyor to enter R5's room. Surveyor observed a staff member with no gown or gloves in R5's room. On 8/11/25, at 8:21 AM, Surveyor observed no indication for R5 having EBP. Surveyor observed no EBP sign or a supply cart with gown and gloves outside R5's room. On 8/12/25, at 2:28 PM, Surveyor observed no indication for R5 having EBP. Surveyor observed no EBP sign or a supply cart with gown and gloves outside R5's room. On 8/13/25, at 9:01 AM, Surveyor interviewed Concierge Coordinator (CC)-K who entered R5's room without donning a gown or gloves for the interview. Surveyor observed no EBP sign or a supply cart with gown and gloves outside R5's room. On 8/13/25, at 10:35 AM, Surveyor notified Director of Nursing (DON)-B of concerns with R5 having a urinary catheter in place throughout the survey, with no EBP in place for R5 throughout the survey. DON-B acknowledged these concerns and indicates the facility is currently making changes with their EBP practice and will be putting residents with urinary catheters in EBP, however, the facility does not have enough supplies at this time and has ordered supplies. DON-B indicates, once the facility receives the EBP supplies, the facility will be putting R5 and all residents who have a urinary catheter, in EBP. 7) R53 was admitted to the facility on [DATE] with diagnosis that include Chronic Obstructive (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Pulmonary (lung) disease, Heart failure, Stage 2 kidney disease, and Metastatic melanoma (skin cancer) progressing to metastatic lung cancer. R53's Annual Minimum Data Set (MDS) assessment dated [DATE] documents R53 is moderately cognitively impaired. R53 has a guardian. R53 is on hospice which was started in June of 2023. Surveyor reviewed R53's medical record and noted R53 developed a Suspected Deep Tissue Injury (DTI) on 7/22/25. R53's MD order dated 8/5/25 documents: DTI to lower mid spine: Cleanse with 1/4 strength Dakins, skin prep to surrounding area, apply calcium alginate, [followed by] border foam dressing daily. Surveyor reviewed R53's MD orders, Comprehensive Care Plan and Certified Nursing Assistant Kardex. Surveyor noted R53's medical record did not contain documentation instructing nursing staff to put on personal protective equipment (PPE) when providing cares to R53. On 8/7/25, at 10:39 AM, Surveyor observed R53's room. Surveyor noted R53's door does not have a sign indicating Enhanced Barrier Precaution (EBP) for R53 and PPE is not visualized outside of R53's room. On 8/11/25, at 12:59 PM, Surveyor observed R53's room. Surveyor noted R53's door does not have a sign indicating EBP for R53 and PPE is not visualized outside of R53's room. On 8/12/25, at 10:06 AM, Surveyor observed R53's room. Surveyor noted R53's door does not have a sign indicating EBP for R53 and PPE is not visualized outside of R53's room. Surveyor entered R53's room to observe wound rounds with Unit Manager (UM)-D. R53 was observed sitting in R53's electric wheelchair and leaning forward. After washing hands and donning gloves, UM-D removed the old dressing and completed R53's wound care treatment. While observing R53's wound care treatment, UM-D and one other staff member assisting, did not wear a gown. Surveyor asked UM-D if UM-D needed to wear a gown while completing wound care. UM-D stated no. On 8/12/25 at 3:05 PM, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the concern that EBP precautions were not followed and gowns were not worn while staff completed wound care on R53. 9) The only sink in the laundry department located in the contaminated laundry sorting room was not functional for 1-2 weeks with no other sink or hand hygiene methods available to staff to use after sorting contaminated laundry and removing personal protective equipment (PPE). The Facility's policy document titled; "Laundry" dated 05/29/2024 documents: Policy: The facility launders linens and clothing in accordance with CDC (Centers for Disease Control and Prevention) guidelines to prevent transmission of pathogens. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Definitions: &ldquo;Contaminated&rdquo; refers to laundry which has been soiled with blood/body fluids or other potentially infectious materials or may contain sharps. Policy explanation and compliance guidelines: 1. Aligning with principles of standard precautions, staff shall consider all previously worn clothing as contaminated. 2. The facility&rsquo;s laundry area will provide readily available hand washing facilities and products as well as adequate PPE. On 08/11/2025, at 12:42 PM, Surveyor was given a tour of the laundry process by Housekeeping Manager (HM)-T and Laundry Staff (LS)-U. Surveyor asked HM-T to explain the laundry process. HM-T informed Surveyor the dirty linens and clothing come down the laundry chute in bags (Surveyor observed laundry in hamper below chute in bags). HM-T stated the laundry staff separate personal items from the facility dirty linens and place them in these hampers for transport through the door to the washer. Surveyor asked HM-T if the sink in the dirty sorting room was the only sink and means of hand hygiene in the department. HM-T informed Surveyor staff do not use the sink in the dirty chute room because there is no water to the sink, and it has been down a week or two and it is the only sink in the department. Surveyor asked HM-T how staff performs hand hygiene after handling contaminated linen with urine and feces before placing and removing their personal protective equipment (PPE). HM-T informed Surveyor we don't use this sink that often, but staff mostly used the employee break room across the hall to wash their hands. Surveyor asked HM-T to clarify that the staff must leave the dirty area and the department to perform hand hygiene after handling soiled facility laundry. HM-T informed Surveyor HM-T knew it is not ideal to walk across the hall to the employee break room and staff probably should not do it that way. HM-T informed Surveyor HM-T does make sure staff remove PPE before staff crosses over the hall to the employee break room to perform hand hygiene. Surveyor asked LS-U to demonstrate how the process of dirty laundry to clean works and the use and removal of PPE was performed by staff. LS-U informed Surveyor gown and gloves and sometimes a mask are put on before staff go into the dirty laundry chute room. LS-U informed Surveyor LS-U brings the dirty clothes out of the dirty laundry room in the sorting hampers into the washer room and laundry is placed in different washers based on the settings listed on the wall. LS-U informed Surveyor the gown is then removed placed in the washer and then staff walk back to the dirty chute room to throw the gloves away because the trash container in the washer room is too close to the clean dryers. LS-U informed Surveyor LS-U walks back to the department exit door. LS-U informed Surveyor staff then walk across the hall to the employee breakroom and wash their hands in the sink. LS-U informed Surveyor LS-U does make sure LS-U&rsquo;s gown goes into the washer before going out the door to wash hands in the employee break room. (Surveyor noted no hand sanitizing gel anywhere in department). Surveyor asked HM-T if the broken sink had been reported to maintenance. HM-T informed Surveyor HM-T reported it last week. On 08/11/2025, at 1:07 PM, Surveyor interviewed Maintenance Director (MD)-F. Surveyor asked MD-F (continued on next page)		

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	if maintenance was aware of the broken sink in the dirty laundry room. MD-F informed Surveyor they were not informed until the end of last week. MD-F informed Surveyor it was scheduled to fixed by the end of this week. On 08/13/2025, at 9:50 AM, Surveyor informed Nursing Home Administrator (NHA)-A about Surveyor's concerns with the broken sink in the laundry area causing staff to leave the contaminated room to wash hands in the employee break room across the hall. Surveyor informed NHA-A no other hand hygiene methods were available to the staff according to the HM-T. Surveyor asked NHA-A if leaving a dirty room to go to the employee break room was an infection control concern. NHA informed Surveyor that "yes"; that was a problem with infection control. NHA-A informed Surveyor MD-F informed NHA-A the laundry sink is fixed now, and proper hand washing was discussed with the staff.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not maintain an effective pest control program to address the flies in the facility. *R15 and R16 informed Surveyor that the facility has a problem with flies and R15 uses items in the room to &lsquo;swat&rsquo; at the flies. *Surveyor observed a fly flying around R34&rsquo;s room during observation of a treatment to the right leg on 8/11/25. *Flies were observed around R8 at mealtime during the survey process and R10 informed Surveyor that R10 had killed 18 flies in 3 days. *R29 complained of so many flies they had to purchase fly strips to catch the flies in their room. *R8, R35, R49, and R78 informed Surveyor at resident council on 8/11/25 the concern of numerous flies throughout the facility. *Surveyors observed flies in resident unit hallways, the common dining room for residents, the conference room and in a resident's bathroom. *During the tour of the kitchen, several flies were observed. *The facility did not have a pest control company to service the facility for the months of May, June, and February 2025 and July of 2024. This deficient practice has the potential to affect all 93 of 93 Residents residing in the facility at the time of the survey. Findings include: Surveyor reviewed the facility's Pest Control Program implemented 4/2/25 which documents: . Guideline: It is the guideline of this facility to maintain and effective pest control program that eradicates and contains common household pests and rodents. &hellip; Explanation and Compliance Guidelines: 1. 1. Facility will maintain a written agreement with a qualified outside pest service to provide comprehensive pest control services on a regular and scheduled basis. 2. 2. Facility will ensure the appropriate chemicals are used to control pests but can be used safely inside the building without compromising Resident health. 3. 3. Facility will maintain a report system of issues that may arise in between scheduled visits with (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the outside pest service and treat as indicated. 4. 4. Facility will utilize a variety of methods in controlling certain seasonal pests, i.e. Flies. These will include indoor and outdoor methods that are deemed appropriate by the outside service and state and federal regulations. 5. 5. Facility will ensure that the outside pest service also treats the exterior perimeter of the facility and any outlying buildings or structures, i.e. dumpster area. 1 1) Surveyor observed flies in R15 and R16's shared room. R15 was admitted to the facility on [DATE] with diagnoses of Rhabdomyolysis (skeletal muscle breaks down rapidly). R15 is currently her own person. R15's admission Minimum Data Set (MDS) completed 6/30/25 documents R15's Brief Interview for Mental Status (BIMS) score to be 12, indicating R15 demonstrates moderately impaired skills for daily decision making. 2) R16 was admitted to the facility on [DATE] with diagnoses of Cerebral Palsy (congenital disorder of movement, muscle tone, or posture), Spastic Hemiplegia Affecting Unspecified Side (one side of body experiences muscle stiffness and weakness), and Insomnia (sleep disorder characterized by difficulty falling asleep). R16 is currently her own person. R16's admission Minimum Data Set (MDS) completed 7/14/25 documents R16's Brief Interview for Mental Status (BIMS) score to be 13, indicating R16 is cognitively intact for daily decision making On 8/6/2025, at 11:49 AM, R16 informed Surveyor there is a problem with flies in the room. R16 stated the flies land on the walls, sit on the chains hanging from the ceiling. R16 stated other people have complained. R16 stated R16 and R15 eat their meals in the room, and the flies landing on the food. R16 informed Surveyor the flies have bit R16. On 8/6/2025, at 11:55 AM, R15 informed Surveyor R15 got bit by a fly on the ear. "I have to use my underwear to kill the flies"; On 8/6/2025, at 12:10 PM, Surveyor observed a fly on R16's bed and another fly at the end of the bed on the air mattress component. On 8/7/2025, at 11:07 AM, Surveyor observed a fly flying and landing on R16's bed. On 8/7/2025, at 12:43 PM, Surveyor observed 2 flies flying around R15 and R16's room. R15 stated R15 is using a washcloth to swat at the flies. 3) R34 was admitted to the facility on [DATE] with diagnoses of Myasthenia Gravis muscles under voluntary control to feel weak), Depression (mood disorder that causes persistent feelings of sadness and loss of interest). R34 is currently his own person. R34's admission Minimum Data Set (MDS) completed 7/22/25 documents R34's Brief Interview for Mental Status (BIMS) score to be 15, indicating R34 is cognitively intact for daily decision making. (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/11/2025, at 1:55 PM, Surveyor observed R34's treatment being completed to R34's right leg. Unit Manager (UM)-C and Unit Manager (UM)-E completed the treatment with Licensed Practical Nurse (LPN)-R coming in and out of the room with supplies. During the observation of the treatment being completed, a fly landed on Surveyor. LPN-R confirmed there is a fly flying around and LPN-R swatted at the fly. On 8/13/2025, at 10:16 AM, Surveyor observed R34's windows. The window on the right was open with a cobweb hanging from it. Surveyor observed two dead flies hanging from it. On 8/13/2025, at 10:44 AM, Surveyor had Housekeeping Supervisor (HS)-T observe R34's window. HS-T confirmed there is a cobweb with 2 flies hanging from R34's slightly open window. On 8/06/2025, at 8:20 AM, Surveyor observed a fly upon entrance into the facility. On 8/6/2025, at 10:16 AM, Surveyor observed a fly flying around the 4 unit in the hallway. Surveyor had a fly land on Surveyor's computer in the hallway while touring the 4 unit. On 8/7/2025, at 8:59 AM, Surveyor observed a fly flying around the nurse's station by unit 4. On 8/7/2025, at 12:49 PM, Surveyor observed a fly flying around room [ROOM NUMBER] and in the hallway of unit 4, and Surveyor observed a fly walking around on the floor. On 8/7/2025, at 2:27 PM, Surveyor observed a fly in the conference room. On 8/11/2025, at 7:59 AM, Surveyor interviewed Maintenance Director (MD)-F regarding the facility pest control. MD-F stated MD-F has not been notified of any fly issues. MD-F informed Surveyor pest control comes in 1 time a month and the facility has some UV lights in hallways with sticky pads and those are changed as needed. MD-F has not been informed of a fly issue in the kitchen. MD-F stated, "there is a fly problem yearly, it is normal". Surveyor requested to view the logs of the monthly pest control visits. On 8/11/2025, at 8:49 AM, Surveyor reviewed the pest control monthly visits and notes there were no pest control visits for July of 2024 or February, May, and June 2025. On 8/11/2025, at 3:20 PM, Surveyor shared the concern with numerous flies throughout the facility with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. Surveyor pointed out the fly in the conference room at the time of exit meeting. No further information was provided by the facility at this time. On 8/12/2025, at 11:16 AM, Surveyor observed Certified Nursing Assistant (CNA)-HH at the nurse's station close to 4 unit with a fly swatter and is swatting at a fly. On 8/13/2025, at 11:18 AM, NHA-A informed Survey pest control comes to the facility monthly, but that pest control has been called to treat for flies. NHA-A also stated blue lights to attract pests were hung yesterday and the facility has ordered five extras to place around the facility. 4) R10 was admitted to the facility on [DATE]. (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R10's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents R10 is cognitively intact. On 8/6/25 at 9:50 AM, R10 informed Surveyor the facility has a problem with flies. R10 stated last week, R10 had killed 18 flies in 3 days. R10 stated R10's shared bathroom frequently has an increase of flies. Surveyor noted 2 flies in R10's room. Surveyor was swatting at a fly during interview. 5) R8 was admitted to the facility on [DATE]. On 8/6/25 at 1:07 PM, Surveyor observed R8 in the common dining area with R8's lunch tray. Surveyor observed a fly, flying around R8's table and observed the fly landing on R8's food. R8 used R8's hand to wave the fly away. At a different table, Surveyor observed 3 residents sitting together. A resident complained that a fly keeps landing on their drink. *) R29 was admitted to the facility on [DATE]. R29's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents R29 is cognitively intact. On 8/6/25, at 3:23 PM, R29 informed Surveyor the facility has a problem with flies. R29 stated that R29's room is close to an exit door which makes it worse. R29 stated R29 bought fly strips online because the flies are everywhere. 6) On 8/6/25 at 12:38 PM, Surveyor noted multiple flies while walking the 200-unit hallway. Surveyor observed a fly landing on Surveyors computer and another fly, flying around Surveyors head. On 8/6/25 at 1:05 PM, Surveyor noted multiple flies while walking the 100-unit hallway. Surveyor counted 3 flies. On 8/7/25 at 11:13 AM, Surveyor was in the 100-unit hallway when a fly landed on Surveyor's hair. *During Resident Council meeting held on 08/11/2025, at 10:30 AM, R8, R35, R49 and R78 informed Surveyor pf the resident's concerns about a large number of flies in the facility. Surveyor asked the resident council members present if the members had any concerns about the cleanliness of the facility. 7) R78 informed Surveyor there were so many fruit flies when R78 was first admitted to the facility. R78 informed Surveyor the flies were so bad because they were everywhere, and it made it uncomfortable for R78 in her room. R78 informed Surveyor "I had to get my own ZEVO (a blue light sticky trap)" because the facility wouldn't do anything about the flies. R78 informed Surveyor staff told R78 the flies were from the previous person in the room. R78 informed Surveyor R78 had fruit flies fill R78's ZEVO trap daily when R78 first started using the ZEVO. R78 informed Surveyor the fruit flies have decreased substantially in her room but R78 still sees a lot of big flies in the dining room. R78 informed Surveyor R78 gets big flies in R78's room if the door is left open. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8) R8 informed Surveyor R8 has flies in R8's room daily. R8 informed Surveyor R8 needs a fly swatter every day. R8 informed Surveyor R8 sees big flies in the dining room daily. 9) R35 informed Surveyor the R35 still has little flies and big flies daily in R35's room, the flies never go away. R35 informed Surveyor there are always flies in the dining room. 10) R49 informed Surveyor the R49 sees sewer flies all over. R49 informed Surveyor R49 knows they are sewer flies because R49 came from an apartment with sewer flies. R49 informed Surveyor R49 had a lot of sewer flies at the apartment and a lot of sewer flies at the facility currently. R49 informed Surveyor there are a lot of flies in the dining room. During the entire survey the survey team observed flies through-out the facility and in the dining room. On 08/13/2025, at 9:50 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A about Surveyor's concerns with the large number of flies in the building reported by members of the resident council. NHA-A informed Surveyor that NHA-A already has a vendor working on getting rid of the flies and are placing traps today for the flies. NHA-A stated the vendor is placing blue light nonchemical traps in several places through-out facility. NHA-A informed Surveyor the facility is committed to getting the fly problem under control. Surveyor observed a blue light trap being placed in the dining room after leaving NHA-A's office. 11) On 8/6/25 at 11:00 a.m. Surveyor was observing meal preparation in the kitchen. There were a few flies in the kitchen. Flies were flying around the food. Dietary staff were covering food to prevent flies from landing on it. On 8/7/25, at 12:39 p.m., Surveyor interviewed Nursing Home Administrator (NHA)-A regarding the flies. Surveyor explained to NHA-A the observation made on 8/6/25, in the kitchen, regarding flies. NHA-A stated he understood the concern and had no additional information.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure residents were free from physical abuse for 1 (R59) of 5 residents reviewed for abuse. This has the potential to affect all residents who resided on the unit where R59 lives from 7/2/25 through 7/9/25 when CNA-FF continued working and had access to facility residents after an allegation of abuse.*R59 informed Surveyor that CNA-FF was rough with a transfer on 7/2/25, had been rough with cares in the past and that CNA-FF was bossy and made R59 feel intimidated. On 7/2/25, R59 informed 3 different facility staff members that CNA-FF was rough with R59. This allegation of abuse was not reported to the Nursing Home Administrator (NHA)-A per the facility abuse policy. After the allegation of abuse, CNA-FF continued working at the facility from 7/2/25 through 7/9/25. During that time, CNA-FF was scheduled to work multiple times on R59's unit. Findings include: The facility policy, with a last reviewed/revised date of 7/1/25, titled Abuse, Neglect and Exploitation documents, in part: It is the guideline of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The facility has a zero-tolerance stance around founded abuse, neglect, exploitation and misappropriation of resident property. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigation include: Identifying staff responsible for the investigation. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations: Focusing the investigation on determining if abuse, neglect exploitation, and/or mistreatment has occurred, the extent, and cause: and providing complete and thorough documentation of the investigation. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after investigation. Examples include but are not limited to: Responding immediately to protect the alleged victim and integrity of the investigation-This should include staying with the alleged perpetrator to ensure no further contact (verbal or physical) until removal from the facility/environment. Increased supervision of the alleged victim and residents, Room or staffing changes, if necessary, to protect the resident from the alleged perpetrator. Reporting/Response: . Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes. It is important staff feel comfortable to report all concerns by assuring that reporters are free from retaliation or reprisal. R59 was admitted to the facility on [DATE] with diagnosis that includes Cerebral Palsy. R59's Medicare 5-day Minimum Data Set (MDS) assessment dated [DATE] documents that R59 is cognitively intact. R59 uses a wheelchair and is dependent for transfers. On 8/7/25 at 8:48 AM, Surveyor interviewed R59. R59 informed Surveyor that a few weeks ago, R59's CNA, CNA-L, needed help getting R59 into the wheelchair. CNA-L went to get help from CNA-FF. Both CNA-L and CNA-FF returned to R59's room. R59 stated that during the transfer, CNA-FF was really, really rough. R59 stated that when R59 was put in R59's wheelchair, R59's feet got caught in some plastic on the wheelchair footrests. While CNA-L was trying to gently guide R59's feet, CNA-FF yanked the chair back hard. R59 stated that the yanking did not cause R59's skin to break but stated that the action really hurt. R59 stated that on other occasions, CNA-FF had been very rough with cares and was bossy and intimidating. Surveyor asked if R59 told anyone about what happened. R59 stated that R59 told CNA-L, a nurse and R59's Occupational Therapist (OT)-GG. R59 stated that OT-GG helped R59 fill out a grievance form. R59 stated that after R59 informed staff about the concern, CNA-FF came back to R59's room and started apologizing. R59 stated that R59 thinks that administration told the staff member of R59's concern and that is why CNA-FF returned to R59's (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room. R59 stated that R59 felt intimidated. Surveyor reviewed the grievance log for the last 6 months and noted that there was no grievance logged about CNA-FF being rough with R59. Surveyor reviewed the Facility Reported Incident folders for the last 6 months and noted that there were no incidents documented about CNA-FF being rough with R59. On 8/7/25 at 9:01 AM, Surveyor interviewed CNA-L. Surveyor asked about the incident with CNA-FF. CNA-L stated that R59 is very sore when R59 wakes up in the AM. CNA-L stated that CNA-L works slower with R59 because of that. CNA-L stated that CNA-FF was helping get R59 into R59's wheelchair via the Hoyer lift. CNA-L indicated that CNA-FF yanked R59 from behind and caused R59 to start yelling about R59's feet. CNA-L indicated that CNA-L could not believe how CNA-FF was treating R59. CNA-L stated that CNA-L felt like CNA-FF was rough with R59 and many other residents during cares and transfers. CNA-L stated that other residents had complained about CNA-FF. Surveyor asked what residents complained. CNA-L indicated that CNA-L cannot recall specific names, but the residents are no longer at the facility. Surveyor asked when CNA-L last saw CNA-FF working at the facility. CNA-L stated that CNA-L had not seen CNA-FF in a while. Surveyor asked if CNA-L told anyone about the incident. CNA-L stated that it is a hard position to be in CNA-L was not sure what to do. CNA-L indicated that R59 told the Social Worker. Surveyor noted that CNA-L had concerns about CNA-FF being rough with R59 on 7/2/25 and other residents previously and did not report this allegation of abuse to NHA-A per facility protocol. On 8/7/25 at 10:40 AM, Surveyor interviewed OT-GG. Surveyor asked if OT-GG recalled a time that R59 reported a CNA being rough. OT-GG stated that a few weeks ago, R59 reported to OT-GG that CNA-FF was rough during cares and a transfer. OT-GG stated that CNA-FF can be rough. OT-GG stated that R59 told OT-GG that CNA-FF pulled too hard during a transfer and hurt R59. R59 asked OT-GG for help writing a grievance. OT-GG indicated that OT-GG told R59 that they could write it out and contact the Social Worker. Surveyor asked who OT-GG gave the grievance form to. OT-GG indicated that OT-GG would normally give it to the Unit Manager or the Social Worker, but OT-GG is not sure who OT-GG gave the form to. On 8/7/25 at 1:10 PM, Surveyor returned to OT-GG and asked about the grievance form. OT-GG stated that OT-GG thinks that OT-GG helped R59 fill out the grievance form because R59 has such a hard time writing. OT-GG unsure where it ended up. OT-GG stated that OT-GG usually takes copies of everything. OT-GG began looking in office. After looking, OT-GG stated that OT-GG could not find the form and thinks maybe R59 handed it in. OT-GG stated that Surveyor should check with Unit Manager (UM)-D. OT-GG stated that a lot of times, the Unit Managers will address the concern with the resident and then feel like that concern is complete and maybe that is the case with this, but OT-GG was not sure. Surveyor noted OT-GG was told by R59 on 7/2/25 that CNA-FF was rough with cares and transfers and did not report this allegation of abuse NHA-A per facility policy. On 8/7/25 at 10:58 AM, Surveyor interviewed UM-D. Surveyor asked if UM-D had received a grievance from R59 or heard about a concern that R59 had about a CNA staff member. UM-D stated that about a month ago, CNA-L and CNA-FF were transferring R59 and R59 was upset with the transfer. UM-D stated that CNA-FF did not push where R59 prefers to be pushed when completing a transfer. UM-D stated that there was not a formal grievance placed. UM-D stated that UM-D took CNA-FF back to R59's room after asking R59's permission. UM-D stated that they all talked, and everything was ok after that. UM-D stated that CNA-FF even took care of R59 after that incident. Surveyor asked if any other residents had concerns about CNA-FF cares. UM-D stated no. UM-D indicated that residents like CNA-FF. Surveyor asked if UM-D received a filled-out grievance form from OT-GG or from R59. UM-D stated that R59 did not want to do a grievance and UM-D did not receive a grievance from OT-GG. On 8/7/25 at 11:09 AM, Surveyor interviewed Social Worker (SW)-I. Surveyor asked if R59 or any other staff member reported a grievance for R59. SW-I stated that SW-J is R59's social worker. SW-I indicated that SW-I had not heard of any grievance for R59 but SW-J would be back to work next week and could address this with Surveyor. On 8/7/25 at 11:20 AM, Surveyor interviewed NHA-A. Surveyor asked what the expectation is if a staff member is told by a resident that another staff member was rough and hurt them. NHA-A stated that they should follow the abuse policy and report it (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to me. Surveyor asked if NHA-A was informed about a CNA being rough with R59. NHA-A stated that NHA-A did not recall the incident of the top of NHA-A's head. Surveyor asked if CNA-FF continues to be employed by the facility. NHA-A stated that NHA-A did not recall the name but stated that NHA-A would get back to Surveyor. On 8/7/25 at 12:22 PM, NHA-A provided Surveyor with a note completed and signed by UM-D regarding the incident. NHA-A stated that there is no documentation of the event aside from this note given to Surveyor. The undated word document signed by UM-D documents: CNA came to get writer regarding resident [R59] and a transfer that happened. [R59] stated that CNA-L and CNA-FF were transferring [R59] and pushed on [R59's] leg when the transfer occurred. Writer asked [R59] to show [UM-D] where they pushed on [R59's] leg. [R59] stated [R59] was fine now just during the transfer it hurt. [R59] has chronic discomfort with transfers due to [R59's] cerebral palsy and leg pain in which [R59] is on pain medication for. [R59] stated [R59] has never had issues with [CNA-FF or CNA-L] but the transfer felt different today. Writer asked if [writer] could bring [CNA-FF] in to speak with us. [R59] agreed. [CNA-FF] apologized that [R59] experienced pain with the transfer. [R59] stated that [R59] understood that it was not done purposeful just wants everyone to be very careful when putting [R59] from Hoyer into chair due to the pain. Writer watched a transfer with staff and saw no issues. Staff is aware of not pushing on residents' leg to position [R59] into the chair. On 8/7/25 at 1:08 PM, Surveyor returned to UM-D and asked when UM-D signed the note regarding CNA-FF and R59. UM-D indicated that the transfer occurred on 7/2/25 and that is when the note was signed. On 8/7/25 at 1:45 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-G who was the nurse working on R59's unit on 7/2/25. Surveyor asked if R59 talked to LPN-G about another staff member. LPN-G stated that R59 informed LPN-G that CNA-FF was rough with cares and R59 does not like having CNA-FF as an aide and did not want CNA-FF as R59's aide. Surveyor asked if LPN-G informed anyone about R59's concerns. LPN-G stated that LPN-G told the Unit Manager. Surveyor asked if any documentation was completed after being told that by R59. LPN-G stated that LPN-G was not sure but stated that residents/staff usually have to fill out a grievance or incident report when something like that happens. Surveyor noted that on 7/2/25, a third staff member was told by R59 about CNA-FF being rough and this allegation of abuse was not reported to NHA-A per facility policy. On 8/7/25 at 3:34 PM, Surveyor informed NHA-A of the concern that 3 staff members were told by R59 that CNA-FF was rough. This allegation of abuse was not communicated to NHA-A. NHA-A stated again that the incident was more of a resident preference with transferring and that UM-D educated, watched a transfer and after asking R59 if CNA-FF could come back to R59, UM-D took CNA-FF to R59, and CNA-FF apologized. Surveyor asked what NHA-A expects if a resident reported a staff member was rough with cares. NHA-A stated that NHA-A would expect the staff member/Unit manager to follow up with NHA-A. NHA-A continued and stated that NHA-A would then try to understand what rough with cares means from the resident. Surveyor asked if NHA-A had spoken to R59. NHA-A stated that NHA-A had not spoken to R59 about this incident. On 8/11/25 at 8:53 AM, Surveyor interviewed SW-J who is R59's social worker. Surveyor asked if SW-J received a grievance from R59 on 7/2/25. SW-J stated that there is no grievance for that. Surveyor asked if SW-J had heard from R59 or another staff member that a CNA was rough. SW-J stated that SW-J never heard from any staff about another staff member being rough with R59. Surveyor asked what the protocol is if a resident reports that a staff member was rough. SW-J stated that SW-J would report that to the unit manager. Surveyor noted that SW-J told Surveyor that SW-J would tell the unit manager of a resident's report of a staff member being rough instead of the NHA-A per facility policy. On 8/7/25 at 10:43 AM, Surveyor interviewed CNA-S. Surveyor asked what CNA-S would do if a resident reported that a different staff member was rough with cares or a transfer. CNA-S stated that CNA-S would report that to a manager right away so they can start investigating. Surveyor noted that CNA-S told Surveyor that CNA-S would tell the unit manager of a resident's report of a staff member being rough instead of the NHA-A per facility policy. On 8/7/25 at 10:36 AM, Surveyor interviewed Nurse Technician (NT)-BB. Surveyor asked what NT-BB would do if a resident reported that a (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	different staff member was rough with cares or a transfer. NT-BB stated that NT-BB would report it right away. NT-BB stated that NT-BB would tell the Administrator, Director of Nursing (DON)-B, and the Charge nurse. NT-BB would then fill out an incident report. On 8/11/24 at 3:31 PM, Surveyor asked NHA-A when CNA-FF's last day of employment was at the facility. NHA-A stated that it was sometime around July 3rd. Surveyor asked why CNA-FF no longer works at the facility. NHA-A stated that CNA-FF was contracted through an agency and CNA-FF's contract had ended. Surveyor reviewed CNA-FF's punch card details for the month of July. Surveyor noted CNA-FF continued to work after the incident with R59 on 7/2/25. Surveyor noted that the last day CNA-FF worked at the facility was 7/9/25. Surveyor reviewed the facility staffing schedule and CNA-FF's punch card details from 7/2/25 through 7/9/25. The facility has a total of 6 units labeled one through 6. R59 is located on unit 1 of the facility. Surveyor noted the following schedule for CNA-FF: 7/2/25, CNA-FF worked from midnight until 6:30 AM, 6:45 until 2:30 PM and then returned at 10:15 PM to work the night shift. CNA-FF was on the staffing schedule to work on unit 1 (R59's unit) and 2 for both shifts. 7/3/25, CNA-FF worked from midnight until 6:31 AM and then returned at 10:06 PM to work the night shift. CNA-FF was on the staffing schedule to work on unit 1 (R59's unit) and 2 from midnight until 6:31 AM and was on the staffing schedule to work on units 3 and 4 when returning at 10:06 PM. 7/4/25, CNA-FF worked from midnight until 6 AM and from 6:15 AM until 2:30 PM. CNA-FF was on the staffing schedule to work on units 3 and 4. 7/5/25, CNA-FF worked from 6:32 AM until 10:32 PM. CNA-FF was on the staffing schedule to work on units 1 (R59's unit) and 2. 7/6/25, CNA-FF worked from 6:30 AM until 10:28 PM. CNA-FF was on the staffing schedule to work on units 3 and 4 for the first shift and units 1 (R59's unit) and 2 for the second shift. CNA-FF did not punch in for work on 7/7/25. 7/8/25, CNA-FF worked from 9:53 PM until midnight. CNA-FF was on the staffing schedule to work on units 1 (R59's unit) and 2. 7/9/25, CNA-FF worked from midnight until 6:34 AM. CNA-FF was on the staffing schedule to work on units 1 (R59's unit) and 2. Surveyor noted that CNA-FF continued to work on R59's unit 6 additional shifts after R59 reported to 3 different facility staff members that CNA-FF was rough. On 8/11/25 at 8:58 AM, Surveyor interviewed DON-B. Surveyor asked what DON-B would expect a staff member to do if a resident reported that a different staff member was rough with cares. DON-B stated that staff should report it to DON-B or NHA-A. On 8/13/25, Surveyor informed NHA-A and DON-B of the continued concern that 3 staff members were informed by R59 that CNA-FF was rough. This allegation of abuse was not reported to the NHA-A per facility policy. CNA-FF continued to work on R59's unit and had access to all residents residing in the facility after an allegation of abuse was made.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the Minimum Data Set (MDS) assessments accurately reflected residents' status for 4 (R33, R46, R53, and R10) of 4 residents reviewed for comprehensive MDS assessments. *R33 had behavioral symptoms not directed toward others, wandering, and elopement behaviors since the time of admission. R33's admission MDS assessment dated [DATE] documented R33 did not exhibit any behavioral symptoms or wandering. *R46 had a Preadmission Screening and Resident Review (PASARR) level 1 and level 2 completed. R46's Annual MDS assessment dated [DATE] documented R46 had not been evaluated by the Level 2 PASARR. *R53 had a PASARR level 1 and level 2 completed. R53's Annual MDS assessment dated [DATE] documented R53 had not been evaluated by the Level 2 PASARR. *R10 had a PASSAR level 1 and level 2 completed. R10's Annual MDS assessment dated [DATE] documented R10 had not been evaluated by the Level 2 PASARR. Findings include: 1.) R33 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease with late onset, obstructive sleep apnea, and diabetes. R33 had a court appointed Guardian. On 6/17/2025 at 1:49 PM in the progress notes, nursing documented R33 was oriented to self only and had Wanderguard (electronic monitoring system to prevent a resident from eloping by activating an alarm) placed to the right ankle due to confusion and wandering. R33 needed frequent redirection. On 6/17/2025 at 10:19 PM in the progress notes, nursing documented R33 had been wandering around the facility needing constant redirection. R33 had been attempting to eat from other residents' finished trays and picking up random items. R33 unknowingly had been exit seeking multiple times during the shift needing constant redirection. R33 had a Wanderguard placed on admission. R33 was witnessed pushing the door open and walking out of it by residents and staff. Staff followed R33 out the door and redirected R33 back into the facility. R33 was immediately put on direct one-on-one temporary supervision due to a new environment and behaviors to ensure safety and allow time to adjust to the facility. On 6/18/2025 at 7:23 AM in the progress notes, nursing documented R33 was a very high elopement risk. R33 had a very restless night with a lot of tossing and turning. R33 was dressed and taken for a walk around the facility. Afterwards R33 remained up for the remainder of the shift. R33 required many redirections. R33's Behavior Care Plan was initiated on 6/18/2025 to address R33's wandering, digging in the trash, and attempting to eat off of other residents' trays. R33's Elopement Care Plan was initiated on 6/18/2025. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/19/2025 at 3:51 AM in the progress notes, nursing documented R33 continued to be a high elopement risk and had one-on-one supervision. On 6/20/2025 at 10:28 PM in the progress notes, nursing documented R33 had one-on-one supervision. R33 was wandering and not receptive to redirection and was not aggressive. On 6/23/2025 at 4:39 AM in the progress notes, nursing documented R33 was a high elopement risk and had one-on-one supervision. R33's Wanderguard was in place. R33 had a rough night with tossing and turning and was wheeled around. R33 was given a shower but continued to be restless. Psychotropic medication was administered and R33 finally settled in shortly after 3:00 AM. On 6/23/2025 at 2:39 PM in the progress notes, nursing documented R33 was wandering throughout the building and was very confused. R33 attempted to exit the building, attempted to open medication and treatment carts, and wandered into other resident rooms. R33 remained on one-to-one supervision. On 6/23/2025, R33's psychological notes were requested from R33's hospital stay and a conversation was had with R33's Guardian and Psych Nurse Practitioner (NP) regarding adjustments to R33's medications. R33's admission Minimum Data Set (MDS) assessment dated [DATE] documented R33 did not have any behavior symptoms or wandering behaviors. In the seven day lookback period, R33 displayed behaviors that were disruptive to others and wandering with multiple elopement attempts. In an interview on 8/13/2025 at 12:51 PM, Surveyor asked Social Worker (SW)-J what sections of the MDS were completed by social services. SW-J stated SW-J completes sections C, D, E, and Q. Surveyor shared with SW-J the concern R33's admission MDS dated [DATE] documented R33 did not have any behaviors or wandering. SW-J stated SW-J did not know why SW-J did not put behaviors for R33. SW-J stated maybe SW-J was thinking of a different resident when SW-J was completing the MDS. 2.) R46 was admitted to the facility on [DATE]. A PASARR level 1 and level 2 were completed in 2022. R46's Annual MDS assessment dated [DATE] documented R46 had not been evaluated by the Level 2 PASARR. In an interview on 8/12/2025 at 10:24 AM, Surveyor shared with MDS Registered Nurse (RN)-DD the concern R33 was not coded on R33's Annual MDS assessment as having the PASARR level 2 completed. MDS RN-DD stated social services completes that section and will let the Social Worker know about the concern. On 8/12/2025 at 3:04 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern R46's Annual MDS was not completed accurately because the Level 2 PASARR section was checked no instead of yes. 3.) R53 was admitted to the facility on [DATE] with diagnosis that include Depressive disorder and generalized anxiety disorder. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R53's Annual Minimum Data Set (MDS) assessment dated [DATE] documents R53 has not been evaluated by the Level 2 PASARR. Surveyor noted that R53 has diagnosis that require a PASARR level 2 be completed. R53's MDS documents that the PASARR 2 was not completed. R53 Electronic Medical Record contains a PASARR level 1 completed on 1/3/23 and a PASARR level 2 completed on 1/12/23. On 8/12/25 at 10:28 AM, Surveyor interviewed MDS Registered Nurse (RN)-DD. Surveyor informed RN-DD of the concern that R53's PASARR level 2 was not marked as completed on the R53's Annual MDS assessment. RN-DD stated that R53's MDS should have been coded that the level 2 PASARR was completed. RN-DD looked at R53's MDS and stated that RN-DD answered the question wrong. On 8/12/25 at 3:05 PM, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the concern that R53's Annual MDS was coded incorrectly when answering the question regarding a PASARR level 2 evaluation. 4.) R10 was admitted to the facility on [DATE] with diagnosis that include Depression with psychosis. R10's last Annual Minimum Data Set (MDS) assessment dated [DATE] documents R10 has not been evaluated by the Level 2 PASARR. Surveyor noted that R10 has diagnosis that require a PASARR level 2 be completed. R10's MDS documents that the PASARR 2 was not completed. R10 Electronic Medical Record contains a PASARR level 1 completed on 7/8/2010 and a PASARR level 2 completed on 8/11/10. On 8/12/25 at 10:28 AM, Surveyor interviewed MDS Registered Nurse (RN)-DD. Surveyor informed RN-DD of the concern that R10's PASARR level 2 was not marked as completed on R10's Annual MDS assessment. RN-DD stated that R10's MDS should have been coded that the level 2 PASARR was completed. RN-DD looked at R10's MDS and stated that RN-DD answered the question wrong. On 8/12/25 at 3:05 PM, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the concern that R10's Annual MDS was coded incorrectly when answering the question regarding a PASARR level 2 evaluation.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good grooming for 7 (R15, R16, R24, R27, R34, R81, and R6) of 8 Residents reviewed for ADLs (Activity of Daily Living). * R15, R16, R24, R27, R34, R81, and R6 did not receive showers at least one time a week. Findings include: The facility's Resident Showers policy and procedure reviewed/revised 6/11/25 documents: "Guideline: It is the practice of this facility to assist Residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice." "Explanation and Compliance Guidelines: 1. Residents will be provided with showers as per request and within reasonable accommodation, or as per facility schedule protocols (at least offered weekly) and based upon Resident safety." 1.) R15 was admitted to the facility on [DATE] with diagnoses of Rhabdomyolysis (skeletal muscle breaks down rapidly), Type 2 Diabetes Mellitus (adult onset of trouble controlling blood sugar), Protein-Calorie Malnutrition (deficiency of both protein and energy), and Hyperlipidemia (high levels of fat particles in blood). R15's admission Minimum Data Set (MDS) completed 6/30/25 documents R15's Brief Interview for Mental Status (BIMS) score to be 12, indicating R15 demonstrates moderately impaired skills for daily decision making. R15 has no ROM impairment. R15 requires set-up for eating and is always incontinent of bowel and bladder. R15 requires partial/moderate assistance for showers/bathing and substantial/maximum assistance for upper and lower dressing, mobility, and transfers. R15's MDS documents it is somewhat important to choose between tub bath or showers. R15's Care Card as of 8/1/25 document R15's shower days is on Wednesday AM. R15's care plan documents the intervention that R15 requires assistance by 1 staff with bathing/showering as scheduled and as necessary. Revised 6/30/25 R15's ADL Care Area Assessment (CAA) for ADLS dated 7/7/25 documents the overall objective is improvement, maintain current level of functioning and minimize risks. There is no other documentation in R15's CAA. On 8/6/2025, at 1:15 PM, Surveyor interviewed R15. R15 informed Surveyor that R15 has not been receiving showers on a regular basis since admission. On 8/7/2025, at 2:14 PM, R15 informed Surveyor that R15 received a shower on 8/6/25, but stated that is the first shower R15 has received since admission to the facility. Surveyor reviewed R15's electronic medical record (EMR) and notes that no shower sheets are uploaded in the system. Based on R15's showers being on Wednesday, R15 missed showers on 6/30/25, 7/6/25, 7/13/25, 7/20/25, and 7/27/25. On 8/12/2025, at 8:33 AM, Surveyor reviewed R15 and R16's documentation of shower sheets that R15 received showers. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R15's shower sheets documented: 7/2/25-no Certified Nursing Assistant(CNA)- signature, MT-N signed but did not work that day according to the facility schedule.7/9/25-Certified Nursing Assistant(CNA)- signature, no nurse signature7/2/25-no Certified Nursing Assistant(CNA)- signature, MT-N signed but did not work that day according to the facility schedule. 7/16/25-no Certified Nursing Assistant(CNA)- signature, MT-N signed but did not work that day according to the facility schedule.7/23/25-Certified Nursing Assistant(CNA)- signature, no nurse signature7/30/25-no Certified Nursing Assistant(CNA)- signature, MT-N signed but did not work that day according to the facility schedule. On 8/12/2025, at 3:17 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern that R15 had not been receiving a weekly shower. No further information has been provided by the facility as to why R15 did not receive showers on consistent weekly basis. 2.) R16 was admitted to the facility on [DATE] with diagnoses of Cerebral Palsy(congenital disorder of movement, muscle tone, or posture), Essential Hypertension(most common type of high blood pressure), Spastic Hemiplegia Affecting Unspecified Side(one side of body experiences muscle stiffness and weakness), and Insomnia(sleep disorder characterized by difficulty falling asleep). R16 is currently her own person. R16's admission Minimum Data Set(MDS) completed 7/14/25 documents R16's Brief Interview for Mental Status(BIMS) score to be 13, indicating R16 is cognitively intact for daily decision making. R16's MDS documents that R16 is always incontinent of bowel and bladder, that R16 is dependent for lower dressing, mobility, and transfers. The MDS documents that R16 requires partial/moderate assistance for upper dressing and showers/bathing. R16 currently has an unhealed pressure injury to the Coccyx. R16's MDS documents it is very important to choose between a tub bath, shower, bed bath, or sponge bath. R16's Care Card as of 8/1/25 document R16's shower day is on Tuesdays AM. R16's care plan documents the intervention that R16 requires assistance by 1 staff with bathing/showering as scheduled and as necessary. Revised 7/21/25 R16's ADL Care Area Assessment(CAA) for ADLS dated 7/17/25 documents the overall objective is avoid complications, maintain current level of functioning and minimize risks. There is no other documentation in R16's CAA. On 8/6/2025, at 1:10 PM, Surveyor interviewed R16. R16 stated has not been getting showers on a regular basis. Surveyor observed R16's hair to be greasy. On 8/7/2025, at 1:58 PM, R16 informed Surveyor that R16 did not get a shower on 8/5/25. R16's hair appears to be greasy. Surveyor reviewed R16's electronic medical record(EMR) and notes that no showers sheets are uploaded in the system. Based on R16's showers being on Tuesday, R16 missed showers on 7/8/25, 7/15/25, 7/22/25, 7/22/25, and 8/5/25. On 8/12/2025, at 8:33 AM, Surveyor reviewed R15 and R16's documentation of shower sheets that R15 and R16 received showers. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16's shower sheets documented: 7/15/25-no CNA signature, nurse signed 7/22/25-no CNA signature, MT-N signed but did not work that day according to the facility schedule. 7/29/25-no CNA signature, MT-N signed but did not work that day according to the facility schedule. On 8/13/2025, at 10:49 AM, R16 informed Surveyor that R16 received a shower late evening on 8/12/25. On 8/12/2025, at 3:17 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern that R16 did not receive a weekly shower per R16's plan of care. No additional information was provided by the facility as to why all R16 did not receive showers on consistent weekly basis. 3.) R24 was admitted to the facility on [DATE] with diagnoses of Epileptic Seizures(brain has sudden, uncontrollable surge of electrical activity), Encephalopathy(group of conditions that cause brain dysfunction), Essential Hypertension(chronic condition of persistently high blood pressure), Dysphagia(difficulty swallowing foods), Gastrostomy Status(artificial opening in stomach used for feeding), and Depression(mood disorder that causes persistent feelings of sadness and loss of interest). R24 currently has a legal guardian. R24's Quarterly MDS completed 6/23/25 documents R24 demonstrates severely impaired skills for daily decision making. R24's memory was not assessed. R24 is dependent for upper/lower dressing, showers/bathing, mobility, and transfers. R24 has both upper and lower extremity range of motion(ROM) impairment on both sides. The MDS does not document that R24 utilizes a splint or brace and documents that R24 is always incontinent of bowel and bladder. R24 currently has a feeding tube. R24's Care Card as of 8/1/25 document R24's shower day is on Fridays PM. R24's care plan documents the intervention that R24 requires assistance by 1 staff with bathing/showering as scheduled and as necessary. Revised 9/20/24 Surveyor reviewed R24's electronic medical record(EMR) and notes the only shower sheets found were dated 8/1/25, 4/11/25, 4/18/25, 3/7/25, 2/7/25, and 11/1/24. Surveyor noted that R24 did not have any documented showers provided for the month of July 2025, June 2025 or May 2025. No additional information was provided as to why R24 did not receive showers per R24's plan of care. 4.) R27 was admitted to the facility on [DATE] with diagnoses of Cerebral Palsy(congenital disorder of movement, muscle tone, or posture), Neuromuscular Dysfunction of Bladder(nerves controlling bladder and urinary sphincter are damaged and not working correctly), Paraplegia(paralysis of lower half of body), and Schizoaffective(combination of schizophrenia and mood disorder symptoms including hallucinations and delusions and manic/depressive episodes). R27 is currently his own person. R27's quarterly minimum data set(MDS) completed 5/31/25 documents R27's brief (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview for mental status(BIMS) score to be 13, indicating R27 is cognitively intact for daily decision making. R27's MDS documents R27 has range of motion impairment on one side of lower extremity. R27's MDS also documents R27 requires substantial/maximum assistance for upper dressing and is dependent for lower dressing. R27 is dependent for mobility and transfers. R27 requires substantial/maximum assistance for showers. R27 has an indwelling catheter and is always incontinent of bowel. R27's admission MDS documents it is somewhat important for R27 to choose between a tub bath, shower, bed bath, or sponge bath. R27's Care Card as of 8/1/25 document R27's shower day is on Thursday PM. R27's care plan documents the intervention that R27 requires assistance by 1 staff with bathing/showering as scheduled and as necessary. Revised 6/11/25 R27's ADL Care Area Assessment(CAA) for ADLS dated 12/3/24 documents the overall objective is improvement, slow or minimize decline, maintain current level of functioning and minimize risks. There is no other documentation in R27's CAA. Surveyor reviewed R27's electronic medical record (EMR) and notes the only shower sheets found were dated 1/30/25, 2/13/25, 2/20/25, 3/6/25. Surveyor noted that R27 had no documented showers for May, June, July August 2025. No additional information was provided as to why R27 did not receive documented showers per R27's plan of care. 5.) R34 was admitted to the facility on [DATE] with diagnoses of Myasthenia Gravis(muscles under voluntary control to feel weak), Protein-Calorie Malnutrition (deficiency of both protein and Native Coronary Artery(plaque buildup narrows the arteries that supply blood to the heart), and Depression(mood disorder that causes persistent feelings of sadness and loss of interest). R34's admission Minimum Data Set(MDS) completed 7/22/25 documents R34's Brief Interview for Mental Status(BIMS) score to be 15, indicating R34 is cognitively intact for daily decision making. R34's MDS documents R34 has no range of motion impairment. R34 is independent with eating. R34 requires partial/moderate assistance for upper dressing and substantial/maximum assistance for transfers. R34 is dependent for lower dressing and mobility. R34's MDS documents R34 is receiving oxygen(O2) therapy. R34's MDS also documents that R34 is at risk for developing a pressure ulcer and currently has one venous and arterial ulcer. It is somewhat important for R34 to choose between a tub bath, shower, bed bath or sponge bath. R34's Care Card as of 8/1/25 document R34's shower day is on Friday PM. R34's care plan documents the intervention that R34 requires assistance by 1 staff with bathing/showering as scheduled and as necessary. Created 7/18/25 Revised 7/21/25 On 8/11/2025, at 12:45 PM, Surveyor interviewed R34. R34 informed Surveyor that R34 has not had a shower since admission. On 8/12/2025, at 2:14 PM, R34 confirmed R34 has not received any showers since arriving at the (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility R34 states R34's leg is wrapped and "they haven't figured out a way to give R34 a shower. Why don't they shower me on my treatment days when its unwrapped";. Surveyor reviewed R34's electronic medical record(EMR) and notes that no showers sheets are uploaded in the system. Based on R34's showers being on Friday, R34 missed 7/18/25, 7/25/25, 8/1/25, 8/8/25. No additional information was provided as to why R34 did not receive showers per R34's plan of care. 6.) R81 was admitted to the facility on [DATE] with diagnoses of Essential Hypertension(chronic condition of persistently high blood pressure), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Hypertensive Heart Disease(long term conditions developed from chronic high blood pressure), Chronic Obstructive Pulmonary Disease(lung disease that block airflow and make it difficult to breathe), Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities), and Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life). R81 has an activated health care power of attorney. R81's annual minimum data set(MDS) completed 7/3/25 documents R81's brief interview for mental status(BIMS) score to be 5, indicating R81demonstrates severely impaired skills for daily decision making. R81's MDS documents R81 has no range of motion impairment. R81is independent with eating. R81's MDS also documents R81 is dependent for upper and lower dressing, showers/bathing, mobility and transfers. R81is always incontinent of bowel and bladder. somewhat important for R81 to choose between a tub bath, shower, bed bath, or sponge bath. R81's Care Card as of 8/1/25 document R81's shower day is on Monday AM. Surveyor notes there is no instructions in R81's care plan or care card for nursing staff on what type of assistance R81 requires for showering. Surveyor notes on 12/12/21 it is documented on R81's care plan that R81 has a history of refusing showers/baths. There is no revisions and no updated interventions for R81 refusing showers. R81's EMR has no documentation that R81 has been refusing showers and what approaches nursing staff has attempted. Surveyor reviewed R81's electronic medical record(EMR) and noted the only shower sheets found were dated 6/30/25, 2/1/25, 1/18/25, 4/28/25, 4/17/25,2/10/25, 1/20/25,11/18/24,10/31/24. On 8/12/2025, at 3:17 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern that R81 had not been receiving a weekly shower. Surveyor requested documentation for showers given back to 11/2024 for R81. DON-B replied, Did the Residents tell you that? Surveyor responded that 3 interviewable Residents confirmed they had not received showers. No further information has been provided by the facility at this time as to why R81 had not received shower on consistent weekly basis. Surveyor was provided 6 documented showers for R81 in July and August. No other documentation that R81 received showers prior to July on a consistent weekly basis. On 7/21/25, and 7/25/25, the nurse signing off on R81's shower sheet did not work that day according to the facility (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	schedule. No additional information was provided. 7.) R6 admitted to the facility on [DATE] and has diagnoses that include nontraumatic intracerebral hemorrhage in subcortical hemisphere, Cerebral Infarction due to occlusion or stenosis of small artery, chronic pancreatitis, Hyperglycemia, gastrostomy status, Hypertension, Chronic Kidney Disease stage 3 and dysphagia. R6's admission Minimum Data Set (MDS) dated [DATE] documents under Section F (Preferences for Routine & Activities): How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Very important. Indicate primary respondent for Daily and Activity Preferences: Family or significant other. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair): Dependent. R6's Care Plan documents: The resident has an ADL (Activity of Daily Living) self-care performance deficit r/t (related to) impaired mobility, CVA (Cerebrovascular Accident) with Right sided Spasticity/deficits - initiated 5/22/25. BATHING/SHOWERING: The resident requires assistance by 1 staff with bathing/showering as scheduled and as necessary. On 8/11/25 at 3:07 PM, Surveyor spoke with R6's mother and Power of Attorney (POA) who reported she has complained about cares because there were times when she'd come in and R6 was in bed and both she and the linen was wet, and she has helped staff change her sometimes. R6's POA reported she has not filed any grievances but does report concerns to the staff if she has any, and things have gotten better since she has voiced concerns. The POA reported she is not sure if R6 gets or has ever gotten a shower and believes staff only do bed baths because she doesn't think there is enough help. Surveyor reviewed R6's medical record and was unable to locate any documentation or evidence R6 has received a shower since admission. Surveyor was unable to locate any progress notes indicating a skin check was completed during shower or any documentation regarding showers. R6's Kardex indicates she is to receive a shower every Friday AM. Review of the Certified Nursing Assistant (CNA) Point of Care (POC) documentation for the last 30 days revealed only 1 entry on 7/15/25 at 1:57 AM, which documented: Question 1 - What type of bathing did resident receive? Options include shower, tub bath, bed bath, resident not available, resident refused, and NA (Not Applicable). Surveyor noted a check mark under "not applicable." Question 2 - Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. Surveyor noted a check mark under "not applicable - not attempted and the resident did not perform this activity prior to the current illness, exacerbation or injury." On 8/12/25 at 3:20 PM, during the daily exit meeting, the facility was advised of concern there is no evidence R6 is receiving or has received a shower since admission. Surveyor advised of facility POC (continued on next page)		

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation the past month of only 1 entry documenting "NA." Surveyor asked for shower sheets or evidence R6 has received showers. Director of Nursing (DON)-B reported she has seen R6 receiving a shower "because her office is just down the hall" but can't speak to how many times. No additional information was provided as to why R6 did not receive any documented showers per R6's plan of care.		

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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 5 (R15, R16, R27, R34, and R8) of 20 residents received necessary care and treatment in accordance with professional standards of practice, a comprehensive person-centered care plan or facility policies and procedures. *R15 was observed not wearing compression stockings during the survey per physician orders and R15's plan of care. *R16 was observed not wearing compression stockings during the survey per physician orders and R16's plan of care. *R27 was observed not wearing compression stockings during the survey per physician orders and R27's plan of care. *R34 did not have a treatment completed to R34's vascular/venous status ulcer on 8/8/25. On 7/18/25, a physician order was obtained for R34 to receive an air mattress and R34 did not receive an air mattress until 7/21/24. *R8 had an unwitnessed fall on 4/8/25 and no neurological checks were documented as completed for R8. Findings include: The facility's Provision of Quality Care policy dated as reviewed/revised on 4/1/25 documents: Guideline: Based on comprehensive assessments, the facility will ensure that Residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the Residents' choices Explanation and Compliance Guidelines: - Each Resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. - Responsibility for interventions on the care plan will be clearly identified. - Qualified persons will provide the care and treatment in accordance with professional standards of practice, the Resident's care plan, and the Resident's choices. 1.) R15 was admitted to the facility on [DATE] with diagnoses of Rhabdomyolysis (skeletal muscle breaks down rapidly), Type 2 Diabetes Mellitus (adult onset of trouble controlling blood sugar), Protein-Calorie Malnutrition (deficiency of both protein and energy), and Hyperlipidemia (high levels of fat particles in blood). (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R15's admission Minimum Data Set (MDS) completed 6/30/25 documents a Brief Interview for Mental Status (BIMS) score to be 12, indicating R15 demonstrates moderately impaired cognition. The MDS documents that R15 has no ROM (range of motion) impairment, that R15 requires set-up for eating and is always incontinent of bowel and bladder. The MDS also documents that R15 requires partial/moderate assistance for showers/bathing and substantial/maximum assistance for upper and lower dressing, mobility, and transfers. R15's physician order dated 6/27/25 documents that R15 is to have compression stockings to bilateral lower extremities, on in AM (morning), off at HS (bedtime). Two times a day for bilateral lower extremity edema. R15's Treatment Administration Records (TARS) documentation for R15's compression stockings from June through August 2025 documents: June 28th and 29th stockings are not signed as placed on R15. June 30th does not indicate the stockings were taken off R15. July 6th and 14th does not indicate the stockings were taken off R15. July 22nd, 25th, 26th, and 27th stockings are not signed as placed on R15. August 3rd and 10th stockings are not signed as placed on R15. August 6th, 7th, 11th, and 12th it is documented R15 is wearing the compression stockings on the TAR however, Surveyor observed no compression stockings on R15 those dates. R15's CNA (Certified Nursing Assistant) care card dated 8/1/25 documents that nursing staff are to place compression stockings to R15's bilateral lower extremities, on in AM and off at HS. On 8/6/2025, at 1:15 PM, Surveyor observed R15 is not wearing compression stockings. Surveyor observed R15 wearing no-show socks and tennis shoes. On 8/7/2025, at 2:14 PM, Surveyor observed R15 is not wearing compression stockings. On 8/11/2025, at 10:29 AM, Surveyor observed R15 is not wearing compression stockings. On 8/12/2025, at 2:18 PM, Surveyor observed R15 is not wearing compression stockings. R15 confirmed to Surveyor that nursing staff have not been putting compression stockings on R15. On 8/12/25, at 1:32 PM, Surveyor interviewed Unit Manager (UM)-E regarding R15 not wearing compression stockings as ordered by the physician. UM-E stated the expectation if there is a physician order and it is on a resident's care card, the compression stockings should be put on and if refused, it should be documented. On 8/12/2025, at 3:17 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern that R15 was observed not wearing their compression stockings as ordered by the physician. Surveyor also informed NHA-A and DON-B that there is no documentation in R15's electronic medical record as to why R15 would not wearing their compression stockings. No additional information was provided as to why R15 was observed not wearing compression stockings per physician orders. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) R16 was admitted to the facility on [DATE] with diagnoses of Cerebral Palsy(congenital disorder of movement, muscle tone, or posture), Essential Hypertension(most common type of high blood pressure), Spastic Hemiplegia Affecting Unspecified Side(one side of body experiences muscle stiffness and weakness), and Insomnia(sleep disorder characterized by difficulty falling asleep). R16 is currently her own person. R16's admission Minimum Data Set(MDS) completed 7/14/25 documents a Brief Interview for Mental Status(BIMS) score to be 13, indicating R16 is cognitively intact. R16's MDS documents that R16 is always incontinent of bowel and bladder and that R16 is dependent for lower dressing, mobility, and transfers. The MDS also documents that R16 requires partial/moderate assistance for upper dressing and showers/bathing and that R16 currently has an unhealed pressure injury to the coccyx. R16's physician order dated 7/21/25 documents that R16 is to have compression stockings to bilateral lower extremities, on in AM, off at HS. Two times a day for bilateral lower extremity edema. R16's Treatment Administration Record (TAR) for July and August of 2025 for the use of compression stocking documents: July 22, 25, 26, and 27 stockings were not documented as being placed on R16. August 3 and 10 stockings were not documented as being placed on R16. August 6,7,11,12 it is documented the compression stockings are on, however, Surveyor observed R16 to be wearing compression stockings. R16's care card dated 8/1/25 instructs nursing staff to place compression stockings to bilateral lower extremities, on in AM and off at HS. On 8/6/2025, at 1:10 PM, Surveyor observed R16 is not wearing compression stockings. Surveyor observed R16 wearing only gripper socks. On 8/7/2025, at 1:58 PM, Surveyor observed R16 is not wearing compression stockings. On 8/11/2025, at 10:30 AM, Surveyor observed R16 is not wearing compression stockings. On 8/11/2025, at 1:23 PM, R16 verified to Surveyor that compression stockings have not been put on today. On 8/12/2025, at 2:18 PM, Surveyor observed R16 is not wearing compression stockings. R16 confirmed to Surveyor that nursing staff have not been putting compression stockings on R16. On 8/12/25, at 1:32 PM, Surveyor interviewed Unit Manager (UM)-E regarding R16 not wearing compression stockings as ordered by the physician. UM-E stated the expectation if there is a physician order and it is on a resident's care card, the compression stockings should be put on and if refused, it should be documented. On 8/12/2025, at 3:17 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern that R16 was observed not wearing their compression stockings as ordered by the physician. Surveyor also informed NHA-A and DON-B that there is no documentation in (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16's electronic medical record as to why R16 would not wearing their compression stockings. No additional information was provided as to why R16 was observed not wearing compression stockings per physician orders. 3.) R27 was admitted to the facility on [DATE] with diagnoses of Cerebral Palsy(congenital disorder of movement, muscle tone, or posture), Neuromuscular Dysfunction of Bladder(nerves controlling bladder and urinary sphincter are damaged and not working correctly), Paraplegia(paralysis of lower half of body), and Schizoaffective(combination of schizophrenia and mood disorder symptoms including hallucinations and delusions and manic/depressive episodes). R27 is currently his own person. R27's quarterly minimum data set(MDS) completed 5/31/25 documents a brief interview for mental status(BIMS) score to be 13, indicating R27 is cognitively intact. R27's MDS documents that R27 has range of motion impairment on one side of lower extremity and that R27 requires substantial/maximum assistance for upper dressing and is dependent for lower dressing. The MDS also documents that R27 is dependent for mobility and transfers, that R27 requires substantial/maximum assistance for showers and that R27 has an indwelling catheter and is always incontinent of bowel. R27's physician order dated 11/22/24 documents that R27 is to have compression stockings to bilateral lower extremities, on in AM, off at HS. Two times a day for bilateral lower extremity edema. R27's Treatment Administration Record (TAR) for R27's compression stockings being placed on R27 for July and August 2025 documents: July 22, 25, 26, and 27 compression stockings are not documented as being placed on R27. August 3 and 10 compression stockings are not documented as being placed on R27. August 6,7,11,12 it is documented the compression stockings are on R27, however, Surveyor observed no compression stockings on R27. R27's care card as of 8/1/25 instructs nursing staff to place compression stockings/tubi grips to bilateral lower extremities, on in AM and off at HS. On 8/7/2025, at 9:02 AM, Surveyor observed that R27 is not wearing compression stockings or tubi grips. On 8/11/2025, at 2:25 PM, Certified Nursing Assistant (CNA)-Q informed Surveyor that R27's care card states R27 is to have compression stockings on, but did not want to wear them because R27 has bandages on. CNA-Q informed Surveyor that CNA-Q did not inform the nurse. On 8/11/2025, at 3:06 PM, Surveyor confirmed that R27 is not wearing compression stockings and notes there is no documentation in R27's electronic medical record as to why R27 is not wearing compression stockings. On 8/12/2025, at 11:48 AM, R27 stated R27 is not wearing compression stockings. On 8/12/2025, at 2:19 PM, R27 confirmed R27 is not wearing compression stockings and does not (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	know why. On 8/13/2025, at 9:34 AM, R27 is not wearing compression stockings and there is no documentation in R27's electronic medical record as to why R27 is not wearing compression stockings. On 8/12/25, at 1:32 PM, Surveyor interviewed Unit Manager (UM)-E regarding R27 not wearing compression stockings as ordered by the physician. UM-E stated the expectation if there is a physician order and it is on a resident's care card, the compression stockings should be put on and if refused, it should be documented. On 8/12/2025, at 3:17 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern that R27 was observed not wearing their compression stockings as ordered by the physician. Surveyor also informed NHA-A and DON-B that there is no documentation in R27's electronic medical record as to why R27 would not wearing their compression stockings. No additional information was provided as to why R27 was observed not wearing compression stockings per physician orders. 4.) R34 was admitted to the facility on [DATE] with diagnoses of Myasthenia Gravis(muscles under voluntary control to feel weak), Protein-Calorie Malnutrition (deficiency of both protein and Native Coronary Artery(plaque buildup narrows the arteries that supply blood to the heart), and Depression(mood disorder that causes persistent feelings of sadness and loss of interest). R34's admission Minimum Data Set(MDS) completed 7/22/25 documents a Brief Interview for Mental Status(BIMS) score to be 15, indicating R34 is cognitively intact. R34's MDS documents R34 has no range of motion impairment, that R34 is independent with eating and that R34 requires partial/moderate assistance for upper dressing and substantial/maximum assistance for transfers. The MDS also documents that R34 is dependent for lower dressing and mobility that R34 is receiving oxygen(O2) therapy and that R34 is at risk for developing a pressure ulcer and currently has a 1 venous ulcer. On 8/6/2025, at 9:28 AM, Surveyor interviewed R34. R34 stated that it took days for R34 to get an air mattress on the bed. R34 stated, "They knew I was coming; they should have had it ready". R34 stated R34 laid on a metal frame for several days and now R34's back hurts. R34's physician order dated 7/18/25 documents an order for an air mattress for R34. On 7/16/2025, Unit Manager (UM)-E documented 3/10 pain located at left lower extremity non healing wound. Non healing wound present on left lower extremity due to venous stasis. On 7/20/25, Licensed Practical Nurse (LPN)-II documented that R34 requested an air mattress. On 7/21/25, LPN-AA documented that R34 was transferred to a bed with an air mattress. R34 settled in well and slept well through the night. On 8/11/2025, at 12:45 PM, R34 informed R34's treatment didn't get done on 8/8/25. R34 stated R34 had to keep reminding them to get the treatment done, but it never did. Surveyor observed the wrap marked 8/6 on R34's leg. R34 confirmed that R34 had to ask for an air mattress after being admitted to the facility. R34 stated R34's back hurt laying on the metal bar of the regular (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mattress. On 8/11/2025, at 12:52 PM, Surveyor brought LPN-R to observed R34's bandage. LPN-R confirmed the bandage is marked 8/6. LPN-R stated to Surveyor LPN-R is not sure if able to get to the treatment today. LPN-R stated, "Have a lot to do yet. If I don't get it done, it will go to PM shift, I don't have time to do treatments today". On 8/12/2025, at 1:32 PM, Surveyor interviewed Unit Manager (UM)-E. Surveyor asked UM-E why R34's treatment had not been completed on 8/8. UM-E does not know why. UM-E agrees the bandage was marked 8/6 when observed on 8/11. Surveyor asked UM-E why R34's air mattress was not placed on R34's bed until 7/21/25 after R34 requested it and after a physician order for an air mattress was written on 7/18/25. UM-E informed Surveyor that UM-E will contact maintenance about a work order for an air mattress and get back with Surveyor. On 8/12/2025, at 3:17 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R34 did not receive an air mattress until 7/21/25, despite a physician order on 7/18/25 and R34 requesting it. Surveyor also shared that R34 has not had R34's treatment completed to R34's venous stasis ulcer. No additional information was provided by the facility in regard to why there was a delay in getting an air mattress for R34 and treatments have not been completed as ordered by physician for R34's venous stasis ulcer. 5.) The facility policy with a last reviewed/revised date of 12/3/24, titled "Fall Prevention Program" documents, in part: When any resident experiences a fall, the facility will: Assess the resident . Document all assessments and actions . Monitor residents' condition and response to interventions as per standard of practice. The facility policy with a last reviewed/revised date of 7/10/25 documents, in part: It is the guideline of this facility to report potential head injuries to the physician and implement interventions to prevent further injury. Assess resident following a known, suspected or verbalized head injury&hellip; Example protocol for actual/suspected head injury may include: Every 15 min, for 1 hour, then; hourly for 4 hours, then&rsquo; every 8 hours (every shift) for 72 hours&hellip; R8 was admitted to the facility 6/1/2014 with diagnosis that include Hemiplegia/Hemiparesis (weakness on one side of the body) following a stroke, stage 2 kidney disease and epilepsy (seizure disorder). R8's Significant change Minimum Data Set (MDS) assessment dated [DATE] documents R8 is moderately cognitively impaired. R8 has impairments on one side of both of R8's upper and lower extremities. R8 requires substantial/maximum assistance for personal hygiene and transfers. R8 has had one fall with major injury since R8's last MDS Assessment. R8's Care Area Assessment for falls dated 3/1/25 documents, in part: [R8] had a recent fall and has a history of falls [related to] [stroke] and weakness. R8's care plan documents the following pertinent interventions: Assist of with toileting needs [as needed], initiated on 10/29/23. Prompt [R8] to toilet upon rising, after meals and [at bedtime] and per request at night. Keep urinal at bedside at night, initiated on 1/13/19. Toilet use: [R8] (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	requires assistance x 2 [standing pivot transfer] with front wheeled walker. Assist x 1 with toileting hygiene. Prompt to use the bathroom every 2-3 hours and [as needed], initiated on 3/23/25. R8's Fall Risk Evaluation dated 2/12/25 documents a score of 8 which puts R8 at moderate risk for falls. R8's progress note dated 4/8/25 at 10:49 AM documents, in part: [R8] had an unwitnessed fall around 700 am. [R8] was discovered by CNA who alerted this nurse. [R8] was found in front of wheelchair, lying on [R8's] left side, and the wheelchair was also on its side. Per [R8], [R8] forgot to lock [R8's] wheelchair. Vital signs taken and documented . Surveyor reviewed R8's electronic medical record for evidence of neurological checks being completed after R8's unwitnessed fall. R8 has one neurological check completed on 4/8/25 at 1:47 PM. Surveyor reviewed R8's fall investigation dated 4/8/25. The first page of the fall packet revealed a "Checklist for Accidents/Incidents." The checklist is arranged with a column of Nurse responsibilities, a column where staff can write in the completed date and a column for staff to put their signature for each responsibility. One of the nurse responsibilities on the checklist is, "[NAME] (sic) checks initiated (only if unwitnessed, resident hits head or states they hit their head). Surveyor noted that the completion date of [NAME] (sic)/Neurological check is blank and there is no staff signature. On 8/12/25 at 2:13 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-OO. Surveyor asked about R8's fall on 4/8/25. LPN-OO stated R8 was found laying on the floor. LPN-OO stated that vitals and an assessment were completed, and the physician was notified. LPN-OO stated R8 did not sustain an injury with this fall. Surveyor asked what the neuro (neurological) check policy is for the facility. LPN-OO indicated that neuro checks should be completed after any unwitnessed fall. LPN-OO stated that LPN-OO did complete a neuro check but could not keep up with them due to her other nurse duties on the unit. On 8/12/25 at 1:30 PM, Surveyor asked LPN-G what should be completed after a resident sustains an unwitnessed fall. LPN-G stated the resident is assessed, then, if safe, assisted back to chair/bed. LPN-G would inform the MD and the resident's power of attorney. LPN-G that staff must fill out the fall packet and checklist. Neuro checks would be started after an unwitnessed fall. On 8/13/25 at 9:04 AM, Surveyor interviewed Nurse Technician (NT)-BB. Surveyor asked what should be completed after a resident sustains an unwitnessed fall. NT-BB stated that the resident is assessed, vital signs completed, and neuro checks started. After caring for the resident, staff must fill out the fall packet. The packet contains a checklist with everything to complete including witness statements. On 8/13/25 at 10:44 AM, Surveyor interviewed Unit Manager (UM)-D. Surveyor asked if UM-D could explain the facilities Neuro check policy regarding falls. UM-D indicated that neuro checks are started after an unwitnessed fall. The neuro checks are started right away and carry on for the appropriate amount of time. UM-D stated that the initial neuro check can be documented in the electronic medical record, but the rest of the neuro checks are documented on paper. On 8/13/25 at 12:47 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked about (continued on next page)		

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8's neuro checks after R8's fall. DON-B reviewed R8's fall packet and did not locate any documented neuro checks. Surveyor alerted DON-B to the fact that the checklist in the fall packet is blank in the row related to neuro checks. DON-B acknowledged the row was blank. On 8/13/25 at 2:45 PM, Surveyor informed Nursing Home Administrator (NHA)-A and DON-B of the concern that on 4/8/25, R8 was transferred to the toilet by a CNA according to documentation, 2 minutes later, R8 sustained an unwitnessed fall. Neurological checks were not completed per facility policy. No additional information was provided.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility did not ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 3 of 6 medication carts reviewed. Insulin vials and pens were not labeled, dated when opened and/or were expired. Findings include: On [DATE], at 8:42 AM, Surveyor observed the unit 5 medication cart. In the right-side drawer, Surveyor located the following: Lispro insulin vial belonging to R75 was open and used but not dated when opened. Lispro insulin pen with no label. Surveyor noted a handwritten residents' first name in black marker. The insulin pen was open and used but not dated when opened. Lantus insulin pen belonging to R6 was open and used but not dated when opened. Lantus insulin pen belonging to R33 was open and used but not dated when opened. Lispro insulin pen belonging to R33 was open and used but not dated when opened. Lantus insulin pen belonging to R3 was open and used but not dated when opened. Lantus insulin pen belonging to R75 was open and used but not dated when opened. On [DATE], at 9:11 AM, Surveyor asked Nurse Technician (NT)-BB how long insulin good for once opened. NT-BB reported she thought 30 days. NT-BB reported the facility policy is to date insulin when opened and showed Surveyor an insulin vial she opened and dated today. Surveyor advised NT-BB of the above insulins that are opened and not dated. NT-BB confirmed the insulin pen with the handwritten name in black marker belonged to R6. On [DATE], at 9:14 AM, Surveyor observed the unit 3 medication cart. In the right-side drawer, Surveyor located the following: Lispro insulin vial (belonging to a deceased resident) was open and used but not dated when opened. Lispro insulin vial belonging to R1 was open and used dated opened [DATE]. Lispro insulin vial belonging to R1 was open and used but not dated when opened. On [DATE], at 9:22 AM, Surveyor asked Licensed Practical Nurse (LPN)-R how long insulin is good for once opened. LPN-R stated, 28 days. Surveyor advised LPN-R of the above insulins that were open, not dated and/or expired. LPN-R confirmed the 1 Lispro insulin vial belonged to a resident that was deceased. On [DATE], at 9:27 AM, Surveyor observed the unit 1 medication cart. In the right-side drawer, Surveyor located the following: Lispro insulin vial belonging to R5 was open and used dated [DATE]. Lispro insulin vial belonging to R5 was open and used but not dated when opened. Surveyor asked LPN-CC how long insulin was good for once opened. LPN-CC reported she thought 30 days. LPN-CC showed Surveyor a binder in the nurse's station, which contained a sheet of paper titled Insulin 28-day Expiration Date Calculator and then reported insulin is good for 28 days after opening. Surveyor noted the sheet of paper in the binder at the nurse's station titled Insulin 28-day expiration date calculator documents: Select a box with the month insulin was initially opened. Locate date on the top row of that box when the insulin was initially opened. Bottom row shows the expiration date (Do not use medication beyond this date). Discard multi-dose vials 28 days after initially opening, or expiration date/beyond use date on vial, whichever is earlier. On [DATE], at 9:42 AM, Surveyor asked Nursing Home Administrator-A for the facility policy and procedure regarding insulin labeling, dating and expiration. The facility policy titled Medication Storage revised [DATE] documents (in part) . 8. Unused medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible or missing labels. These medications are destroyed in accordance with out Destruction of Unused Drugs Policy. On [DATE], at 3:30 PM, during the daily exit meeting, Surveyor informed the facility of the above concerns regarding insulins that were not labeled, dated and/or were expired. Surveyor informed the facility policy provided does not include insulin dating or expiration dates. Director of Nursing (DON)-B reported they are trying to find additional information. No additional information was provided.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview the facility did not ensure 1 (R27) of 3 Residents reviewed for indwelling catheters were treated with dignity and respect.*R27's urinary catheter bag was left uncovered with yellow urine in the catheter bag visible to peers, staff, and visitors.Findings Include:R27's quarterly minimum data set (MDS) completed 5/31/25 documents R27 has an indwelling catheter.R27's comprehensive care plan documents:R27 has indwelling catheter due to diagnosis of Neurogenic BladderInitiated 11/23/24 Revised 6/11/25On 8/11/25, at 9:55 AM, Surveyor observed Certified Nursing Assistants (CNA) - X and (CNA) - Y bring R27 out of R27's room. R27 was in a wheelchair that was reclined. Surveyor observed CNA-X push R27 down the hall, turn left at the nurse's station, and continue pushing R27 down the hallway and placed R27 in the activity room. Surveyor observed other Residents in the activity room. Surveyor observed R27's catheter bag laying at the bottom of R27's legs with the urine side facing up which would be visible to other Residents, visitors, and staff. R27's foley catheter bag was not covered in a privacy bag.On 8/11/2025, at 3:06 PM, Surveyor observed R27 in the main dining room in a wheelchair. R27's foley catheter bag was hanging on the right side of the wheelchair with the urine side visible to other Residents, visitors, and staff. R27's foley catheter bag was not covered in a privacy bag. R27 was playing bingo. On 8/12/2025, at 11:48 AM, Surveyor observed R27 in the activity room and R27's foley catheter bag was covered in a privacy bag. Surveyor asked R27 if R27 prefers to have R27's bag covered in a privacy bag. R27 stated, Why would I want everyone to see my pee? On 8/12/2025, at 1:32 PM, Surveyor interviewed Unit Manager (UM)-E regarding R27's foley catheter bag. UM-E confirmed the expectation is have the foley catheter bag always in a privacy bag and not visible to other Residents, visitors, and staff.On 8/12/2025, at 3:17 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R27 did not have R27's foley catheter bag covered in a privacy bag on 8/11/25 on 2 different occasions in common areas resulting in R27's foley catheter bag visible to other Residents, visitors, and other staff.		

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NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not promote and facilitate 1 (R65) of 1 Resident's right to self-determination through support of R65's choice about an aspect of R65's life that is significant to R65. R65 changed rooms in the facility on 7/25/25. R65 had boxes with items important to R65 on R65's dresser and closet area. R65 went to a group activity in a common area on 8/4/25. When R65 returned to R65's room, R65's boxes and items important to R65 were gone. R65 informed Surveyor that Social Worker (SW)-J and Nurse Technician (NT)-BB entered R65's room without permission and removed R65's items. Findings include: The facility policy with a last reviewed date of 7/1/25 titled, Resident Rights documents, in part: The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The resident has the right to be informed of and participate in his or her treatment, including: . The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. The right to be informed, in advance, of changes to the plan of care. The right to be informed in advance, of the care to be furnished and the type of caregiver or professional that will furnish care. The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice, including, but not limited to: . The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. R65 was admitted to the facility on [DATE]. R65's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents that R65 is cognitively intact. On 8/6/25 at 10:36 AM, R65 informed Surveyor that R65 changed room at the end of July. R65 stated that R65 thinks R65 had 3 boxes on his dresser. R65 pointed to the dresser in R65's room and Surveyor noted that there were no boxes on R65's dresser. R65 stated that R65 had 2 other boxes on the opposite corner in R65's room. Surveyor did not observe any boxes in R65's room. R65 stated that R65 went to a group activity and when R65 returned to R65's room, R65's boxes were gone. R65 stated that R65 found out that SW-J and NT-BB went in R65's room and tossed the room. Surveyor asked if R65 was told prior to the group activity that staff would be entering R65's room. R65 stated no. Surveyor asked what was missing from R65's room. R65 stated that R65 had emptied some of each of the boxes so they were not all the way full. R65 stated that R65 is missing a cup that R65 used to hold ink pens and sharpies. The pens and sharpies are gone too. R65 stated that there was a paper flag banner used at group party/activity at the facility and that was gone. R65 stated a small [NAME] ball that was also given away at a facility group activity was gone. R65 stated that these items did not have any monetary value, but it was sentimental. R65 stated that R65 had a collection of used plastic shopping bags that R65 uses on a regular basis and that was gone. R65 stated that R65 was missing some shelf food and a reusable tote bag as well. R65 stated that there is probably more but R65 can't remember everything that was in the boxes. R65 stated that all the staff needed to do was talk to R65. R65 stated that if R65 thought R65 had time to empty the rest of R65's boxes. R65 stated that R65 approached staff members about his room after the items were removed. R65 stated that staff told R65 that R65 was hoarding and that they needed to remove trash from R65's room. R65 stated that R65 asked staff to go through the boxes and belongings removed from R65's room. R65 was told that it was trash and that it had already been taken to the dumpster. R65 stated that R65 had given a list of missing items to Unit Manager (UM)-D and directed Surveyor to speak to UM-D. On 8/11/25 at 5:01 PM, Surveyor interviewed NT-BB. Surveyor asked if NT-BB had gone into R65's room to remove anything. NT-BB stated to R65 they were belongings but really it was garbage that R65 was saving. NT-BB stated that there was food that was sitting out greater than 24 hours and that was thrown (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	away. NT-BB told R65, after the fact, that the next time R65 wants to save food, staff can label it and put it in the refrigerator. NT-BB stated that R65 had 2 empty pizza boxes and old medicine cups that NT-BB threw away. NT-BB stated that R65 was also stock piling and hiding facility silverware and dishes that NT-BB removed and took to the kitchen. Surveyor asked if NT-BB remembered a paper flag banner or [NAME] ball. NT-BB stated No. On 8/12/25 at 9:36 AM, Surveyor interviewed SW-J regarding R65's items being removed from R65's room. SW-J stated that SW-J just removed garbage. SW-J stated that SW-J care planned R65 as a hoarder. SW-J stated that there were no belongings removed from the room. SW-J stated that they removed old napkins, straws, cups with mold, about 30 facility plates, and empty cigarette packs. SW-J stated there was a box of garbage with a moldy sandwich and cookies removed. Surveyor asked if R65 was aware that SW-J was going to enter R65's room. SW-J stated yes and stated that it occurred on the same day that SW-J care planned R65 as a hoarder. R65's care plan initiated 8/4/25 documents: The resident has a behavior problem [related to] hoarding. Pertinent interventions include Encourage resident to express their feelings. Social services will go in resident's room to remove old food, drink, garbage, plates, silver wear, cups, etc. On 8/12/25 at 10:38 SW-J returned to Surveyor with a post it note dated 8/4/25 and reads, [R65] refused to clean room. Went in with nursing. Surveyor asked if R65 was involved in the care planning regarding hoarding. SW-J stated no, R65 was not involved in that decision. R65 has behaviors and SW-J indicated that it couldn't work like that because of R65's behaviors. On 8/12/25 at 1:31 PM, Surveyor asked R65 if SW-J spoke to R65 about R65's new care plan regarding hoarding and an intervention that stated SW-J can enter R65's room to room items. R65 stated Absolutely not. Surveyor noted that R65's right to be involved in R65's care planning process was dismissed by facility staff. On 8/12/25 at 10:32 AM, Surveyor asked UM-D about a list of missing belongings given to UM-D by R65. UM-D stated that UM-D spoke to R65 about the list and reviewed the list with Nursing Home Administrator (NHA)-A. Surveyor asked what was missing from R65's room. UM-D stated that R65 reported missing pens and clips. UM-D stated that there was a [NAME] ball missing which UM-D informed NHA-A about. UM-D stated that there was some shelf food missing as well. On 8/13/25 at 10:31 AM, Surveyor interviewed NHA-A. Surveyor asked if NHA-A had heard about R65's items missing in R65's room. NHA-A stated that NHA-A had heard that R65 wanted to speak to NHA-A, but NHA-A had not had a chance to speak to him yet but will speak to R65 soon. Surveyor asked if UM-D had provided a list of items that R65 was missing. NHA-A stated that UM-D and NHA-A are working to get R65's items back. NHA-A was aware of a [NAME] ball, pens and clips. Surveyor informed NHA-A that according to R65, R65 is also missing a collection of used shopping bags, a reusable tote bag, shelf food, and a paper banner that held sentimental value. NHA-A stated that NHA-A will follow up with that. Surveyor informed NHA-A of the concern that R65 went to a group activity and was not notified before staff entered R65's room to remove items. R65 returned to R65's room and R65 told Surveyor that R65's room was tossed. On the same day that staff removed items without R65's permission, R65 had a care plan intervention entered that SW-J can enter R65's room to remove items. SW-J informed Surveyor that SW-J did not review that care plan with R65 prior to implementation. R65 informed Surveyor that R65 did not know anything about that care plan intervention. Surveyor informed NHA-A that R65 has the right to self-determination about R65's room and the right to be involved in R65's care plan. NHA-A stated that NHA-A understood that R65 has those rights and stated that NHA-A will meet with SW-J and R65 to determine how to move forward.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure formulated advance directives were documented accurately for 1 (R3) of 20 residents reviewed for code status. Documentation in R3's medical record indicated R3 desired to be a full code (cardiopulmonary resuscitation to be administered) and a do not resuscitate (DNR). Findings include: The facility policy and procedure titled Residents' Rights Regarding Treatment and Advance Directives dated [DATE] documents: Explanation and Compliance Guidelines: 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate and advance directive. 3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. 7. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives. 8. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. 9. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. R3 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (a brain disorder characterized by changes in mental and cognitive function), diabetes, chronic obstructive pulmonary disease, dementia, depression, anxiety, and coronary artery disease. R3's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R13 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13. R3's Power of Attorney (POA) was activated. On [DATE], the Resident Code Status form was completed and witnessed by Social Worker (SW)-J and Unit Manager (UM)-D. The form documented R3's POA verbally elected R3 to be a full code. The form was not signed by R3's POA. On [DATE], the State Emergency Care Do Not Resuscitate Order (DNR) form was completed by SW-J and SW Assistant (SWA)-I documenting R3's POA verbally elected R3 to be a DNR. The form was signed by R3's physician. On [DATE], the State Emergency Care Do Not Resuscitate Order (DNR) form was completed by SWA-I documenting R3's POA verbally elected R3 to be a DNR. The form was signed by R3's physician. R3's electronic medical record (EMR) dashboard documents R3 is DNR with a physician order in place. Progress notes entered by R3's physician and nurse practitioner (NP) in R3's EMR document R3 is a full code. Full code was documented by R3's physician and NP from the time of admission with the most recently documented progress note on [DATE] at 7:00 AM by R3's physician. On [DATE] at 4:22 PM in the progress notes, SWA-I documented R3 is a long term resident in facility who chooses CPR as her code status. On [DATE] at 2:01 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern R3's code status was unclear. Surveyor showed NHA-A the documentation in R3's EMR of the verbal consents from R3's POA for the election of full code on [DATE], the State DNR form completed [DATE], the EMR banner indicating DNR, and the documentation in the progress notes by R3's physician, NP, and SWA-I that R3 was a full code. NHA-A agreed the documentation was confusing and was not sure what R3's wishes were. NHA-A stated NHA-A would talk to SWA-I to get clarification. In an interview on [DATE] at 2:51 PM, Surveyor asked Licensed Practical Nurse (LPN)-G where LPN-G would look to find out the code status of a resident. LPN-G stated LPN-G would look at the front of the resident's physical chart. LPN-G stated you can look in the computer, too, but LPN-G would look at the physical chart. Surveyor reviewed R3's physical chart found at the nurses' station on the unit. The first form indicating a code status was the verbal consent code status form from [DATE] indicating R3 was a full code. The State DNR form dated [DATE] was further down in the chart with multiple other papers between. Surveyor did not observe the State DNR form dated (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] in the chart. Surveyor noted if staff looked in the physical chart to determine what R3's code status was, the first document indicated full code. On [DATE] at 8:24 AM in the progress notes, SWA-I documented SWA-I confirmed the code status for R3 with R3's POA. R3 is DNR code status.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility did not ensure a safe, clean, comfortable, and homelike environment for 3 (R5, R34 and R65) of 3 residents. *R5's wall and heat register in R5's room was observed to be coated with dirt and a thick layer of dust. R5's curtains hanging over the heat register was observed to be coated with dirt and black spots. *R34's window in R34's room was observed to have a thick white film and appears cloudy. The outside of the window was observed to be dirty. Near R34's window, there is a cobweb with two dead flies hanging from it. R34's window blinds appear to be broken and not functional. *R65's air conditioning and heating unit on R65's wall in R65's room was observed to be disconnected and coming off the wall on the left side. On the left side of the unit, Surveyor observed an exposed metal pipe covered in dirt and cobwebs. R65's shared bathroom flooring is curved up to meet the tile on the walls. The flooring was observed to be peeling off the wall, exposing dirt and the dry wall behind it. Findings include: The facility policy with a reviewed/revised date of 7/1/25 titled "Safe and Homelike Environment" documents, in part: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment; housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment; 1.) R65 was admitted to the facility on [DATE]. R65's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents that R65 is cognitively intact. Surveyor reviewed R65's electronic medical record. Surveyor noted that R65 had a recent room change at the facility and has been in R65's current room since July 25, 2025. On 8/6/25 at 10:36 AM, R65 informed Surveyor that the individual air/heating unit in R65's room is ancient and loud. R65 stated that R65 has hit R65's leg when walking on that side of the bed due to the way the unit is hanging. Surveyor observed the unit. Surveyor noted the left side of the unit was coming off the wall and hanging down lower than the right side of the unit. Surveyor observed a metal pipe from a previous heating unit/radiator to the left of the current individual air/heating unit in R65's room. The metal piping is coming up from the floor and is covered with a thick layer of dirt. Surveyor observed cobwebs on the pipe, wall and air/heating unit. R65 directed Surveyor to R65's bathroom. Surveyor observed what appeared to be laminate flooring covering the floor and curling up about 3 inches to meet the tiled wall. Surveyor observed the laminate flooring is peeling away from the wall in multiple areas. Surveyor noted where the floor is peeling away, there is dirt and dust covering the exposed areas. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/25 at 11:18 AM, Surveyor interviewed Maintenance Director (MD)-F. Surveyor asked if MD-F had any concerns with R65's room. MD-F stated that MD-F had not been into R65's room since R65 moved in there. Surveyor asked if there is any scheduled work to be completed in R65's room. MD-F stated that MD-F can look. MD-F looked in the computerized system to check. MD-F stated there is nothing scheduled. Surveyor informed MD-F of the concern that R65's air/heating unit is detached on the left side and not connected flush to R65's wall. MD-F was willing to enter R65's room, but R65 had informed Surveyor that R65 did not want to be disturbed and wanted to sleep. MD-F and Surveyor entered a different resident room so that Surveyor could explain Surveyor's observations. Surveyor informed MD-F of the concern of a metal pipe that is exposed on the left side of R65's air/heating unit. Surveyor noted that in the current resident's room, there is a covering noted over the old unit's metal piping. Surveyor pointed to the covering and informed MD-F that the covering observed is not present in R65's room and R65's metal pipe is exposed and covered in dirt and cobwebs. Surveyor informed MD-F of the concern that R65's laminate flooring is peeling off R65's wall in R65's shared bathroom. MD-F thanked Surveyor for making MD-F aware. On 8/13/25 at 11:30 AM, Surveyor informed Nursing Home Administrator (NHA)-A of the concerns that R65's air/heating unit is detached on the left side and not connected flush to R65's wall, that there is an exposed metal pipe coming up from the floor on the left side of the unit that is covered in dirt and cobwebs, and that the laminate flooring in R65's bathroom is peeling off the wall exposing dirt. NHA-A stated that the maintenance department has ordered more new air/heating units in case they were needed, and they are waiting for them to come in. NHA-A indicated that NHA-A will address Surveyor's concerns with MD-F. 2.) On 8/11/25, at 8:21 AM, Surveyor observed R5's wall to the left of the bed. Surveyor noted the grids on top of the heat register where the air comes out, to be dirty and coated with thick dust. Surveyor noted the wall above the register grid to be black and coated in heavy dirt. Surveyor also noted, R5's curtains hanging directly over the heat register to be coated with dirt and black spots scattered on the curtains. On 8/13/25, at 9:01 AM, Surveyor interviewed Concierge Coordinator (CC)-K who indicates housekeeping, maintenance and herself make observations of resident rooms to ensure cleanliness and ensure equipment is working, prior to residents being admitted into the facility. CC-K states the facility has a couple resident rooms that require touch ups, and the facility avoids putting residents in these rooms. Surveyor notified CC-K of concerns with R5's heat register, wall, and curtain being coated in dirt with multiple black spots. CC-K walked Surveyor down to R5's room for observation. CC-K acknowledged these concerns and states she will be putting in a work order to have maintenance and housekeeping address these concerns. CC-K states R5 was recently admitted to the facility and the previous resident was in that room long term. CC-K states the facility is discarding curtains and placing blinds in resident rooms which tells her the previous resident was in R5's room for a long time prior to R5 being admitted . On 8/13/25, at 10:35 AM, Surveyor notified Director of Nursing (DON)-B of concerns above. DON-B acknowledged these concerns. 3.) R34 was admitted to the facility on [DATE]. On 8/13/25, at 10:16 AM, Surveyor observed R34's windows. Both windows have a very thick white film on the inside, appearing very cloudy like, the window on the right is slightly up with a (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cobweb hanging from it with two dead flies hanging from it. The outside windows are very dirty on the outside. The windowsill in between the inside and outside windows are very dirty with debris. There is no cord on the right side to pull up the blinds on the windows. On 8/13/25, at 10:28 AM, Surveyor interviewed Housekeeping (HK)-T in regard to the process of cleaning Resident rooms. HK-T explained there is daily cleaning expectations and then every Resident room is deep cleaned on a monthly basis. HK-T explained a monthly calendar is maintained to schedule the deep cleans. With a deep clean, one of the expectations is that the windows are cleaned including the frame, inside windows, and windowsills. HK-T stated if the staff notice something is not working right or appears to be broke it would be passed on to maintenance. HK-T stated HK-T does not know why HK-T's staff can't clean the outside windows. HK-T does not if it is the maintenance department or an outside company responsibility to clean the outside windows. HK-T has sometimes asked permission from the facility to clean the outside windows. HK-T informed Surveyor that R34's window was last deep cleaned on 7/28/25 and 8/26/25 is the next scheduled deep clean. On 8/13/25, at 10:44 AM, Surveyor and HK-T went to R34's room. Surveyor received permission from R34 to enter and observe R34's windows. It was determined the windows are extremely dirty on the outside. HK-T agreed that the inside sills should have been cleaned by the housekeeper and will follow up. HK-T agreed there is no pull strip to raise up the blind. HK-T had to pull the blind to the side to observe the extremely dirty window and the dirty windowsills. HK-T stated the windowsills between the inside and outside windows should have been cleaned in the deep clean and got missed. HK-T stated maybe it is because the blind would not open. On 8/13/2025, at 11:18 AM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A regarding R34's dirty windows and broken blind. Surveyor shared with NHA-A that HK-T agreed the windows were extremely dirty, the sills between the inside and outside windows are very dirty with cobwebs and two dead flies and the blind is broken and cannot be raised up. NHA-A acknowledged the concern and has no further information to provide at this time.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R53) of 2 residents with allegations of abuse were reported to the Nursing Home Administrator (NHA)-A per facility policy, the state agency and one or more law enforcement entities.*On 7/2/25, R59 informed 3 different facility staff members that CNA-FF was rough with R59. This allegation was not reported to the Nursing Home Administrator (NHA)-A, the state agency and one or more law enforcement entities. Findings include:The facility policy, with a last reviewed/revised date of 7/1/25, titled Abuse, Neglect and Exploitation documents, in part: It is the guideline of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The facility has a zero-tolerance stance around founded abuse, neglect, exploitation and misappropriation of resident property. Reporting/Response: . Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. It is important staff feel comfortable to report all concerns by assuring that reporters are free from retaliation or reprisal. Promoting a culture of safety and open communication in the work environment prohibiting retaliation against any employee who reports a suspicion of a crime. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.R59 was admitted to the facility on [DATE] with diagnosis that includes Cerebral Palsy.R59's Medicare 5-day Minimum Data Set (MDS) assessment dated [DATE] documents that R59 is cognitively intact. R59 uses a wheelchair and is dependent for transfers.On 8/7/25 at 8:48 AM, Surveyor interviewed R59. R59 informed Surveyor that a few weeks ago, R59's CNA, CNA-L, needed help getting R59 into the wheelchair. CNA-L went to get help from CNA-FF. Both CNA-L and CNA-FF returned to R59's room. R59 stated that during the transfer, CNA-FF was really, really rough. R59 stated that when R59 was put in R59's wheelchair, R59's feet got caught in some plastic on the wheelchair footrests. While CNA-L was trying to gently guide R59's feet, CNA-FF yanked the chair back hard. R59 stated that the yanking did not cause R59's skin to break but stated that the action really hurt. R59 stated that on other occasions, CNA-FF had been very rough with cares and was bossy and intimidating. Surveyor asked if R59 told anyone about what happened. R59 stated that R59 told CNA-L, a nurse and R59's Occupational Therapist (OT)-GG. R59 stated that OT-GG helped R59 fill out a grievance form. R59 stated that after [R59] informed staff about the concern, CNA-FF came back to R59's room and started apologizing. R59 stated that R59 thinks that administration told the staff member of R59's concern and that is why CNA-FF returned to R59's room. R59 stated that R59 felt intimidated.Surveyor reviewed the grievance log for the last 6 months and noted that there was no grievance logged about CNA-FF being rough with R59.Surveyor reviewed the Facility Reported Incident folders for the last 6 months and noted that there were no incidents documented about CNA-FF being rough with R59. On 8/7/25 at 9:01 AM, Surveyor interviewed CNA-L. Surveyor asked about the incident with CNA-FF. CNA-L stated that R59 is very sore when R59 wakes up in the AM. CNA-L stated that CNA-L works slower with R59 because of that. CNA-L stated that CNA-FF was helping get R59 into R59's wheelchair via the Hoyer lift. CNA-L indicated that CNA-FF yanked R59 from behind and caused R59 to start yelling about R59's feet. CNA-L indicated that CNA-L could not believe how CNA-FF was treating R59. CNA-L stated that CNA-L felt like CNA-FF was rough with R59 and many other residents during cares and transfers. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA-L stated that other residents had complained about CNA-FF. Surveyor asked what residents complained. CNA-L indicated that CNA-L cannot recall specific names, but the residents are no longer at the facility. Surveyor asked when CNA-L last saw CNA-FF working at the facility. CNA-L stated that CNA-L had not seen CNA-FF in a while and stated, I hope [CNA-FF] doesn't come back for there [the residents] sake. Surveyor asked if CNA-L told anyone about the incident. CNA-L stated that it is a hard position to be in CNA-L was not sure what to do. CNA-L indicated that R59 told the Social Worker. Surveyor noted that CNA-L had concerns about CNA-FF being rough with R59 and other residents and did not report this allegation of abuse to NHA-A per facility policy. On 8/7/25 at 10:40 AM, Surveyor interviewed OT-GG. Surveyor asked if OT-GG recalled a time that R59 reported a CNA being rough. OT-GG stated that a few weeks ago, R59 reported to OT-GG that CNA-FF was rough during cares and a transfer. OT-GG stated that CNA-FF can be rough. OT-GG stated that R59 told OT-GG that CNA-FF pulled too hard during a transfer and hurt R59. R59 asked OT-GG for help writing a grievance. OT-GG indicated that OT-GG told R59 that they could write it out and contact the Social Worker. Surveyor asked who OT-GG gave the grievance to. OT-GG indicated that OT-GG would normally give it to the Unit Manager or the Social Worker, but OT-GG is not sure who OT-GG gave the grievance form to. On 8/7/25 at 1:10 PM, Surveyor returned to OT-GG and asked about the grievance form. OT-GG stated that OT-GG thinks that OT-GG helped R59 fill out the grievance form because R59 has such a hard time writing. OT-GG unsure where it ended up. OT-GG stated that OT-GG usually takes copies of everything. OT-GG began looking in office. After looking, OT-GG stated that OT-GG could not find the form and thinks maybe R59 handed it in. OT-GG stated that Surveyor should check with Unit Manager (UM)-D. OT-GG stated that a lot of times, the Unit Managers will address the concern with the resident and then feel like that concern is complete and maybe that is the case with this, but OT-GG was not sure. Surveyor noted OT-GG was told by R59 that CNA-FF was rough with cares and transfers and did not report this allegation of abuse NHA-A per facility policy. On 8/7/25 at 1:45 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-G who was the nurse working on R59's unit on 7/2/25. Surveyor asked if R59 talked to LPN-G about another staff member. LPN-G stated that R59 informed LPN-G that CNA-FF was rough with cares and R59 does not like having CNA-FF as an aide and did not want CNA-FF as R59's aide. Surveyor asked if LPN-G informed anyone about R59's concerns. LPN-G stated that LPN-G told the Unit Manager. Surveyor asked if any documentation was completed after being told that by R59. LPN-G stated that LPN-G was not sure but stated that residents/staff usually have to fill out a grievance or incident report when something like that happens. Surveyor noted that on 7/2/25, a third staff member was told by R59 about CNA-FF being rough and this allegation of abuse was not reported to NHA-A per facility policy. On 8/7/25 at 11:20 AM, Surveyor interviewed NHA-A. Surveyor asked what the expectation is if a staff member is told by a resident that another staff member was rough and hurt them. NHA-A stated that they should follow the abuse policy and report it to me. Surveyor asked if NHA-A was informed about a CNA being rough with R59. NHA-A stated that NHA-A did not recall the incident of the top of NHA-A's head. NHA-A stated that NHA-A would get back to Surveyor. On 8/7/25 at 12:22 PM, NHA-A returned to Surveyor and provided Surveyor with a note completed and signed by UM-D regarding the incident. NHA-A stated that the incident occurred about 2 months ago. NHA-A indicated that the incident was not a report of rough with cares or transport but more of a preference that R59 had for transferring. NHA-A indicated that UM-D provided education to CNA-FF and watched CNA-FF and CNA-L complete a transfer after the fact. UM-D did ask R59 if UM-D could bring CNA-FF back to R59's room before allowing CNA-FF to return to R59's room. NHA-A stated that there is no documentation of the event aside from the note that given to Surveyor. The undated word document signed by UM-D documents: CNA came to get writer regarding resident [R59] and a transfer that happened. [R59] stated that CNA-L and CNA-FF were transferring [R59] and pushed on [R59's] leg when the transfer occurred. Writer asked [R59] to show [UM-D] where they pushed on [R59's] leg. [R59] stated [R59] was fine now just during the transfer it hurt. [R59] has chronic discomfort with transfers due to [R59's] (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cerebral palsy and leg pain in which [R59] is on pain medication for. [R59] stated [R59] has never had issues with [CNA-FF or CNA-L] but the transfer felt different today. Writer asked if [writer] could bring [CNA-FF] in to speak with us. [R59] agreed. [CNA-FF] apologized that [R59] experienced pain with the transfer. [R59] stated that [R59] understood that it was not done purposeful just wants everyone to be very careful when putting [R59] from Hoyer into chair due to the pain. Writer watched a transfer with staff and saw no issues. Staff is aware of not pushing on residents' leg to position [R59] into the chair. On 8/7/25 at 1:08 PM, Surveyor returned to UM-D and asked when UM-D signed the note regarding CNA-FF and R59. UM-D indicated that the transfer occurred on 7/2/25 and that is when the note was signed. On 8/11/25 at 8:53 AM, Surveyor interviewed SW-J who is R59's social worker. Surveyor asked if SW-J received a grievance from R59 on 7/2/25. SW-J stated that there is no grievance for that. Surveyor asked if SW-J had heard from R59 or another staff member that a CNA was rough. SW-J stated that SW-J never heard from any staff about another staff member being rough with R59. Surveyor asked what the protocol is if a resident reports that a staff member was rough. SW-J stated that SW-J would report that to the unit manager. Surveyor noted that SW-J told Surveyor that SW-J would tell the unit manager of a resident's report of a staff member being rough instead of the NHA-A per facility policy. On 8/7/25 at 10:43 AM, Surveyor interviewed CNA-S. Surveyor asked what CNA-S would do if a resident reported that a different staff member was rough with cares or a transfer. CNA-S stated that CNA-S would report that to a manager right away so they can start investigating. Surveyor noted that CNA-S told Surveyor that CNA-S would tell the unit manager of a resident's report of a staff member being rough instead of the NHA-A per facility policy. On 8/11/25 at 8:58 AM, Surveyor interviewed DON-B. Surveyor asked what DON-B would expect a staff member to do if a resident reported that a different staff member was rough with cares. DON-B stated that staff should report it to DON-B or NHA-A. On 8/13/25 at 2:50 PM, Surveyor informed NHA-A and DON-B of the concern that on 7/2/25, 3 staff members were informed by R59 that CNA-FF was rough. This allegation of abuse was not reported to the NHA-A per facility policy, was not reported to the state agency and was not reported to one or more law enforcement entities.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure an allegation of abuse was thoroughly investigated for 1 (R59) of 2 residents reviewed. R59 informed Surveyor that Certified Nursing Assistant (CNA)-FF was rough when caring for R59. On 7/2/25, R59 informed 3 different facility staff members of the alleged abuse incident. The allegation of abuse was not reported to Nursing Home Administrator (NHA)-A and the facility did not complete a thorough investigation into R59's allegation of abuse. Findings include: The facility policy, with a last reviewed/ revised date of 7/1/25, titled Abuse, Neglect and Exploitation documents, in part: It is the guideline of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The facility has a zero-tolerance stance around founded abuse, neglect, exploitation and misappropriation of resident property. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigation include: Identifying staff responsible for the investigation. Investigating different types of alleged violations, Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. Focusing the investigation on determining if abuse, neglect exploitation, and/or mistreatment has occurred, the extent, and cause: and providing complete and thorough documentation of the investigation. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after investigation. Examples include but are not limited to: Responding immediately to protect the alleged victim and integrity of the investigation-This should include staying with the alleged perpetrator to ensure no further contact (verbal or physical) until removal from the facility/environment. Increased supervision of the alleged victim and residents, Room or staffing changes, if necessary, to protect the resident from the alleged perpetrator. R59 was admitted to the facility on [DATE] with diagnosis that includes Cerebral Palsy. R59's Medicare 5-day Minimum Data Set (MDS) assessment dated [DATE] documents that R59 is cognitively intact. R59 uses a wheelchair and is dependent for transfers. On 8/7/25 at 8:48 AM, Surveyor interviewed R59. R59 informed Surveyor that a few weeks ago, R59's CNA, CNA-L, needed help getting R59 into the wheelchair. CNA-L went to get help from CNA-FF. Both CNA-L and CNA-FF returned to R59's room. R59 stated that during the transfer, CNA-FF was really, really rough. R59 stated that when R59 was put in R59's wheelchair, R59's feet got caught in some plastic on the wheelchair footrests. While CNA-L was trying to gently guide R59's feet, CNA-FF yanked the chair back hard. R59 stated that the yanking did not cause R59's skin to break but stated that the action really hurt. R59 stated that on other occasions, CNA-FF had been very rough with cares and was bossy and intimidating. Surveyor asked if R59 told anyone about what happened. R59 stated that R59 told CNA-L, a nurse and R59's Occupational Therapist (OT)-GG. R59 stated that OT-GG helped R59 fill out a grievance form. R59 stated that after [R59] informed staff about the concern, CNA-FF came back to R59's room and started apologizing. R59 stated that R59 thinks that administration told the staff member of R59's concern and that is why CNA-FF returned to R59's room. R59 stated that R59 felt intimidated. On 8/7/25 at 9:01 AM, Surveyor interviewed CNA-L. Surveyor asked about the incident with CNA-FF. CNA-L stated that R59 is very sore when R59 wakes up in the AM. CNA-L stated that CNA-L works slower with R59 because of that. CNA-L stated that CNA-FF was helping get R59 into R59's wheelchair via the Hoyer lift. CNA-L indicated that CNA-FF yanked R59 from behind and caused R59 to start yelling about R59's feet. CNA-L indicated that CNA-L could not believe how CNA-FF was treating R59. CNA-L stated that CNA-L felt like CNA-FF was rough with R59 and many other residents during cares and transfers. CNA-L stated that other residents had complained about CNA-FF. Surveyor asked what residents complained. CNA-L indicated (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that CNA-L cannot recall specific names, but the residents are no longer at the facility. Surveyor asked when CNA-L last saw CNA-FF working at the facility. CNA-L stated that CNA-L had not seen CNA-FF in a while and stated, I hope [CNA-FF] doesn't come back for there [the residents] sake. Surveyor asked if CNA-L told anyone about the incident. CNA-L stated that it is a hard position to be in CNA-L was not sure what to do. CNA-L indicated that R59 told the Social Worker. On 8/7/25 at 10:40 AM, Surveyor interviewed OT-GG. Surveyor asked if OT-GG recalled a time that R59 reported a CNA being rough. OT-GG stated that a few weeks ago, R59 reported to OT-GG that CNA-FF was rough during cares and a transfer. OT-GG stated that CNA-FF can be rough. OT-GG stated that R59 told OT-GG that CNA-FF pulled too hard during a transfer and hurt R59. R59 asked OT-GG for help writing a grievance. OT-GG indicated that OT-GG told R59 that they could write it out and contact the Social Worker. Surveyor asked who OT-GG gave the grievance to. OT-GG indicated that OT-GG would normally give it to the Unit Manager (UM) or the Social Worker (SW), but OT-GG is not sure who OT-GG gave the grievance form to. On 8/7/25 at 1:10 PM, Surveyor returned to OT-GG and asked about the grievance form. OT-GG stated that OT-GG thinks that OT-GG helped R59 fill out the grievance form because R59 has such a hard time writing. OT-GG unsure where it ended up. OT-GG stated that OT-GG usually takes copies of everything. OT-GG began looking in office. After looking, OT-GG stated that OT-GG could not find the form and thinks maybe R59 handed it in. OT-GG stated that Surveyor should check with Unit Manager (UM)-D. OT-GG stated that a lot of times, the Unit Managers will address the concern with the resident and then feel like that concern is complete and maybe that is the case with this, but OT-GG was not sure. On 8/7/25 at 1:45 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-G who was the nurse working on R59's unit on 7/2/25 when the allegation of abuse occurred. Surveyor asked if R59 talked to LPN-G about another staff member. LPN-G stated that R59 informed LPN-G that CNA-FF was rough with cares and R59 does not like having CNA-FF as an aide and did not want CNA-FF as R59's aide. Surveyor asked if LPN-G informed anyone about R59's concerns. LPN-G stated that LPN-G told the Unit Manager. Surveyor asked if any documentation was completed after being told that by R59. LPN-G stated that LPN-G was not sure but stated that residents/staff usually have to fill out a grievance or incident report when something like that happens. Surveyor reviewed the grievance log for the last 6 months and noted that there was no grievance logged, or investigation completed about CNA-FF being rough with R59. Surveyor reviewed the Facility Reported Incident folders for the last 6 months and noted that there were no incidents documented, or investigation completed about CNA-FF being rough with R59. Surveyor noted that CNA-L, OT-GG and LPN-G all had concerns about CNA-FF being rough with R59 and this allegation was not thoroughly investigated by the facility. On 8/7/25 at 10:58 AM, Surveyor interviewed UM-D. Surveyor asked if UM-D had received a grievance from R59 or heard about a concern that R59 had about a CNA staff member. UM-D stated that about a month ago, CNA-L and CNA-FF were transferring R59 and R59 was upset with the transfer. UM-D stated that CNA-FF did not push where R59 prefers to be pushed when completing a transfer. UM-D stated that there was not a formal grievance placed. UM-D stated that UM-D took CNA-FF back to R59's room after asking R59's permission. UM-D stated that they all talked, and everything was ok after that. UM-D stated that CNA-FF even took care of R59 after that incident. Surveyor asked if any other residents had concerns about CNA-FF cares. UM-D stated no. UM-D indicated that residents like CNA-FF. Surveyor asked if UM-D received a filled-out grievance form from OT-GG or from R59. UM-D stated that R59 did not want to do a grievance and UM-D did not receive a grievance from OT-GG. On 8/7/25 at 11:20 AM, Surveyor interviewed NHA-A. Surveyor asked what the expectation is if a staff member is told by a resident that another staff member was rough and hurt them. NHA-A stated that they should follow the abuse policy and report it to me. An investigation would follow. On 8/7/25 at 12:22 PM, NHA-A provided Surveyor with a note completed and signed by UM-D regarding the incident. NHA-A stated that the incident occurred about 2 months ago. NHA-A indicated that the incident was not a report of rough with cares or transport but more of a preference that R59 had for transferring. NHA-A indicated that (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	UM-D provided education to CNA-FF and watched CNA-FF and CNA-L complete a transfer after the fact. UM-D did ask R59 if UM-D could bring CNA-FF back to R59's room before allowing CNA-FF to return to R59's room. NHA-A stated that there is no other documentation of the event aside from the note given to Surveyor. The undated word document signed by UM-D documents: CNA came to get writer regarding resident [R59] and a transfer that happened. [R59] stated that CNA-L and CNA-FF were transferring [R59] and pushed on [R59's] leg when the transfer occurred. Writer asked [R59] to show [UM-D] where they pushed on [R59's] leg. [R59] stated [R59] was fine now just during the transfer it hurt. [R59] has chronic discomfort with transfers due to [R59's] cerebral palsy and leg pain in which [R59] is on pain medication for. [R59] stated [R59] has never had issues with [CNA-FF or CNA-L] but the transfer felt different today. Writer asked if [writer] could bring [CNA-FF] in to speak with us. [R59] agreed. [CNA-FF] apologized that [R59] experienced pain with the transfer. [R59] stated that [R59] understood that it was not done purposeful just wants everyone to be very careful when putting [R59] from Hoyer into chair due to the pain. Writer watched a transfer with staff and saw no issues. Staff is aware of not pushing on residents' leg to position [R59] into the chair. On 8/7/25 at 1:08 PM, Surveyor returned to UM-D and asked when UM-D signed the note regarding CNA-FF and R59. UM-D indicated that the transfer occurred on 7/2/25 and that is when the note was signed. Surveyor noted that the above document signed by UM-D is the only documentation provided to Surveyor by the facility about the incident on 7/2/25. On 8/13/25 at 2:50 PM, Surveyor informed NHA-A and DON-B of the following concern: R59 reported to 3 different facility staff that CNA-FF was rough on 7/2/25. The facility did not interview other staff members involved. The facility did not interview other residents in the facility about their cares. The facility did not complete a thorough investigation into the allegation of abuse that R59 told to facility staff on 7/2/25.		

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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 record review and interview, the facility did not accurately screen residents for a mental disorder for 2 (R4 and R9) of 2 residents reviewed for Preadmission Screen and Resident Review (PASARR) Level I and requiring a Level II screening.R4 was admitted to the facility with diagnoses of mental disorders and was not evaluated on the PASARR Level I screen as having any mental disorders. The Level II PASARR was never completed due to the inaccurate PASARR Level I screen.R9 was admitted to the facility with diagnoses of mental disorders and was evaluated as having a serious mental disorder on the PASARR Level I screen. R9 did not have a completed Level II PASARR screen when identified as having a positive Level I PASARR screen.Findings include:The facility's policy and procedure entitled, Resident Assessment - Coordination with PASARR Program dated 9/18/24, documents:The facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs.Explanation and Compliance GuidelinesAll applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening.PASARR Level I - initial pre-screening that is completed prior to admissionPositive Level I Screen - necessitates a PASARR Level II evaluation prior to admission.PASARR Level II - comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs.The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority.R4 was admitted to the facility on [DATE], with diagnoses of bipolar disorder (a mental health condition characterized by extreme shifts in mood, energy, and activity levels). R4's PASARR Level I screen was completed on 5/21/24, documenting R4 was not suspected of having a serious mental illness or a developmental disability. Surveyor notes, R4 has a diagnosis of bipolar disorder which is a serious mental illness. Surveyor notes, R4's Level I PASARR being completed incorrectly indicating R4 did not have a serious mental illness. Surveyor also notes, R4 does not have a PASARR Level II in the Electronic Medical Record (EMR).R9 was admitted to the facility on [DATE], with diagnoses of schizoaffective disorder (a severe chronic mental health disorder that affects how a person thinks, feels, and behaves) and bipolar disorder. R9's PASARR Level I screen was completed on 3/6/25. Surveyor notes R9 was documented as having a serious mental illness on the PASARR Level I. This document was signed by SW-J. Surveyor notes R9 does not have a PASARR Level II in the EMR.On 8/11/25, at 1:11 PM, Surveyor interviewed SW-J regarding the screening process for PASARR Level I and PASARR Level II. SW-J states she is responsible for completing PASARR's for residents within the facility. Surveyor asked about R4 and R9's PASARRs. SW-J states R9 had a PASARR Level I completed and doesn't understand why it doesn't come back indicating R9 requires a Level II PASARR. SW-J acknowledged R9 having a diagnosis of schizophrenia and stated, not everyone with schizophrenia requires a Level II PASARR. SW-J then stated a diagnosis of bipolar does not always require a Level II PASARR as well. SW-J states R9 would have to be displaying symptoms such as self-harm in order to qualify for a Level II PASARR. Surveyor asked about R4's Level I PASARR and why R4's PASARR Level I indicates R4 does not have a serious mental illness. SW-J stated R4 would have to display symptoms or have a major change in condition. SW-J then stated again, bipolar is not automatic for a Level II PASARR.On 8/11/25, at 3:36 PM, Surveyor notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of concerns with R4 and R9 not having PASARR Level II completed when R4's EMR and R9's EMR document them as having a serious mental illness. Surveyor notified NHA-A and DON-B of concerns with R4's Level I (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR indicating R4 does not have a serious mental illness when having a diagnosis of bipolar disorder. NHA-A and DON-B acknowledged these concerns. Surveyor requested additional information if available.		

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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 observations, interviews, and record review the facility did not ensure that residents with pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 3 (R1, R16 and R53) of 5 residents reviewed for pressure injuries. *R53 developed a facility acquired, Suspected Deep Tissue Injury (DTI) on 7/22/25. The pressure injury was incorrectly staged on 7/29/25 when it developed slough and continued to be staged as a DTI. The wound treatment was recommended to be changed but facility staff continued treating the wound with skin prep as previously ordered. On 8/5/25, the facility documented the same measurement of an unstageable wound and documented an area of DTI with a new measurement. With the changes in R53's wound, R53's care plan was not updated. On 8/13/25, Surveyor was provided with a late entry progress note from R53's MD documenting a stage 2 wound in the sacral area. Surveyor noted the incorrect location and stage. The late-entry MD progress note documented that skin prep can be used as treatment as of 7/31/25. Surveyor noted that despite the late entry progress note, facility staff did not follow recommendations listed on the 7/29/25 wound assessment. On 8/14/25, Surveyor was provided a correction to the late entry progress note from R53's MD documenting R53's wound as an unstageable wound in the lower back, just to the right of the midline. During survey, Surveyor observed R53's heels not floated as care planned. *R1 is at risk for pressure injuries and has a history of pressure injury to heels. Surveyor observed R1's heels resting directly on R1's bed and not being floated. *R16's pressure injury treatments were not always completed as ordered during the months of July and August 2025. Findings include: The facility policy with a last reviewed date of 4/17/25 titled, "Pressure Injury Prevention and Management" documents, in part: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries; Assessments of pressure injuries will be performed by a licensed nurse and documented on the medical record. The staging of pressure injuries will be clearly identified to ensure correct coding on the [Minimum Data Set Assessment]; Training in the completion of the pressure injury risk assessment, full body skin assessment, and pressure injury assessment will be provided as needed; After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment; Basic or routine care interventions could include, but are not limited to: Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.); Provide appropriate, pressure-redistributing, support surfaces; Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present; Treatment decisions will be based on the characteristics of the wound, including the stage, size, exudate (if present), presence of pain, signs of infection wound be, wound edge and surrounding tissue characteristics; Interventions will be documented in the care plan and (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communicated to all relevant staff. Compliance with interventions will be documented in the weekly summary charting. The attending physician will be notified of: The presence of a new pressure injury upon identification. The progression towards healing, or lack of healing, of any pressure injuries weekly&hellip; The National Pressure Injury Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP) and Pan Pacific Pressure Injury Alliance published &ldquo;Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline&rdquo; in 2019 which documents, in part: International NPUAP/EPUAP Pressure Ulcer Classification System defines a Suspected deep tissue injury as a &ldquo;purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.&rdquo; &hellip; NPUAP/EPUAP defines Unstageable pressure injury as full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage cannot be determined&hellip; R53 was admitted to the facility on [DATE] with diagnosis that include: Chronic Obstructive Pulmonary (lung) disease, Heart failure, Stage 2 kidney disease, Depression and Metastatic melanoma (skin cancer) progressing to metastatic lung cancer, History of spinal fusion L2, 3-4 and disc herniation in 1998. R53&rsquo;s Annual Minimum Data Set (MDS) assessment dated [DATE] documents, R53 is moderately cognitively impaired. R53 is independent for bed mobility and chair to bed transfer. R53 is occasionally incontinent of bladder and always incontinent of bowel. R53 is not at risk for pressure injuries and does not have an unhealed pressure injury. R53&rsquo;s Pressure injury Care Area assessment dated [DATE] documents [R53] is at risk for pressure injuries [related to] incontinence, weight loss from disease process and limited mobility. R53 has a guardian. R53 is on hospice which was started in June of 2023. R53&rsquo;s Potential for impaired skin integrity care plan initiated on 6/20/23 documents the following interventions: Assist to reposition approximately [every] 2 hours and [as needed]. Assist resident into chair as needed. Apply cushion to [wheelchair]. Barrier cream after each incontinent episode and [as needed]. Free float heels in bed. Lotion skin with cares. Monitor skin with all cares. Report any changes to nurse. R53&rsquo;s Certified Nursing Assistant (CNA) Kardex (provided during survey) documents, in part: Bed Mobility: the resident requires no assistance by staff to turn and reposition in bed an as necessary. Resident Care: Assist to reposition approximately [every] 2 hours and [as needed]. Free float heels in bed. R53&rsquo;s progress note dated 7/9/25 at 10:11 AM, documents, in part: Resident being sent to hospital [due to] being unable to keep any intake down. Hospice at bedside&hellip; R53 was admitted to the hospital from 7/9-7/10/25. R53&rsquo;s hospital Discharge summary dated [DATE] documents, in part: &hellip; [R53] was sent (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the emergency department . due to swallowing difficulties and apparent abdominal pain&hellip; [R53] had a CT scan that showed worsening metastatic disease and a thickened area of bowel concerning for infection versus mass. [R53&rsquo;s] guardian was contacted who agreed with continuing hospice care&hellip; Will discharge back to [facility] under hospice care with medications as previously ordered. R53&rsquo;s Braden Scale Evaluation (an evaluation to predict pressure injury risk) dated 7/10/25 documents a score of 16 making R53 at moderate risk for pressure injury development. R53&rsquo;s progress note dated 7/10/25 at 5:06 PM documents, in part: &hellip; No skin issues noted&hellip; R53&rsquo;s progress note dated 7/11/25 at 10:57 AM documents, in part: &hellip; Resident slept on and off throughout shift. Continue to monitor. R53&rsquo;s progress note dated 7/13/25 at 12:25 PM documents, in part: &hellip; Spent most of this shift sleeping&hellip; R53&rsquo;s progress note dated 7/13/25 at 10:08 PM documents, in part: &hellip; Resident did not eat dinner&hellip; slept most of shift. R53&rsquo;s progress note dated 7/14/25 6:48 AM documents, in part: &hellip;Resident is currently in bed sleeping&hellip; R53&rsquo;s progress note dated 7/14/25 at 11:07 AM documents, in part: Resident sleeping throughout shift&hellip; Surveyor noted facility staff documented multiple days after R53&rsquo;s hospitalization that R53 was sleeping. On 8/12/25 at 9:26 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-G. Surveyor asked how R53&rsquo;s health was after returning from the hospital to the facility. LPN-G indicated that LPN-G did not think that R53 would come back to the facility because R53 was so sick. LPN-G stated that R53 is not as mobile as R53 had been and indicated that R53&rsquo;s health was declining. On 8/12/25, Surveyor reviewed the last 30 days of R53&rsquo;s CNA tasks documentation of R53 being turned and repositioned every 2 hours. CNAs are directed to complete this documentation every shift. The question asks Did you turn and reposition? Surveyor counted 3 out of the 30 days that CNAs documented an answer each shift, leaving the other 27 days without completed documentation each shift. Surveyor noted that the following shifts were documented as No, indicating CNA did not assist resident with turning and repositioning: On 7/13/25 at 11:54 AM, CNA charted No to turning and positioning. On 7/20/25 at 11:51 PM, CNA charted No to turning and repositioning. On 7/22/25 at 2:15 AM, CNA charted No to turning and repositioning. On 7/23/25 at 1:33 AM, CNA charted NO to turning and repositioning. On 7/24/25 at 2:10 AM, CNA charted No to turning and positioning. On 7/29/25 at 5:39 AM, CNA charted No to turning and repositioning. On 8/5 at 10:38, charted No to turning and repositioning. R53's Nutrition progress note dated 7/14/25 at 1:38 PM documents, in part: readmitted post hospital stay for [nausea/vomiting] . Continues with variable intake 25-100% . Tolerating diet [without] (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	issues per nursing, resident sleeping on attempt to visit. Magic cup [two times a day] and Mighty shake 4oz [three times a day] in place for nutrition support; accepts 100%. Skin intact. Resident with [history significant weight] loss, likely [related to] disease progression, variable intakes and Hospice care. Further [weight] loss anticipated and likely unavoidable. [Continue] current diet and . [continue] to offer food/fluids as tolerated and follow food preferences . Surveyor reviewed R53's meal intakes for the last 30 days. Surveyor noted R53 eats 0 to 100% of meals. Surveyor noted that not every meal was documented by Certified Nursing Assistants. R53's progress note dated 7/22/25 at 12:50 PM documents: [Suspected Deep Tissue Injury (SDTI)] noted to lower mid spine. Area measures 2 [Centimeters (CM)] x 1.5 CM x 0 CM. Area noted to be dark purple and red in color and not blanchable. Skin surrounding wound noted to be light pink and blanchable. Area cleansed with normal saline and boarder foam dressing applied. Resident instructed that [R53] needs to lay on [R53's] sides to sleep due to SDTI. Hospice ordered an air mattress for Resident as well. Will continue to monitor. R53's Initial Wound assessment dated [DATE] documents: Date wound was identified: 7/22/25. Where was the wound acquired? Acquired after admission to facility. Type of wound? Pressure. Vertebrae (upper-mid) Pressure 2 cm x 1.5 cm Suspected Deep Tissue Injury. 100% granulation&hellip; Resident has poor intake of food. Repositioning completed every 2-3 hours and as needed&hellip; Treatment in place, air mattress, repositioning every 2-3 hours and as needed. Physician notified&hellip; R53's skin integrity care plan documents the following interventions dated 7/22/25: Use pillows to prop, reposition and offload resident off of [R53's] back every 2 hours. APM (alternating pressure mattress). R53's Braden Scale evaluation score dated 7/22/25 is 14 making R53 at moderate risk for developing a pressure injury. R53's MD orders dated 7/22/25 documents, DTI to lower mid spine: Skin prep and cover with foam dressing twice daily. Two times a day for wound care. Surveyor reviewed R53's Treatment Administration Record (TAR) and noted facility staff completed the treatment 2 times a day from 7/22/25 through 7/29/25. R53's Weekly wound assessment dated [DATE] documents, in part: Wound Measurement date 7/29/25. Pressure wound of Vertebrae (upper-mid) 2 cm x 1.5 cm Suspected Deep Tissue Injury. 50% granulation, 50% slough&hellip; Resident has slough present on wound. Treatment was changed to Dakin's quarter strength, skin prep, cover with calcium alginate and a border foam&hellip; Surveyor noted that R53's wound developed slough. The facility incorrectly staged the wound as a SDTI instead of an unstageable or stage 3 pressure injury. According to NPUAP/EPUAP pressure ulcer classification system a wound that develops slough is not a SDTI, this would be staged as an unstageable or stage 3 wound depending on the characteristics of the wound bed. Surveyor reviewed R53's care plan and noted that R53's care plan was not updated with a new care plan intervention after R53's DTI progressed to a pressure injury with slough. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R53's MD orders and noted facility staff did not enter the new recommended treatment change documented on the 7/29/25 wound assessment. Surveyor reviewed R53's TAR and noted facility staff continued treating R53's wound that had developed slough with skin prep and border foam dressing from 7/29/25 through 8/5/25. R53's Weekly wound assessment dated [DATE] documents, in part: Wound Measurement date 8/5/25. Pressure wound of Vertebrae (upper-mid) 2 cm x 1.5 cm Unstageable. 50% granulation. 50% slough. Are abnormalities noted to wound edges/peri-wound? No&hellip; Resident has slough present on wound. Treatment was changed to Dakin's quarter strength, skin prep, cover with calcium alginate and a border foam. DTI distal to prior DTI noted measuring 2 x 1. Repositioning is being completed every 2-3 hours and as needed. Resident is on hospice and not able to take in nutrition appropriately. Resident on hospice services [related to] terminal lung cancer. Surveyor noted that the measurement of the initial pressure injury remained the same as the initial wound assessment on 7/22/25 and weekly wound assessment on 7/29/25. Surveyor noted that the facility documented no abnormalities noted to the wound edges/peri-wound. Surveyor noted facility staff documented a measurement of an additional DTI distal to the prior DTI. R53's MD order dated 8/5/25 documents: DTI to lower mid spine: Cleanse with 1/4 strength Dakin's, skin prep to surrounding area, apply calcium alginate, [followed by] border foam dressing daily. One time a day for wound care. Surveyor noted that the treatment change recommended on 7/29/25 and 8/5/25 was implemented by facility staff on 8/5/25. Surveyor reviewed R53's care plan and noted that R53's care plan was not updated with a new care plan intervention after R53 developed an additional "DTI distal to prior DTI." On 8/7/25 at 10:39 AM, Surveyor observed R53 on R53's back in bed. R53's head of bed (HOB) is elevated 40%. Survey noted air mattress to R53's bed is on and functioning. R53's heels resting on bed and not elevated/floated. On 8/7/25 at 1:06 PM, Surveyor observed R53 on R53's back in bed. R53 has a pillow under R53's left lower back. R53's heels resting on bed and not elevated/floated. On 8/11/25 at 12:59 PM, Surveyor observed R53 sleeping in bed. R53 has 2 pillows placed under R53's back. Surveyor noted R53's left heel was resting on bed and not elevated/floated. Surveyor noted multiple observations of R53's heels resting on the bed and not elevated/floated per care plan intervention. On 8/11/25 at 8:25 AM, Surveyor interviewed CNA-EE. Surveyor asked what interventions were in place for R53's heels. CNA-EE indicated that CNA-EE was not sure. CNA-EE stated that R53 gets cream on R53's back. CNA-EE stated again that CNA-EE was not sure about what is done. On 8/12/25 at 9:26 AM, Surveyor interviewed LPN-G. Surveyor asked what interventions were in place for R53's skin. LPN-G stated that LPN-G would have to check the medical record. LPN-G looked in the electronic medical record and stated that R53 has an air mattress and is being turned. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted staff did not mention free floating of heels as part of R53's care plan interventions. On 8/12/25 at 10:06 AM, Surveyor observed wound rounds with Unit Manager (UM)-D. R53 was observed sitting in R53's electric wheelchair and leaning forward. After washing hands and donning gloves, UM-D removed the dressing with a date of 8/11/25 written on it. UM-D did not measure the wound. The wound was cleansed, and the treatment completed. A new dressing with the date of 8/12/25 was placed on R53's pressure injury. Surveyor observed 2 separate wounds. Surveyor observed a dime size round unstageable pressure injury with 100% slough to the mid/lower back just to the right of R53's spine. Surveyor observed a small purple DTI located on R53's mid-spine to the left and above the unstageable wound. UM-D stated that R53's wound started as a DTI and was dark purple. UM-D indicated that the area with slough opened up and a spot of purple remained to the upper left side in the peri-wound. UM-D stated with this assessment the small area/DTI is more separated from the original wound than it was in the previous week assessment. UM-D stated that R53 has an unstageable pressure injury and a DTI. Surveyor noted that during the wound observation, Surveyor made no observations of any mass that could have potentially led to the development of the pressure injury. Surveyor noted UM-D did not point out any masses during the wound treatment of R53's wounds. After R53's wound care was completed, Surveyor asked why UM-D thinks that R53 developed a pressure injury. UM-D stated that R53 is unable to eat normally, and it is hard to keep any food down because of R53's stage 4 cancer diagnosis. Surveyor noted that UM-D made no mention of any mass that could have led to the development of R53's pressure injury. Surveyor asked about R53's mobility after hospitalization. UM-D stated that R53 was in bed a couple days but then was getting up in R53's wheelchair. Surveyor asked what interventions are in place for R53's skin. UM-D indicated that R53 got an air mattress the day that the pressure injury was found. UM-D indicated that they did not place an air mattress on before that because it caused a fall risk for R53. Surveyor asked if measuring a wound is part of the weekly wound round. UM-D indicated they measure weekly. Surveyor asked why R53's wound was not measured during the wound treatment observation. UM-D stated that UM-D completed the measurements earlier this morning. UM-D stated that the unstageable wound measured 1.5 cm x 1.5 cm, and the DTI measured 0.5 cm x 1 cm. Surveyor asked if the wound dressing dated 8/11/25 that surveyor observed at beginning of the wound rounds on 8/12/25 was removed and then replaced after measuring earlier this morning. UM-D stated that UM-D measured the wounds yesterday (8/11/25). Surveyor asked who enters the treatment orders if a treatment change is recommended for R53. UM-D stated that UM-D would enter the orders. Surveyor reviewed R53's electronic medical record and did not locate a pressure injury wound assessment or measurements documented dated 8/11/25. R53's Weekly wound assessment of the Unstageable pressure injury dated 8/12/25 documents, in part: Wound Measurement date 8/12/25. Pressure wound of Vertebrae (upper-mid) 1.5 cm x 1.5 cm. Unstageable. 100% slough. Are abnormalities noted to wound edges/peri-wound? No&hellip; Treatment in place. Area has 100% slough noted to be expected. Peri wound DTI 0.5 x 1.0 has separated from the peri wound intact skin separating between unstageable and DTI presenting as 2 areas instead of one&hellip; R53's Weekly wound assessment dated [DATE] documents, in part. Wound Measurement date (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/12/25. Type of wound pressure. Vertebrae (upper-mid) 0.5 x 1 Suspected Deep Tissue Injury. 100% eschar&hellip; Encouraging to turn and reposition every 2-3 hours and as needed. Peri wound DTI 0.5 x 1.0 has separated from the peri wound of the initial wound separating between unstageable and DTI presenting as 2 areas instead of one. Surveyor noted that the facility documented a separate DTI and documented that the DTI had 100% eschar. According to NPUAP/EPUAP pressure ulcer classification system a wound that is 100% eschar is an unstageable wound. Surveyor noted during observation of R53&rsquo;s wounds, that R53 had a small purple DTI. Surveyor did not observe eschar. On 8/12/25 at 1:51 PM, Surveyor interviewed Director of Nursing (DON)-B, and UM-D. DON-B indicated that the Unit managers complete the wound rounds each week. DON-B, who is wound certified, oversees the wound program at the facility. The resident&rsquo;s primary doctor with their colleagues and the medical director oversees DON-B&rsquo;s wound program. Surveyor shared concern that R53 had a decline in R53&rsquo;s health after R53&rsquo;s hospitalization and R53 was not put on an air mattress to prevent pressure injury development. DON-B indicated that R53 was up and moving around soon after that hospitalization. The pressure injury developed because of R53 has not been able to eat and keep anything down. R53 has multiple contributing factors including, cancer, smoking, his kyphosis and positioning. DON-B indicated that Hospice is also involved in R53&rsquo;s cares and did not order an air mattress. After developing the pressure injury, an air mattress was ordered and placed on R53's bed. Surveyor shared concern that after the wound developed slough on 7/29/25, the wound was staged incorrectly and still documented as a DTI. In addition, the treatment recommendations on the 7/29/25 weekly wound assessment were not implemented and staff continued to treat a wound with slough with skin prep. The next week on 8/5/25, R53 developed (what the facility documented) a DTI distal to prior DTI. DON-B stated that the development of slough is not worsening of the wound, the development of slough is to be expected. DON-B stated that the distal DTI documented with the unstageable wound on 8/5/25 was part of the original wound and that this was not a new area. DON-B stated there was not a good way to document the DTI assessment because it really was part of the original wound. Surveyor asked why the treatment change on 7/29/25 was not entered as an MD order. UM-D stated that UM-D would need UM-D&rsquo;s computer and would have to look into it. UM-D did not return to Surveyor. On 8/12/25 at 3:05 PM, Surveyor informed Nursing Home Administrator and DON-B of the concern that R53 developed a DTI to R53&rsquo;s back on 7/22/25. On 7/29/25, the wound was assessed with 50% slough and 50% granulation and was staged incorrectly as a DTI instead of an unstageable or stage 3 pressure injury. The treatment was recommended to be changed, and facility staff did not enter the order change. Staff continued to treat the pressure injury with slough and granulation with skin prep. On 8/5/25, there was an area documented by facility staff as a DTI and an area of unstageable pressure injury. After any changes in the wound, the care plan was not updated with new interventions. On 8/13/25 at 8:21 AM, DON-B informed surveyor that the facility does an investigation after a resident develops a pressure injury. DON-B provided Surveyor with a folder that included the investigation, hospital records, and an Unavoidable vs Avoidable pressure injury form completed by R53&rsquo;s primary MD. The Verification of Investigation form signed by DON-B on 7/31/25 documents in part: &hellip; (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/22/25 Resident presented with bruising to lower-mid back vertebrae&hellip; suspected deep tissue injury&hellip; Resident is unable to sit fully upright due [to] lordosis/kyphosis, leaning to left which anatomically off loads pressure to affected area&hellip; Resident has had a progressive decline in condition which started in early July due to resident being unable to swallow, and insisting to go to ER for further workup&hellip; Resident had no skin concerns upon return on 7/10/25. Risk of adding air mattress would have caused increased injury as Resident continued self-transferring as care planned. Resident complained of pain to back on 7/22/25. DON questioned Resident if [R53] remained on gurney while in ER and resident stated &ldquo;[R53] could not recall the type of bed it was.&rdquo; Presentation of wound appeared to be a bruise however due to location and residents&rsquo; recent hospitalization [and] lack of intake, writer opted to classify discoloration as a DTI due to hospice service unable to rule out if area was truly a DTI vs metastatic changes based on [history] of melanoma and lung cancer, as lung cancer alone causes changes to integumentary system. [Registered Nurse/Assistant Director of Nursing] assessed back with bruise/DTI noted with MD contacted and treatment put into place. On 7/29/25, resident noted to have changes to area which opened presenting with slough, however, the peri wound had bruising/DTI remaining&hellip; considered changing wound to potentially a Kennedy ulcer/lesion based on resident&rsquo;s lack of intake, history of metastatic melanoma which can present as a DTI and no other signs of pressure present&hellip; On 7/31/25&hellip;writer/DON&hellip; discussed with MD area of concern. MD/[Nurse Practitioner] agreed wound appeared to be unavoidable due to resident&rsquo;s diagnosis/prognosis in which integumentary changes would be inevitable&hellip; On 8/13/25 at 9:13 AM, Surveyor interviewed DON-B about the investigation folder. Surveyor stated that a week after developing a pressure injury, the wound progressed and developed slough. Surveyor asked why the treatment order change documented in the 7/29/25 wound assessment was not entered by facility staff as an MD order. DON-B stated that DON-B does not feel like the wound worsened. DON-B stated that treatment with skin prep is still appropriate. Surveyor asked why DON-B did not reach out to the physician if DON-B felt like the treatment order change was not necessary. DON-B indicated that UM-D would be entering the orders and DON-B could not speak for UM-D, but DON-B would talk to the doctor before changing an order. Surveyor asked if DON-B was not sure what the wound was (pressure, Melanoma, Kennedy ulcer or pressure related to hardware from previous spinal surgery), why did a physician not assess the wound. DON-B stated that the MD/NP&rsquo;s are not always wound certified. DON-B stated that R53's pressure injury was discussed with MD on 7/31/25 when MD determined that the pressure injury was unavoidable. On 8/13/25 at 12:58 PM, DON-B gave Surveyor a progress note entered by R53&rsquo;s MD. The progress note entered into R53&rsquo;s medical record on 8/13/25 at 12:47 PM documents, in part: Date of service 7/31/25&hellip; Chief complaint: The patient was seen at the request of the nurse. The patient has a wound on the lower back that came up just over a week ago. The patient has multiple comorbidities including [congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), hypertension] and low albumin levels. [R53] does not ambulate. [R53] has had surgery on his lower back in the past with insertion of hardware. The recommendations for wound care from 7/29/25 were reviewed and I had decided to continue with the previous wound care which was skin prep and foam. This was because of [R53&rsquo;s] end stage COPD, [R53] being on palliative care and this particular wound care [is] much more comfortable for him&hellip; Physical exam: &hellip; SKIN. Positive: warm, dry, wounds. Notes: the patient has a stage 2 decubitus in the sacral area just to the right of the midline. The base has yellowish, with minimal drainage and a small surrounding area of redness. The pictures were reviewed as well&hellip; ASSESSMENTS AND PLANS: &hellip; Pressure ulcer of right lower back, stage 2: discussed with nursing&hellip; Discussed wound care. Will continue the skin prep with foam for now. The patient has multiple comorbidities, and the (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound is likely to decline. The patient is on Morphine for pain which makes him lethargic and [R53] is unable to keep the weight off the wound. Given all [R53's] comorbidities, the wound is likely to decline&hellip;Wound care with skin prep and foam. Surveyor noted that the MD progress note documents that the MD assessment revealed a stage 2 sacral pressure wound. Surveyor noted that the location of the wound observed by Surveyor was on R53's Mid back, not in the sacral area as documented in the MD progress note. Surveyor noted that the MD described the base of the wound as yellowish. According to the NPUAP/EPUAP slough is defined as yellow, tan, gray, green or brown. According to the NPUAP/EPUAP, a stage 2 pressure injury is described as Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red&hellip; Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. Surveyor noted the wound described by MD is staged incorrectly. Surveyor noted that MD stated that the treatment will be skin prep and foam on 7/31/25. Surveyor noted that this recommendation came 2 days after the original recommendation for a change in treatment after the development of slough in the wound on 7/29/25. On 8/13/25 at 1:05 PM, Surveyor returned to DON-B to discuss the MD progress note. DON-B stated that DON-B noted the discrepancy and had contacted the MD to correct it. On 8/13/25 at 2:45 PM, NHA-A and DON-B were informed of the concerns regarding R53's facility-acquired pressure injury that developed on 7/22/25. The pressure injury was incorrectly staged on 7/29/25 when it developed slough and continued to be staged as a DTI. The wound treatment was recommended to be changed but facility staff continued treating the wound with skin prep as previously ordered. On 8/5/25, the facility documented the same measurement of an unstageable wound and documented an area of DTI with a new measurement. With the changes in R53's wound, R53's care plan was not updated. A late entry progress note entered by R53's MD documents a stage 2 wound in the sacral area. Surveyor noted the incorrect location and stage. The late-entry MD progress note documented that skin prep can be used as treatment as of 7/31/25. Surveyor noted that facility staff did not follow recommendations listed on the 7/29/25 wound assessment. On 8/14/25, Surveyor received a corrected MD progress note with a date of service 7/31/25 that documents the following: The patient has an unstageable wound in the lower back, just to the right of the midline. The base has yellowish slough, because of which staging is not possible. There is minimal drainage and a small surrounding area of redness/discoloration&hellip; Pressure ulcer of right lower back, unstageable&hellip; On 8/27/25, the facility provided Surveyor with an additional hospice note dated 8/27/25. The hospice note written by RN-SS documents: Writer spoke with [Name] NP (Nurse Practitioner) regarding the swelling to R53's back. Two pressure injuries are still present. There is now a mass underneath the previous open areas. Writer suspects this is related to patient's metastatic lung cancer and that tumor growth has been impeding wound healing. There has been swelling to the area for approximately the last two weeks. The area of swelling has gotten progressively larger and the mass has grown significantly the last five days. The area is hard, but not warm. Facility has been		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure 1 (R24) of 4 Residents with limited range of motion receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.*R24 was not wearing R24's right hand splint/ right elbow brace during the survey. There was no documentation R24 was provided with physician ordered neck exercises. Surveyor did not observe any range of motion being performed.Findings include:Surveyor reviewed the facility's Prevention of Decline in Range of Motion policy and procedure revised 11/11/24:..PolicyResident who enters the facility without limited range of motion will not experience a reduction in range of motion unless the Resident's clinical condition demonstrated that a reduction in range of motion is unavoidable.Policy Explanation and Compliance Guidelines1. The facility in collaboration with the medical director, director of nurses and as appropriate, physical/occupational consultant shall establish and utilize a systematic approach for prevention of decline in range of motion, including assessment, appropriate care planning, and preventive care.2. Assessment for Range of Motiona. Licensed nurses will assess Resident's range of motion on admission/readmission, quarterly, and upon significant change.B. Residents who exhibit limitations in range of motion, initially and thereafter, will be referred to the therapy department for a focused assessment of range of motion.c. Nursing assistants will report any significant changes in range of motion, as noted during daily care activities, to the Resident's nurse when any changes are noted.3. Appropriate Care Planninga. Based on the comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motions.c. Care plan interventions will be developed and delivered through the facility's restorative program, or through specialized rehabilitative services as ordered by the attending practitioner.d. Interventions will be documented on the Resident's person centered care plan.e. A nurse with responsibility for the Resident will monitor for consistent implementation of the care plan interventions. Refusals of care or problems associated with range of motion exercises will be documented in the medical record.f. Modifications to the plan of care will be made as needed.4. Preventive Careb. Staff will be educated on basic, restorative nursing care that does not require the use of a qualified therapist or licensed nurse oversight.iii. Encouraging Residents to remain active and assisting with any exercises according to plan of care.iv. Assisting Residents in adjustment to their disabilities and use of any assistive devices.R24 was admitted to the facility on [DATE] with diagnoses of Epileptic Seizures (brain has sudden, uncontrollable surge of electrical activity), Encephalopathy (group of conditions that cause brain dysfunction), Essential Hypertension (chronic condition of persistently high blood pressure), Dysphagia (difficulty swallowing foods), Gastrostomy Status (artificial opening in stomach used for feeding), and Depression (mood disorder that causes persistent feelings of sadness and loss of interest). R24 currently has a legal guardian.R24's Quarterly Minimum Data Set (MDS) completed 6/23/25 documents R24 demonstrates severely impaired skills for daily decision making. R24's memory was not assessed. R24 is dependent for upper/lower dressing, showers/bathing, mobility, and transfers. R24 has both upper and lower extremity range of motion (ROM) impairment on both sides. Splint or brace assistance is not documented on R24's MDS. R24 is always incontinent of bowel and bladder. R24 currently has a feeding tube.R24's current physician orders document:7/3/24 Continue to don (apply/wear) resting hand splint to right hand, complete range of motion as tolerated and have patient attempt to assist with upper body cares when possible.4/7/24 Do neck exercises frequently and gently three times daily: [NAME] to chest, chin to sky, ear to shoulder bilaterally, chin to shoulders bilaterally.R24's comprehensive care plan documents:R24 has an activities of daily living (ADL) self-care performance deficit due generalized muscle weakness Initiated 3/1/24 Revised 9/20/24Intervention: R24 has contractures of the right arm/hand, right lower extremity. Provide skin (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care to keep clean and prevent skin breakdown. Initiated 3/4/24 Revised 2/5/25R24's Kardex, instructions to nursing staff updated 8/1/25 documents (R24) is wear elbow brace to right elbow on AM (morning) off HS (at bedtime).Surveyor reviewed R24's Occupational Therapy Discharge Summary signed by Occupational Therapist (OT)-KK on 7/3/24.(R24) is demonstrating tolerance to resting splint for 7 hour intervals at this time when donned by therapy staff, inconsistent follow through for splint use with support staff presently. Continue to encourage daily donning of resting splint at this time for contracture management and prevention. Discharge recommendations by OT-KK: Continue to encourage involvement with self care routine, bed mobility, donning of splint and ranging of right upper extremity as tolerated. Surveyor reviewed R24's electronic medical record (EMR) and noted there is no documentation of R24's neck exercises being performed.On 8/6/2025, at 11:47 AM, Surveyor observed R24 in bed and observed R24 is not wearing a right hand splint.On 8/7/2025, at 11:37 AM, R24 is observed in bed and has no right hand splint on hand.On 8/7/25, at 12:47 PM, Surveyor observed R24's right hand. Surveyor observed R24's 2nd right finger is contracted under R24's thumb and all digits are contracted into R24's palm.On 8/7/2025, at 1:57 PM, per Kardex R24 should have a right elbow brace on, and Surveyor observed R24 with no right elbow brace on. On 8/11/2025, at 10:53 AM, Surveyor observed R24 in bed and observed R24 has no splint on R24's right hand or a right elbow brace on. Surveyor did not observe either the splint or the brace to be visible in R24's room.On 8/12/2025, at 1:27 PM, Surveyor asked Unit Manager (UM)-E about R24's splint, elbow brace, and the neck exercises. UM-E informed Surveyor that UM-E will need to look into it.On 8/12/2025, at 3:17 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern that R24 has not had R24's right hand splint and/or a right elbow brace on during observations. Surveyor has also not observed any range of motion exercises performed by staff, and there is no documentation in R24's electronic medical record of neck exercises being performed.On 8/13/2025, at 12:35 PM, UM-E shared that UM-E has never seen a therapist write a physician order and agreed there is confusion whether R24 should be wearing a right hand splint only, a right elbow brace only, or both. UM-E shared with Surveyor that UM-E has spoken to therapy and has gotten rid of the physician orders to eliminate discrepancies and OT and Physical Therapy (PT) will be assessing R24 for appropriate devices.		

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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 each resident received adequate supervision and assistance devices to prevent accidents for 3 (R8, R24 and R81) of 5 residents reviewed for falls. *R8 requires the assistance of 2 with a toilet transfer. R8 was transferred to the toilet on 4/8/25 and left alone in the bathroom. R8 sustained an unwitnessed fall 2 minutes later. In interviews with Director of Rehab, Director of Nursing and other staff members, facility staff indicated R8 should not be left alone in the bathroom. R8's care plan was not updated with a resident specific intervention after this fall. *R24's fall interventions were not in place during Surveyor observations. *R81's fall interventions were not in place during Surveyor observations. Findings include: The facility policy with a last reviewed/revised date of 12/3/24, titled "Fall Prevention Program" documents, in part: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls; Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. Interventions will be monitored for effectiveness. The plan of care will be revised as needed. When any resident experiences a fall, the facility will : Assess the resident. Complete a pain evaluation and post-fall evaluation. Complete an incident report and include immediate intervention. Notify physician and family. Review the resident's care plan and update as indicated. Document all assessments and actions. Obtain witness statements in the case of injury. Monitor residents' condition and response to interventions as per standard of practice. 1.) R8 was admitted to the facility 6/1/2014 with diagnoses that include Hemiplegia/Hemiparesis (weakness on one side of the body) following a stroke, stage 2 kidney disease and epilepsy (seizure disorder). R8's Significant change Minimum Data Set (MDS) assessment dated [DATE] documents R8 is moderately cognitively impaired. R8 has impairments on one side of both of R8's upper and lower extremities. R8 requires substantial/maximum assistance for personal hygiene and transfers. R8 has had one fall with major injury since R8's last MDS Assessment. R8's Care Area Assessment for falls dated 3/1/25 documents, in part: [R8] had a recent fall and has a history of falls [related to] [stroke] and weakness. R8's care plan documents the following pertinent interventions: Assist of with toileting needs [as needed], initiated on 10/29/23. Prompt [R8] to toilet upon rising, after meals and [at bedtime] and per request at night. Keep urinal at bedside at night, initiated on 1/13/19. Toilet use: [R8] requires assistance x 2 [standing pivot transfer] with front wheeled walker. Assist x 1 with toileting hygiene. Prompt to use the bathroom every 2-3 hours and [as needed], initiated on 3/23/25. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8's Fall Risk Evaluation dated 2/12/25 documents a score of 8 which puts R8 at moderate risk for falls. R8's Occupational Therapy (OT) Evaluation and Plan of Treatment note dated 3/24/25 documents, in part: [R8] only [evaluated] to determine transfer status. [R8] required [minimum/moderate] assist of two with 2 wheeled walker to stand from toilet for safety. Ataxic gait pattern with knees buckling&hellip; R8's progress note dated 4/8/25 at 10:49 AM documents, in part: [R8] had an unwitnessed fall around 700 am. [R8] was discovered by CNA who alerted this nurse. [R8] was found in front of wheelchair, lying on [R8's] left side, and the wheelchair was also on its side. Per [R8], [R8] forgot to lock [R8's] wheelchair. Vital signs taken and documented . R8's fall investigation dated 4/8/25 documents, in part: This part of the investigation was filled out by CNA-NN. Did you observe the resident during your shift? Yes. Did you assist the resident with anything during your shift? Yes, restroom&hellip; What time was the resident last checked or seen by you? 2 [minutes] before fall. What was the resident doing at that time? Using restroom&hellip; How did you find out the resident fell? I heard it. Surveyor noted that CNA-NN assisted the resident to the restroom [ROOM NUMBER] minutes prior to the fall. Surveyor noted that CNA-NN left R8 unassisted in the bathroom and R8 had an unwitnessed fall. On 8/12/25 at 1:06 PM and 8/13/25 at 11:10 AM, Surveyor attempted to reach CNA-NN by telephone for interview. CNA-NN was unavailable. R8's fall investigation dated 4/8/25 documents, in part: This part of the investigation was filled out by Licensed Practical Nurse (LPN)-OO&hellip; Date of fall 4/8/25. Time of fall 7:10 AM. Location of where fall occurred: bathroom. Was fall witnessed. No&hellip; Description of fall: [R8] was found laying on left side with wheelchair tipped over behind&hellip; What did the resident/family report was the reason of the fall. [R8] reported losing [R8's] balance, stumbling into unlocked wheelchair and falling sideways. When was the last time resident was rounded on? Less than five minutes before&hellip; [R8] reports losing [R8's] balance. [R8] stood up to use sink and falling back into unlocked wheelchair&hellip; Surveyor noted that LPN-OO documented an unwitnessed fall when R8 was left alone in the bathroom. On 8/12/25 at 2:13 PM, Surveyor interviewed LPN-OO. Surveyor asked what happened when R8 fell on 4/8/25. LPN-OO stated that R8 was in the bathroom and tried to transfer back into the wheelchair. R8's foot got caught and R8 fell on R8's bottom. LPN-OO stated that the CNA had transferred R8 to the toilet and went to go answer a different residents call light. The CNA returned to R8's bathroom and found R8 laying on the floor. LPN-OO stated that vitals and an assessment were completed, and the MD was notified. LPN-OO stated R8 did not sustain an injury with this fall. Surveyor asked what R8's transfer status at the time of the fall was. LPN-OO stated that LPN-OO believed that R8 was a one assist. Surveyor asked if it is typical to leave resident in bathroom. LPN-OO stated it is normal. R8's Interdisciplinary Team (IDT) fall committee review dated 4/8/25 documents, in part: &hellip; Are interventions effective? Answer left blank. If not, why? Continues to self-transfer. Unsafe (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors noted/observed? Yes. Care plan revisions: continue with plan of care, continues to self-transfer&hellip; Surveyor noted the IDT team acknowledges that R8 &ldquo;continues&rdquo; to self-transfer. Surveyor noted despite the documentation of self-transfers continuing, a new care plan intervention was not documented in the IDT note. Surveyor reviewed R8&rsquo;s fall care plan and noted a new intervention was not placed after R8&rsquo;s fall on 4/8/2025. On 8/13/25 at 9:04 AM, Surveyor interviewed Nurse technician (NT)-BB. Surveyor asked what is R8&rsquo;s toilet transfer status. NT-BB indicated that R8 does self-transfer quite a bit. NT-BB stated that R8 transfers alone onto the toilet and will call for help to get off. Surveyor noted staff are aware that R8 has a history of self-transferring. On 8/12/25 at 1:46 PM, Surveyor interviewed Unit Manager (UM)-D. Surveyor asked if staff could leave a resident alone in the bathroom if that resident's toilet transfer status is assistance x 2 with a standing pivot transfer with front wheeled walker. UM-D stated that staff do not have to stay in the bathroom, they don&rsquo;t walk away but stand outside the door. UM-D stated that it would specifically say on the care plan if staff can not leave the bathroom. Surveyor asked about R8&rsquo;s toilet transfer status. UM-D stated that R8 would typically self-transfer onto the toilet. Most of R8&rsquo;s fall are when R8 is coming out of the bathroom. UM-D stated that R8 will now typically tell UM-D first before going to the bathroom so UM-D can get help or help R8. Surveyor noted that R8 is known for self-transferring. Surveyor noted per UM-D staff would not have to stay with R8 while R8 is in the bathroom. On 8/13/25 at 9:12 AM, Surveyor interviewed CNA-PP. Surveyor asked if CNA-PP would leave a resident alone in the bathroom if the resident&rsquo;s toilet transfer status is assistance x 2 standing pivot transfer with front wheeled walker. CNA-PP stated that CNA-PP would not leave the resident alone and CNA-PP would stay with the resident the whole time. On 8/12/25 at 9:26 AM, Surveyor interviewed LPN-G. Surveyor asked if LPN-G would leave a resident alone in the bathroom if the resident&rsquo;s toilet transfer status is assistance x 2 standing pivot transfer with front wheeled walker. LPN-G stated that LPN-G thinks that staff should stay with the resident. On 8/12/25, Surveyor interviewed Director of Rehab (DOR)-JJ. Surveyor asked when R8 was last seen by the therapy department. DOR-JJ stated it was on 3/20/25. Surveyor asked what R8&rsquo;s transfer status was on 3/20/25. DOR-JJ stated R8 required minimum/moderate assist of two with 2 wheeled walker to stand from toilet for safety. Surveyor asked if staff should stay with R8 when R8 is transferred onto the toilet. DOR-JJ stated yes. Surveyor noted some nursing staff, and the Director of Rehab stated that a resident whose toilet transfer status is an assist of two standing pivot transfer with 2 wheeled walker should not be left alone in the bathroom. On 8/13/25 at 12:47 PM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor shared concern (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that R8 had a fall in the bathroom after being left in the bathroom by CNA. DON-B reviewed the fall investigation and noted that CNA-NN charted that CNA-NN was with R8 in the restroom [ROOM NUMBER] minutes prior to R8's unwitnessed fall. DON-B agreed R8 should not have been left alone. Surveyor informed DON-B that R8's care plan was not updated at the fall. On 8/13/25 at 2:45 PM, Surveyor informed Nursing Home Administrator (NHA)-A and DON-B of the concern that on 4/8/25, R8 was transferred to the toilet by CNA-NN, according to documentation, 2 minutes later, R8 sustained an unwitnessed fall. In interviews with Director of Rehab, DON-B and other staff members, facility staff agreed that R8 should not be left alone in the bathroom. R8's care plan was not updated after the fall. 2.) R24 was admitted to the facility on [DATE] with diagnoses of Epileptic Seizures (brain has sudden, uncontrollable surge of electrical activity), Encephalopathy (group of conditions that cause brain dysfunction), Essential Hypertension (chronic condition of persistently high blood pressure), Dysphagia (difficulty swallowing foods), Gastrostomy Status (artificial opening in stomach used for feeding), and Depression (mood disorder that causes persistent feelings of sadness and loss of interest). R24 currently has a legal guardian. R24's Quarterly MDS completed 6/23/25 documents R24 demonstrates severely impaired skills for daily decision making. R24's memory was not assessed. R24 is dependent for upper/lower dressing, showers/bathing, mobility, and transfers. R24 has both upper and lower extremity range of motion(ROM) impairment on both sides. Splint or brace assistance is not documented on R24's MDS. R24 is always incontinent of bowel and bladder. R24 currently has a feeding tube. R24's Admission/Readmission/Routine Head-to-toe Evaluation completed 6/23/25 documents R24 is high risk for falling with a score of 16-60. R24's Fall Care Plan Documents: R24 is at risk for falls, accidents and incidents r/t generalized weakness, abnormalities of gait and mobility, and muscle spasms Created 3/1/24 Revised 9/20/24 -Anticipate and meet the resident's needs.4/8/24 Revised 9/20/24-Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Keep call light near left hand.3/1/24 Revised 10/10/24 -Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility9/20/24 -Encourage to wear appropriate footwear or gripper socks9/18/24 -Fall Mat beside the bed while in bed9/20/24-Follow facility fall protocol.3/1/24 Revised 9/20/24-Pt evaluate and treat as ordered or PRN.3/4/24 Revised 9/20/24-Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes.3/4/24 Revised 9/20/24 R24's Care Card as of 8/1/25 documents: Keep call light near left hand. Fall mat beside the bed while in bed. Encourage to wear appropriate footwear or gripper socks. On 8/6/2025, at 9:18 AM, Surveyor observed R24 in a low bed, call light within reach, head of bed elevated to 30 degrees. Surveyor observed a fall mat folded up against the wall. On 8/6/2025, at 11:46 AM, Surveyor observed no fall mat on the floor next to R24's bed. On 8/7/2025, at 7:45 AM, R24 is in bed, with the fall mat next to the bed on the left side, R24's (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	call light is draped over R24's overbed table, which is pushed past the blue fall mat, way out of reach of R24. On 8/7/2025, at 9:08 AM, Surveyor observed R24's call light is still draped over R24's overbed table not within reach of R24. On 8/7/2025, at 10:56 AM, Surveyor observed R24's call light still draped over the overbed table which is not accessible to R24. On 8/7/2025, at 11:12 AM, Surveyor observed Licensed Practical Nurse (LPN)-II exit R24's room. Surveyor asked LPN-II does LPN-II monitor for fall interventions for a Resident. LPN-II stated that CNAs should have put fall interventions into place when placing a Resident in bed. LPN-II will assess to see if fall interventions were in place at time of a Resident fall. Surveyor observed R24's call light not within reach on 8/7/25, at 10:56 AM, LPN-II was in R24's room at 11:12 AM, providing care to R24's gastrostomy tube and did not adjust R24's draped call light within reach of R24's left hand in bed. On 8/12/2025, at 8:54 AM, R24 is observed in bed, the fall mat is on the floor next to the bed, R24's call light is observed behind and under R24's pillow. Surveyor notes that R24's fall interventions of fall mat on floor next to bed and call light within reach were observed to not be implemented for safety. 3.) R81 was admitted to the facility on [DATE] with diagnoses of Essential Hypertension (chronic condition of persistently high blood pressure), Type 2 Diabetes Mellitus (adult onset of trouble controlling blood sugar), Hypertensive Heart Disease (long term conditions developed from chronic high blood pressure), Chronic Obstructive Pulmonary Disease (lung disease that block airflow and make it difficult to breathe), Major Depressive Disorder (persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities), and Dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life). R81 has an activated health care power of attorney. R81's annual minimum data set (MDS) completed 7/3/25 documents R81's brief interview for mental status (BIMS) score to be 5, indicating R81 demonstrates severely impaired skills for daily decision making. R81's MDS documents R81 has no range of motion impairment. R81 is independent with eating. R81's MDS also documents R81 is dependent for upper and lower dressing, showers/bathing, mobility and transfers. R81 is always incontinent of bowel and bladder. R81's Fall Care Area Assessment (CAA) completed 7/14/25 documents R81 is high risk for falls due to dementia and high-risk medications. R81's CAA documents the goal is to avoid complications, maintain current level of functioning, and minimize risks. R81's Fall Care Plan Documents: R81 is at risk for falls, accident and incident r/t (related to) cognition-unaware of safety needs, incontinence Created 1/5/18 Revised 2/21/21. -Soft touch call light - 5/8/20 Revised 10/23/23 -Anticipated and meet the Residents needs. Encourage the Resident to call for assistance - 1/5/18 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Be sure overbed table is within reach with all necessary items in place - 1/17/18 Revised 11/19/18 -Bed against wall - 11/17/21 Revised 10/29/23 -Body pillows on while in bed - 1/7/19 -Dycem to wheelchair - 5/16/18 Revised 9/27/18 -Fall assessment to be completed upon admission, after falls, quarterly, and as needed - 10/29/23 -Follow therapy recommendations for transfers and mobility - 1/5/18 -Frequently used items to remain within reach - 5/15/18 Revised 9/27/18 -Low bed with mat on floor - 4/19/18 Revised 11/19/18 -Offer snack around 4PM - 4/6/23 Revised 10/29/23 -Place call light within reach while in room - 1/5/18 -PT to screen for therapy needs, Resident to be offered to stay up in wheelchair after lunch - 9/20/24 -Review information on past falls and attempt to determine cause of falls - 10/29/23 -Scoop mattress - 7/10/23 Revised 10/29/23 -Updated MD as needed - 10/29/23 R81's Care Card as of 8/1/25 documents: R81 is to have body pillow in bed, Dycem in wheelchair, low bed with fall mat. Scoop mattress. Keep personal items within reach while in bed. Offer snack around 4PM. Bed up against wall. Keep overbed table within reach, reminder signs in room to call for assist. Soft touch call light On 8/6/2025, at 10:01 AM, Surveyor observed R81 in bed. Surveyor noted R81's bed is positioned up and not in a low position, there is no mat on floor next to bed. R81's bed is pushed against the wall to the left (if looking at bed from doorway). Surveyor observed no body pillows on either side of R81. Surveyor noted there wasn't Dycem on the seat of R81's wheelchair. R81's overbed table was pushed away from R81's bed and not within reach of R81. On 8/6/2025, at 1:26 PM, Surveyor observed R81 eating lunch with head of bed elevated. Surveyor observed R81's bed in a regular/elevated position and not low as care planned. No mat was observed on the floor and no body pillows were observed on either side of R81. On 8/7/2025, at 7:56 AM, Surveyor observed R81 in bed, which is in the regular/elevated position and not low. There is no mat observed on the floor next to the bed. Surveyor observed no body pillows on either side of R81. On 8/7/2025, at 7:59 AM, Surveyor observed no Dycem in wheelchair outside of R81's room and no Dycem in the rolling positioning wheelchair in R81's room. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/2025, at 11:23 AM, Surveyor observed R81 up in the rolling/positioning wheelchair. R81 was observed sitting on sling and Surveyor observed no Dycem in the chair. On 8/7/2025, at 2:07 PM, Surveyor observed R81 up in the rolling/positioning wheelchair, in their room and there is no Dycem observed in the wheelchair. Surveyor observed, the call light is not within reach of R81. On 8/11/2025, at 7:47 AM, Surveyor observed R81 sleeping in a low bed, no mat on the floor and no body pillows on either side of R81. On 8/11/2025, at 9:36 AM, Surveyor observed R81 in bed, which is in a regular/elevated position, no mat is observed on the floor next to bed and no body pillows on either side of R81. On 8/12/2025, at 8:51 AM, Surveyor observed R81 in bed, regular/elevated position, the head of bed is observed to be elevated while R81 ate breakfast. Surveyor observed no mat on the floor and no body pillows on either side of R81. Surveyor notes that R81's fall interventions including a fall mat on the floor next to bed, call light within reach, body pillows on either side of R81, overbed table within reach, and Dycem in R81's wheelchair were not implemented during observations during the survey. On 8/7/2025, at 2:08 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-QQ regarding Residents fall interventions. Surveyor asked CNA-QQ how does CNA-QQ know what fall interventions to put into place. CNA-QQ stated CNA-QQ would check the Resident care card. On 8/12/2025, at 3:17 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that Surveyor had multiple observations of fall interventions not being in place during the survey.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not provide the necessary respiratory care and services for 1 (R34) of 2 Residents receiving oxygen (O2) therapy.*On 8/7/25, Surveyor observed R34's humidifier bottle completely empty and the humidifier bottle should have been changed on 8/6/25 per physician orders.Findings Include:The facility's Oxygen Administration policy and procedure reviewed and revised 1/8/24 documents:Policy:Oxygen is administered to Residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the Resident's goals and preferences.Policy Explanation and Compliance Guidelines:1. O2 is administered under orders of a physician, except in the case of an emergency. In such case, O2 is administered and orders for O2 are obtained as soon as practicable when the situation is under control.2. Staff shall document the initial and ongoing assessment of the Resident's condition warranting oxygen and the response to oxygen therapy.c. Change humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer. Use only sterile water for humidification.R34 was admitted to the facility on [DATE] with diagnoses of Myasthenia Gravis (muscles under voluntary control to feel weak), Protein-Calorie Malnutrition (deficiency of both protein and Native Coronary Artery (plaque buildup narrows the arteries that supply blood to the heart), and Depression (mood disorder that causes persistent feelings of sadness and loss of interest). R34 is currently his own person. R34's admission Minimum Data Set (MDS) completed 7/22/25 documents R34's Brief Interview for Mental Status (BIMS) score to be 15, indicating R34 is cognitively intact for daily decision making. R34's MDS documents R34 is receiving oxygen (O2) therapy. R34's current physician orders document to change oxygen tubing and humidifier weekly one time a day on Wednesday with a start of 7/23/25. R34's physician orders also document to have R34 at continuous O2 at 2 liters via nasal cannula to keep O2 saturations above 90% every shift for respiratory failure with hypoxia.R34's comprehensive care plan documents: R34 has O2 therapy due to respiratory failure with hypoxia-Initiated 7/18/25 and revised 7/21/25Interventions:-Monitor for signs/symptoms of respiratory distress and report to MD as needed: Respirations, pulse oximetry. Increased heart rate (Tachycardia), restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, skin colorInitiated 7/18/25-O2 settings: Humidified O2 nasal cannula at 2 liters continuousInitiated 7/18/25 Revised 7/21/25On 8/6/25, at 9:27 AM, Surveyor observed R34's O2 tank located in R34's room. Surveyor observed the O2 set at 1.5 liters which is not what the physician orders indicate for R34. R34's physician orders document the setting should be at 2 liters. Surveyor observed the humidifier bottle is almost empty and not dated when last changed. R34 is currently wearing the nasal cannula.On 8/7/25, at 11:00 AM, Surveyor observed R34 wearing the nasal cannula. Surveyor observed the dehumidifier bottle is completely empty with the O2 tank running. Surveyor reviewed R34's Treatment Administration Record (TAR) for August. Surveyor noted that R34's TAR documents that R34 had a new humidifier bottle signed out on 8/6/25 as being placed on R34's O2 tank. Surveyor noted the observation of the empty humidifier bottle is not consistent with a new bottle having been placed on 8/6/25 or there is a possible concern with the humidification from R34's oxygen tank. On 8/8/25, at 9:43 AM, Licensed Practical Nurse (LPN)-AA documented:.Patient complained of sore nasal passages. Nasal cannula exacerbates pain. Initially stated a treatment was placed in his nostril but they were still sore. Humidifier changed but patient stated that did not help. Patient then stated that Vicks Vapor rub was supposed to be placed under his nose and above his lips. But that did not happen. This writer was not aware of this situation. He agreed to try a O2 mask. Rebreather mask was available and offered. He stated it felt confining. Will continue monitor. DON and supply personnel are aware.On 8/12/25, at 2:14 PM, Surveyor observed R34 with the nasal cannula not positioned in R34's nose. Surveyor interviewed R34 and asked why R34 did not have the nasal cannula on R34's nose. R34 (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated R34's nasal passages hurt pretty bad right now and thinks they have an infection. R34 stated R34 informed the nurse. Surveyor noted that R34's O2 is running at 1.5 liters not 2.0 liters per physician orders. On 8/12/25, at 3:17 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern that Surveyor observed on 8/7/25, R34's humidifier bottle on R34's O2 tank to be completely empty. Surveyor shared that on 8/6/25 per physician order, the humidifier bottle should have been changed on 8/6/25. On 8/8/25, R34 complained of sore nasal passages. No further information was provided as to why R34's humidifier bottle was completely empty on 8/7/25, when the humidifier bottle should have been changed on 8/6/25, and may have caused R34's sore nasal passages. Surveyor also shared that R34's O2 was running at 1.5 liters, not 2.0 liters per physician orders.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R9) of 3 residents was provided pain management consistent with professional standards of practice.R9 reported being in constant pain that frequently affected sleep and day to day activities. R9 was consistently receiving Oxycodone for pain management, which was prescribed on [DATE], and later discontinued on [DATE]. R9 was documented as having pain 10 out of 10 and went without Oxycodone pain medication on [DATE] and [DATE], after Oxycodone was discontinued on [DATE], which resulted in R9 going to the emergency room (ER) for pain management on [DATE].Findings include:R9 was admitted to the facility on [DATE], and has diagnoses that include paralytic syndrome (a condition where there's a loss of muscle function, resulting in the inability to move part or all of the body), fracture of 1st cervical vertebra and 7th cervical vertebra (a break in the vertebrae in the neck, otherwise known as a broken neck), intervertebral disc degeneration of the lumbar region (breakdown of discs in spine causing pain in lower back), fibromyalgia (widespread muscle pain and fatigue), and chronic pain syndrome. R9's admission Minimum Data Set (MDS) assessment, documents R5's Pain Care Area Assessment (CAA), dated [DATE], documents R5 has near constant pain related to fractures.R9's Quarterly MDS assessment, dated [DATE], documents, R9 is cognitively intact. R9's pain assessment documents, R9 has a scheduled pain regimen and as needed (PRN) pain regimen. R9 is in constant pain frequently affecting sleep and day to day activities. R9's pain assessment documents a pain level of 7 out of 10. R9's care plan, documents, R9 has chronic pain related to fracture of first cervical vertebra/intervertebral disc degeneration, and lumbar region.Interventions include:R9's pain is alleviated/relieved by repositioning and pain medications (date initiated [DATE]).Interventions include:Anticipate R9's need for pain relief and respond immediately to any complaint of pain (date initiated [DATE]).Identify and record previous pain history and management of that pain and impact on function. Identify previous response to analgesia including pain relief, side effects, and impact on function (date initiated [DATE]).Monitor and document for side effects of pain medication (date initiated [DATE]).Monitor, record, and report to the nurse, loss and appetite, refusal to eat, and weight loss (date initiated [DATE]).Notify the physician if interventions are unsuccessful or if current complaint is a significant change from R9's past experience of pain (date initiated [DATE]). Surveyor reviewed the facility's list of grievances filed and notes R9 filed a grievance on [DATE]. The grievance details concern with medication administration for R9. The grievance summary of investigation documents the following:R9 concerned with oxycodone being discontinued. R9 did have Oxycodone in house, however, R9's prescription from admission expired. R9 is not willing to wait for the nurse to get a new prescription from the Medical Director (MD) and a reason with the nurses as residents' medications were still in house. Medications were not discontinued.The grievance summary of findings documents the following:R9 had medications in house. R9 is unwilling to wait for order.The grievance summary of the actions taken, documents the following:R9 demanded to be sent to the hospital. Nursing staff notified the hospital R9 did have an order for oxycodone and oxycodone was in house and R9 did not want to wait for nurses to make phone call to get prescription updated. Upon R9's return, medications were reviewed and reinstated as ordered.Surveyor notes the grievance documenting R9 had an order for Oxycodone however, Surveyor notes the grievance then states nursing staff had to contact the MD for an order. Surveyor reviewed R9's Medication Administration Record (MAR) for [DATE] which documents the following:Oxycodone Oral Tablet 5 mg (milligrams). Give 5 mg by mouth every 6 hours as needed for pain (start date [DATE], at 5:00 PM, with a stop date of [DATE] at 11:59 PM). Surveyor notes R9 received Oxycodone every shift [DATE] through [DATE], with the last dose of Oxycodone signed out on [DATE] at 1:00 AM.Oxycodone Oral Tablet 5 mg. Give 5 mg by mouth every 6 hours as needed for pain (start date [DATE] at 4:30 PM).Surveyor notes R9 did not have an order for Oxycodone from [DATE], at 11:59 PM, until [DATE], at 4:30 PM.Celecoxib (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oral Capsule 200 mg. Give 1 capsule by mouth every 24 hours as needed for pain (start date [DATE], at 8:00 AM and discontinue date [DATE], at 12:09 PM). Surveyor notes R9 received Celecoxib on [DATE] and [DATE] with documentation of R9 having a pain level of 10. Celecoxib Oral Capsule 200 mg. Give 1 capsule by mouth every 24 hours as needed for pain (start date [DATE], at 4:00 PM). Pain evaluation every shift (start date [DATE], at 11:00 PM). Surveyor notes the following after reviewing R9's MAR: R9 did not have an order for Oxycodone from [DATE], at 11:59 PM, until [DATE], at 4:30 PM. R9's MAR documents R9 having a pain level of 10, 10, and 5 on [DATE] and a pain level of 6 on day shift on [DATE]. R9's pain evaluation in [DATE] documenting pain from 0 to 10. R9 was documented of having pain level of 7 on [DATE], with no indication of Oxycodone or Celecoxib being administered for pain. Surveyor reviewed R9's Electronic Medical Record (EMR) which documents a progress note dated [DATE], documenting R9 requested to go to the emergency room (ER) for pain management. R9 was documented as not being happy with Oxycodone order being discontinued. R9 was notified Oxycodone was not available when requested and R9 placed a call to 911 and was sent out to the ER for evaluation. On [DATE], at 9:54 AM, Surveyor interviewed R9 who states the facility does not always have pain medication and R9 has been without pain medication in the past. R9 states R9 is working with therapy but unable to get out of bed due to lack of strength and pain management. R9 states R9 has been at the hospital before due to uncontrolled pain. On [DATE], at 10:14 AM, Surveyor interviewed Director of Rehabilitation (DOR)-JJ who states R9 often expresses pain throughout therapy sessions which often affects R9's therapy sessions. Therapy is working with R9 on techniques for mobility as it relates to R9's pain management and therapy goals. On [DATE], at 10:35 AM, Surveyor interviewed Director of Nursing (DON)-B to discuss R9's pain management. Surveyor asked DON-B about the grievance filed by R9 on [DATE] for pain medications. DON-B states R9 was receiving pain medications and did not go without pain medications. Surveyor reviewed R9's MAR with DON-B which documents R9 was receiving as needed (PRN) Oxycodone consistently in March and [DATE], and R9's Oxycodone order was stopped on [DATE], with last dose given on [DATE]. Surveyor noted to DON-B, R9 did not receive Oxycodone the rest of the day on [DATE] and [DATE] which then resulted in R9 going to the ER for evaluation for pain management. Surveyor asked DON-B why R9 went without pain medication and if there was documentation of facility staff contacting R9's MD to discuss pain management. Surveyor also asked DON-B why the grievance states R9 had an order for pain medication when Oxycodone was discontinued on [DATE]. DON-B acknowledged these concerns and states she will investigate it. Surveyor requested additional information if available and notified DON-B of concerns with R9's pain management which resulted in R9 going to the ER for evaluation.		

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NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not assess the risk for possible entrapment, the continued need, review the risks & benefits, and obtain consent on a quarterly basis for 3 (R24, R27, and R81) of 8 Residents reviewed having enabler bars. Findings Include: The facility's Proper Use of Bed Rails/Enabler Bars/Assist Bars reviewed/revised 3/14/25 documents: Guideline: It is the guideline of this facility to utilize a person-centered approach when determining the use of bed rails (may also be referred to side rails, safety rails, grab bars, assist bars, transfer bars). Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. Informed Consent .7. Informed consent from the Resident or Resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. 9. Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail. Ongoing Monitoring and Supervision .17. The facility will continue to provide necessary treatment and care to the Resident who has bed rails in accordance with professional standards of practice and the Resident's choices. This should be evidenced in the Resident's records, including their care plan, including, but not limited to, the following information: a. The type of specific direct monitoring and supervision provided during the use of bed rails, including documentation of the monitoring. b. The identification of how needs will be met during the use of the bed rails, such as for re-positioning, hydration, meals, use of the bathroom and hygiene. c. Ongoing assessment to assure that the bed rail is used to meet the Resident's needs. d. Ongoing evaluation of risks. e. The identification of who may determine when the bed rail will be discontinued. f. The identification and interventions to address any residual effects of the bed rail (generalized weakness, skin breakdown). 18. Responsibilities of ongoing monitoring and supervision are specified as follows: a. Direct care staff will be responsible for care and treatment in accordance with plan of care. b. A nurse assigned to the Resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rail. c. The interdisciplinary team will make decisions regarding when the bed rail will be used or discontinued, or when to revise the care plan to address any residual effects of the bed rail. 1) R24 was admitted to the facility on [DATE] with diagnoses of Epileptic Seizures (brain has sudden, uncontrollable surge of electrical activity), Encephalopathy (group of conditions that cause brain dysfunction), Dysphagia (difficulty swallowing foods), Gastrostomy Status (artificial opening in stomach used for feeding). R24 currently has a legal guardian. R24's Quarterly Minimum Data Set (MDS) completed 6/23/25 documents R24 demonstrates severely impaired skills for daily decision making. R24's memory was not assessed. R24 is dependent for upper/lower dressing, showers/bathing, mobility, and transfers. R24 has both upper and lower extremity range of motion (ROM) impairment on both sides. Splint or brace assistance is not documented on R24's MDS. R24 is always incontinent of bowel and bladder. R24 currently has a feeding tube. R24's comprehensive care plan includes a focused problem that R24 uses enable/assistive devices bilateral enabler bars to allow R24 to participate in activity in which they would otherwise be unable to participate. Created 6/11/24 Revised 9/20/24 Interventions created 6/11/24 and revised 9/20/24 include: -Discuss and record with the Resident/family/caregivers, the risks and benefits of enabler/assistive device, when the enabler/assistive device should/will be applied, routines while enabler/assistive device and any concerns or issues regarding enabler/assistive device. -Ensure valid consent on chart prior to initiating enabler/assistive device. -Monitor/document/report as needed any changes regarding effectiveness of (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	enabler/assistive device if appropriate; any negative or adverse effects noted, including decline in mood, change in behavior, decrease in activities of daily living (ADL) self-performance, decline cognitive ability or communication, contracture formation, skin breakdown, signs/symptoms of delirium, falls/accidents/injuries, agitation, weakness. On 6/7/24, a physician order was obtained for enabler bars times 2 to assist with self-positioning. Surveyor reviewed R24's electronic medical record (EMR) and notes consent for enabler bars was obtained on 5/13/24. On 6/7/24, a safety device evaluation was completed indicating consent was obtained. Surveyor notes there is no documentation of ongoing monitoring including re-assessment was completed on a quarterly basis after the initial evaluation. On 8/6/2025, at 11:45 AM, Surveyor observed R24 has one enabler bar on the right side of the bed. On 8/11/2025, at 3:20 PM, Director of Nursing (DON)-B states the expectation after the initial consent for repositioning bars/enabler bars is an evaluation should be done on a quarterly basis and annual basis. Surveyor shared the concern Surveyor is unable to locate documentation R24 was re-assessed for the need including safety and risks/benefits of R24's enabler bar on a quarterly basis. DON-B stated DON-B will follow-up. On 8/12/2025, at 3:17 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and DON-B that no further information has been provided as to why R24 has not been re-evaluated for the need for the enable bar including safety, risks/benefits on a quarterly basis. 2) R27 was admitted to the facility on [DATE] with diagnoses of Cerebral Palsy (congenital disorder of movement, muscle tone, or posture), and Paraplegia (paralysis of lower half of body). R27 is currently his own person. R27's quarterly minimum data set (MDS) completed 5/31/25 documents R27's brief interview for mental status (BIMS) score to be 13, indicating R27 is cognitively intact for daily decision making. R27's MDS documents R27 has range of motion impairment on one side of lower extremity. R27's MDS also documents R27 requires substantial/maximum assistance for upper dressing and is dependent for lower dressing. R27 is dependent for mobility and transfers. R27 requires substantial/maximum assistance for showers. R27's comprehensive care plan includes a focused problem that R27 uses enable/assistive devices bilateral enabler bars to allow R27 to participate in activity in which they would otherwise be unable to participate. Created 12/2/24 Revised 6/11/25 Interventions created 12/2/24 and revised 6/11/25-Discuss and record with the Resident/family/caregivers, the risks and benefits of enabler/assistive device, when the enabler/assistive device should/will be applied, routines while enabler/assistive device and any concerns or issues regarding enabler/assistive device-Ensure valid consent on chart prior to initiating enabler/assistive device-Monitor/document/report as needed any changes regarding effectiveness of enabler/assistive device if appropriate; any negative or adverse effects noted, including decline in mood, change in behavior, decrease in activities of daily living (ADL) self-performance, decline cognitive ability or communication, contracture formation, skin breakdown, signs/symptoms of delirium, falls/accidents/injuries, agitation, weakness. On 11/22/24, a physician order was obtained for enabler bars times 2 to assist with self-positioning. Surveyor reviewed R27's electronic medical record (EMR) and notes consent for enabler bars was obtained on 11/22/24. Surveyor notes there is no documentation of ongoing monitoring including re-assessment completed on a quarterly basis after the initial evaluation of the enable bars for R27. On 8/7/2025, at 9:02 AM, Surveyor observed R27 has bilateral enabler bars on the bed. On 8/11/2025, at 3:20 PM, Director of Nursing (DON)-B states the expectation after the initial consent for repositioning bars/enabler bars, is an evaluation should be done on a quarterly basis and annual basis. Surveyor shared the concern Surveyor is unable to locate documentation R27 was not re-assessed for the need including safety and risks/benefits of the enabler bars on a quarterly basis. DON-B stated DON-B will follow-up. On 8/12/2025, at 3:17 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and DON-B that no further information has been provided as to why R27 has not been re-evaluated for the need including safety, risks/benefits of the enable bars on a quarterly basis. 3) R81 was admitted to the facility on [DATE] with diagnoses of Dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life). R81 has an (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activated health care power of attorney.R81's annual minimum data set (MDS) completed 7/3/25 documents R81's brief interview for mental status (BIMS) score to be 5, indicating R81demonstrates severely impaired skills for daily decision making. R81's MDS documents R81 has no range of motion impairment. R81's MDS also documents R81 is dependent for upper and lower body dressing, showers/bathing, mobility and transfers.R81's comprehensive care plan includes a focused problem that R81 uses enable/assistive devices bilateral enabler bars to allow R81 to participate in activity in which they would otherwise be unable to participate. Created 6/5/24 Interventions created 6/5/24 include: -Discuss and record with the Resident/family/caregivers, the risks and benefits of enabler/assistive device, when the enabler/assistive device should/will be applied, routines while enabler/assistive device and any concerns or issues regarding enabler/assistive device.-Ensure valid consent on chart prior to initiating enabler/assistive devise.-Monitor/document/report as needed any changes regarding effectiveness of enabler/assistive device if appropriate; any negative or adverse effects noted, including decline in mood, change in behavior, decrease in activities of daily living (ADL) self-performance, decline cognitive ability or communication, contracture formation, skin breakdown, signs/symptoms of delirium, falls/accidents/injuries, agitation, weakness.On 12/2/24, a physician order was obtained for enabler bars times 2 to assist with self-positioning.Surveyor reviewed R81's electronic medical record (EMR) and notes consent for enabler bars was obtained on 6/5/24. Surveyor notes there is no documentation of ongoing monitoring and supervision including re-assessment was not completed on a quarterly basis after the initial evaluation.On 8/6/2025, at 10:00 AM, Surveyor observed bilateral enabler bars on R81's bed.On 8/11/2025, at 3:20 PM, Director of Nursing (DON)-B states that the expectation after the initial consent for repositioning bars/enabler bars, an evaluation should be done on a quarterly basis and annual basis. Surveyor shared that Surveyor is unable to locate documentation R81 was re-assessed for the need including safety and risks/benefits of the enabler bars on a quarterly basis. DON-B stated DON-B will follow-up.On 8/12/2025, at 3:17 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and DON-B that no further information has been provided as to why R81 has not been re-evaluated for the need including safety, risks/benefits on a quarterly basis.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure menus were followed and served as posted for 2 (R65 and R59) of 2 residents reviewed. *R65's meal tray did not match the facility's planned menu on 8/7/25 breakfast tray, 8/11/25 breakfast tray and 8/11/25 lunch tray. *R59's food preferences were not followed. On 8/6/25 Surveyor observed white bread on R59's tray when white bread is one of R59's dislikes. R59's meal tray did not match the facility's planned menu on 8/7/25 breakfast tray and 8/11/25 lunch tray. Findings include: The facility policy with a revised date of 10/2022, titled "Menus" documents, in part: Menus will be planned in advance to meet the nutritional needs of the resident/patients in accordance with established national guidelines. Menus will be developed to meet the criteria through the use of an approved menu planning guide. . . . Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. . . . Menus will be posted in the Dining Services department, dining rooms and resident/patient care areas. 1.) R65 was admitted to the facility on [DATE]. R65's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents R65 is cognitively intact. On 8/6/25, at 10:36 AM, R65 informed Surveyor R65's meals are not always served as ordered/planned. R65 stated the menus posted do not match what is served on R65's meal tray. R65's MD (Medical Doctor) order dated 7/11/25 documents: Regular diet, regular texture, thin consistency diet. On 8/7/25, at 8:33 AM, Surveyor observed R65's breakfast meal tray sitting in R65's room. Surveyor observed scrambled eggs, bacon and an English muffin. Surveyor observed R65's meal tray ticket. Listed on the meal tray ticket is R65's Room number, dining preference and diet. Surveyor noted that the meal served is not listed on R65's meal tray ticket. On 8/7/25 at 10:44 AM, Surveyor observed a posted meal menu on the wall of the entrance to the 200-unit hallway. The menu is typed and listed the following for breakfast is: Scrambled eggs. Bacon. Toasted English muffin. Cold cereal. Surveyor noted on 8/7/25 R65's tray did not match the posted menu. R65 did not receive cold cereal. On 8/11/25, at 8:32 AM, Surveyor observed Certified Nursing Assistant (CNA)-EE delivering meal trays to resident's room. CNA-EE removed the tray from the warmer, knocked on a resident's door and delivered the tray to the resident's tray table. Surveyor asked (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA-EE if CNA-EE had to do any checks before delivering the tray. CNA-EE stated that kitchen staff checks to make sure it is correct, and CNA-EE will make sure that the tray is correct as well. On 8/11/25, at 8:38 AM, Surveyor observed CNA-EE deliver R65's breakfast tray to R65's room. On 8/11/25 at 8:41 AM, Surveyor observed R65's breakfast meal tray sitting in R65's room. Surveyor observed scrambled eggs with ham and a blueberry muffin. Surveyor observed R65's meal tray ticket. Listed on the meal tray ticket is R65's Room number, dining preference and diet. Surveyor noted that the meal served is not listed on R65's meal tray ticket. On 8/11/25, at 8:43 AM, Surveyor observed a posted meal menu on the wall of the entrance to the 200-unit hallway. The menu is handwritten and listed for breakfast is Eggs with ham. Blueberry muffin. Surveyor reviewed the week 4 planned menu that was printed and provided to Surveyor on 8/6/25. The planned menu documents for Breakfast on Day one of week 4 is: Cream of Wheat, Scrambled Eggs with Ham, Blueberry Muffin. Surveyor noted the handwritten menu hanging on the wall of the entrance to the 200-unit hallway does not match the menu provided to Surveyors on entrance to the facility. Surveyor noted that on 8/11/25, R65's breakfast tray did not match the planned menu provided to Surveyors on entrance to the facility. R65 did not receive Cream of Wheat. On 8/11/25, at 12:53 PM, Surveyor observed R65's lunch meal tray sitting in R65's room. Surveyor observed a dinner roll, Turkey and gravy, sweet potato, mixed vegetables (peas, carrots, lima beans, corn) and a butterscotch pudding. Surveyor observed R65's meal tray ticket. Listed on the meal tray ticket is R65's Room number, dining preference and diet. Surveyor noted that the meal served is not listed on R65's meal tray ticket. On 8/11/25 at 12:55 PM, Surveyor observed a posted meal menu on the wall of the entrance to the 200-unit hallway. The menu is typed and listed for lunch is Oven Roasted Turkey, Roasted Turkey gravy, Roasted butternut Squash, Brussels Sprouts, Dinner Roll and Butterscotch Delight. Surveyor noted on 8/11/25, R65's lunch tray did not match the posted menu. R65 did not receive Brussel sprouts or butternut squash but received mixed vegetables instead. On 8/12/25, at 1:31 PM, R65 informed Surveyor the facility does not let R65 know if they are changing the planned menu. On 8/13/2025, at 11:55 AM, Surveyor informed Nursing Home Administrator (NHA)-A that R65's meal tray did not match the posted menu during the above times during survey. No additional information was provided. 2.) R59 was admitted to the facility on [DATE], with diagnoses that include Cerebral palsy, right upper arm contracture and cancer. R59's Quarterly Minimum Data Set (MDS) Assessment, dated 8/2/25, documents a Brief (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview for Mental Status (BIMS) score of 15, indicating R59 is cognitively intact. On 8/6/25 at 1:00 PM, R59 informed Surveyor that dietary gives R59 food that is documented in R59's dislikes list. Surveyor observed R59's lunch tray sitting on R59's tray table. R59's meal tray ticket located on R59's tray table does not document what is on R59's lunch tray but does document R59's dislike list. R59's dislike list documented on the meal tray ticket is: bread white, beef, sausage. Surveyor observed R59 eating lunch. R59's lunch meal tray included: [NAME] bun, unidentifiable meat, carrots, green beans, squash, rice with string beans and gravy, coffee, red juice, and vanilla ice cream. Surveyor noted R59 had a white bun on R59's lunch tray despite white bread being listed as a dislike on R59's meal Tray ticket. On 8/7/25 at 8:34 AM, Surveyor observed R59's breakfast meal tray. R59's breakfast meal ticket documents: Personal menu items 4oz yogurt cup. Dislikes as follows: bread white, beef, sausage, ground beef, hamburgers. Surveyor noted ground beef and hamburgers have been assed to R59's dislike list. Surveyor observed: yogurt, English muffin, egg patty, bacon, and cranberry juice. On 8/7/25 at 10:44 AM, Surveyor observed a posted meal menu on the wall of the entrance to the 200-unit hallway. The menu is typed and listed the following for breakfast: Scrambled eggs. Bacon. Toasted English muffin. Cold cereal. Surveyor noted that on 8/7/25, R59's tray did not match the posted menu. R59 did not receive cold cereal. On 8/11/25 at 8:32 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-EE concerning the facility protocol for ensuring the meal served matches the diet ticket and what is on the menu. CNA-EE stated CNA-EE thinks dietary staff checks the tray before it leaves the kitchen and that staff that give out trays are supposed to also verify that all information matches as well. On 8/11/25 at 8:43 AM, Surveyor observed a posted meal menu on the wall of the entrance to the 200-unit hallway. The menu is handwritten and listed for breakfast is: Eggs with ham. Blueberry muffin. Surveyor reviewed the week 4 planned menu that was printed and provided to Surveyor on 8/6/25. The menu lists for breakfast on Day one of week 4 is: Cream of Wheat, Scrambled Eggs with Ham, Blueberry Muffin. Surveyor noted that the handwritten menu hanging on the wall of the entrance to the 200-unit hallway does not match the menu provided to Surveyors on entrance to the facility On 8/11/25 at 8:50 AM, Surveyor observed R59's breakfast meal tray. R59's breakfast meal ticket documents: Personal menu items 4oz yogurt cup. Dislikes as follows: bread white, beef, sausage, ground beef, hamburgers. Surveyor observed scrambled eggs with ham and a blueberry muffin on R59's tray. Surveyor noted that on 8/11/25, R59's breakfast meal tray did not match the posted menu or R59's meal preferences. R59 did not receive cream of wheat or yogurt listed on R59's meal ticket. On 8/11/25 at 12:49 PM, Surveyor observed R59's lunch meal tray. Surveyor observed the following items: sweet potato, peas, carrots, lima beans, corn, white dinner roll, turkey and gravy. Surveyor noted R59 was served a white dinner roll despite white bread being listed on R59's (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dislike list. On 8/11/25 at 12:55 PM, Surveyor observed a posted meal menu on the wall of the entrance to the 200-unit hallway. The menu is typed and listed for lunch is: Oven Roasted Turkey, Roasted Turkey gravy, Roasted butternut Squash, Brussels Sprouts, Dinner Roll and Butterscotch Delight. Surveyor noted that on 8/11/25, R59's lunch meal tray did not match the facility's posted menu. R59 received sweet potato and mixed vegetables and did not receive the roasted butternut squash and Brussel sprouts. On 8/13/2025 at 11:24 Surveyor interviewed Dietary Manager (DM)-RR. DM-RR stated that DM-RR started filling in this week as the facility's Dietary Manager because the previous Dietary Manager walked out. Surveyor asked how food preference slips are filled out. DM-RR stated nursing fills the preference slips out with residents. The slips are provided by the front desk receptionist. The slips are turned in and then given to the kitchen staff who will change the resident's preferences. DM-RR indicated that DM-RR had not received any meal preference slips since starting. DM-RR stated that these issues were not addressed by the previous Dietary Manager because the Dietary Manager did not do the job. On 8/13/25 at 11:30 AM, Surveyor interviewed the front desk receptionist, Receptionist-Z. Receptionist-Z stated that Receptionist-Z was not aware and has not received any meal preference slips from nursing. On 8/13/25 at 11:55, Surveyor informed Nurse Home Administrator (NHA)-A that R59's meal tray did not match the posted menu 2 times during survey and that R59's dislike list is not being followed. NHA-A stated that NHA-A will follow up on the concerns. No additional information was provided.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure hospice collaboration and communication processes were established to ensure continuity of care between hospice and the facility for 1 (R8) of 3 residents reviewed for hospice. R8's hospice visit documentation, hospice plan of care, hospice responsibilities and services being provided, and hospice daily nursing visit notes, were not kept in R8's facility's electronic medical record or in R8's hospice binder. Findings include: The facility's policy, titled Hospice Services Facility Agreement, and dated 07/10/2024, documents: .4. The written agreement(s) will set out at least the following: a. The services the hospice will provide b. The hospice's responsibilities for determining the appropriate hospice plan of care. c. The service the facility will continue to provide based on each resident's plan of care. d. A communication process, including how the communication will be documented between the facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. f. A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. g. An agreement that it is the facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. h. A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related symptoms. 5. The facility has a designated (the Assistant Director of Nursing, or specify the member from the interdisciplinary team) to be responsible for working with hospice representatives to coordinate care to the resident provided by facility and hospice staff. This designee: .d. Obtaining the following information from the hospice: i. The most recent hospice plan of care specific to each resident ii. Hospice election form iii. Physician certified and recertification of the terminal illness specific to each resident iv. Names and contact information for hospice personnel involved in the hospice care of each resident v. Instructions on how to access the hospice's 24-hour on call system vi. Hospice medication information specific to each resident vii. Hospice physician and attending physician (if any) orders specify to each resident e. Ensuring that the facility provides orientation to hospice staff of the following: i. Facility policy and procedures ii. Resident rights iii. Appropriate forms iv. Record keeping requirements. 7. The facility will, under a written agreement, ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the facility to attain for maintain the resident's highest practicable physical, mental, and psychosocial well-being R8 is being cared for by legacy hospice. Legacy hospice has a document titled Hospice Services Agreement, that's dated 4/19/2019, that documents, in part: .2. RESPONSIBILITIES OF FACILITY. b) Facility shall maintain responsibility for any resident conditions that are not related to the resident's terminal illness. e) Facility shall meet the resident's personal care and nursing needs in accordance with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. f) when facility personnel are directed by hospice to administer prescribed therapies to residents who are under hospice's care. Facility personnel shall administer the therapies in accordance with applicable law and facility policies and procedures. h) Facility shall designate a member of the facility's interdisciplinary team who is responsible for working with hospice to coordinate care provided by facility staff and hospice staff to any resident under hospice's care. Such interdisciplinary team (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member shall be responsible for the following:i) Collaborating with hospice and coordinating facility staff participating in the hospice care planning process for those residents who are under hospice's careii) Communicating with hospice and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family.iv) .Obtaining the following information from hospice:a. The most recent hospice plan of care specific to each resident;b. Hospice election formc. physician certification and recertification of the terminal illness specific to each residentd. Names and contact information for hospice personnel involved in hospice care of each residente. Instructions on how to access the hospice's 24-hour on-call systemf. Hospice medication information specific to each resident.3. Communicationb) . Prior to the admission of any resident to Hospice, Hospice and facility shall work together to develop a written communication protocol governing how they will communicate all information needed for their residents care (such as physicians orders, and medication information), including how such communication will be documented to ensure that the needs of the residents are addressed and met 24 hours a day. The communication protocol shall include, among other things, a procedure that clearly outlines the chain of communication between the parties in the event of a crisis or emergency develops, a change of condition occurs, and/or changes to the Hospice plan of care are indicated, and it must also address how Hospice physician orders will be communicated to the facility staff. Such protocol shall be distributed to all Hospice and facility staff involved in the residence care.R8 was admitted to the facility on [DATE] with diagnoses that include right sided stroke, epilepsy, depression and dementia.R8's Quarterly Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 12, indicating that R8 is moderately cognitively impaired. R8 is on hospice.R8's MD hospice note, dated 2/28/25, documents malignant neoplasm of unspecified part of left bronchus or lung. I certify that the patient is terminally ill with a life expectancy of 6 months or less if the terminal illness runs its course.On 8/12/25, at 12:33 PM, Surveyor observed the unit 1 nurses' station. On a shelf within the nurses' station, Surveyor observed binders specific for residents on hospice. Surveyor did not observe a hospice binder for R8. Surveyor asked Licensed Practical Nurse (LPN)-G for R8's hospice binder. LPN-G could not locate R8's hospice binder. LPN-G went to ask Unit-manager (UM)-D for help locating the binder. UM-D did not locate R8's hospice binder.On 8/12/25, at 1:09 PM, Surveyor observed UM-D's office space while trying to locate UM-D for interview. UM-D was not present. Surveyor observed a binder near UM-D's desk. The binder had R8's name on it and the word Hospice.On 8/12/25, at 1:12 PM, Surveyor interviewed UM-D. UM-D informed Surveyor that R8's hospice binder is empty and is waiting for hospice to fax over R8's information. UM-D stated that hospice emails UM-D the information weekly or bi-weekly, due to hospice not being able to directly upload to the facility's electronic medical record system. UM-D stated orders are verified weekly with hospice. UM-D stated if other facility staff need information regarding R8's care, UM-D has the hospice staff and facility staff phone numbers. UM-D provided Surveyor with printed emails of R8's hospice record.Surveyor reviewed the hospice emails sent to UM-D. Surveyor noted R8 started hospice therapy on 2/24/25. Surveyor noted a hospice wound care order dated 7/1/25 which documents: cleanse toe wound with wound cleanser and cover with bandage to prevent rubbing. Surveyor reviewed R8's facility's physician orders. Surveyor noted the MD order communicated by hospice to UM-D was not entered into R8's facility MD orders. Surveyor noted that per the Hospice Services Agreement, the facility is to preform nursing cares for R8. Surveyor noted the facility has no documentation in R8's electronic medical record regarding R8's wound care treatment ordered by hospice.R8's physician order, dated 2/19/24, documents Wheelchair with cushion: check placement every shift. R8's facility progress note, dated 7/27/25, documents [R8] does not have cushion. Surveyor noted R8 has an active facility order for a wheelchair cushion. Surveyor noted facility staff documented R8 does not have a wheelchair cushion. Surveyor observed on 8/12/25, at 1:11 PM, R8 in a wheelchair without a cushion. Surveyor reviewed hospice email communication and noted R8's wheelchair cushion is not documented in the hospice (continued on next page)		

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

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NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation. On 8/13/25, at 10:20 AM, Surveyor interviewed UM-D regarding R8's empty hospice binder. UM-D informed Surveyor that there should be hospice documentation and communication in the binder, and the binder should not be empty. UM-D stated UM-D spoke with Director of Nursing (DON)-B about the binder, and UM-D and DON-B have been working on a solution for an extended period of time with no avail. UM-D stated UM-D and DON-B both agree that the binder will be completed going forward. On 8/13/25 at 2:50 PM, Surveyor informed Nursing Home Administrator (NHA)-A and DON-B of the concern that the facility did not have effective communication between hospice and facility staff. R8's hospice binder was empty and did not include hospice visit documentation, hospice plan of care, hospice's responsibilities and services being provided, and R8's hospice daily nursing visit notes. No additional information was provided.		