STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525490	A. Building B. Wing	02/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aria of Waukesha	1451 Cleveland Ave Waukesha, WI 53186

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility did not ensure a resident with a pressure injury was comprehensively assessed. This was observed with 1(R47) of 4 residents reviewed with pressure injury. * R47 was re-admitted into the facility from the hospital on 1/5/26. The medical record documents a stage 2 wound on the coccyx, with only a measurement, on 1/5/26. On 1/8/26, the wound consult assessment assesses stage 3 pressure injury with treatment. The medical record does not have documentation of treatment implementation until 1/8/26, along with a revised plan of care not initiated until 1/29/26. This resulted in actual harm to R47.Findings include:The facility policy and procedure Wound Management-Wound Prevention and Treatment dated 10/11/24. The Provision and Procedure:1.b.) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.;2. Upon admission, the resident will receive a head-to-toe check to identify any skin issues. And RN will assess any noted pressure injuries and complete an initial comprehensive assessment.;7. When the resident is admitted with a pressure ulcer, the admitting nurse will document the size, location, appearance, odor if any, drainage if any, and current treatment ordered.8. Interventions will be implemented in the resonance care plan to prevent deterioration and promote the pressure ulcers healing.9. The admitting nurse will notify the attending physician of the condition of the pressure ulcer.R47 was readmitted to the facility on [DATE] with diagnoses that include morbid obesity and diabetes mellitus.R47's initial admission Minimum Data Set (MDS) assessment was completed on 7/18/25 and documents a BIMS (Brief Interview for Mental Status) score of 13, indicating that R47 is cognitively intact. The MDS documents that R47 is at risk for the development of pressure injuries and has had no pressure injury at the time of the MDS assessment. Section GG (Functional Abilities) documents that R47 has impairment to one side of R47's lower extremities and is independent when rolling left and right in bed but requires partial to moderate assistance to transition from laying to sitting on the side of the bed. R47's Hospital Discharge summary dated [DATE]. This Hospital Discharge Summary does not document the presence of a coccyx wound or treatment orders for a coccyx wound.On 2/09/2026, at 9:27 AM, Surveyor observed R47 in their bed. R47 was lying on their side. R47 stated to Surveyor they have a wound on their back with a band-aid on it. R47 medical record nurses note dated 1/5/26 documents a Stage 2 to coccyx approximately 3 centimeters (cm) by 3 cm. This was documented by Registered Nurse (RN)-H.There is no documentation on 1/5/26 that includes characteristics of the wound, drainage, odor or treatment. R47's next assessment of the coccyx is by an outside wound consultation on 1/8/26. This consultation assesses stage 3 pressure injury on the coccyx. Noted to be present upon admission. The wound measures 6.3 cm by 4.6 cm by 0.1 cm; light sero-sanguinous drainage; 20% slough; 50% granulation tissue; 30% intact normal color. The treatment that was ordered was Leptospermum honey apply once daily and as needed.R47's Plan of Care (POC) includes Impaired skin integrity related to stage 3 pressure injury to coccyx. The date initiated is 1/29/26. The goal date is 4/28/26. The Interventions are:- Administer a dietary supplement as ordered.-Encourage and assist resident to elevate heels off surface of bed.- Encourage Resident to frequently shift (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	weight.-Encourage the use of lifting devices while in bed.- Monitor for signs and symptoms of skin infection.- Monitor nutritional status.- Monitor resonant for wound related pain, notify Medical Doctor (MD) if pain is unmanaged with current pain regimen and non-pharmacological interventions.- Monitor residence nutritional intake.- Monitor skin for redness, specifically over bony promises.- Pressure relieving cushion to wheelchair.- Provide skin care per facility guidelines and PRN as needed.- Update MD with signs or symptoms of infection or changes in wound status.- Utilize pressure relieving devices on appropriate surfaces.- Wound assessment conducted weekly.Surveyor noted that R47's plan of care was not initiated with the new onset of the pressure injury upon readmission on [DATE].R47's plan of care prior to 1/29/26 for skin, date initiated 7/22/25, documents that R47 is at risk for impaired skin integrity and pressure injury Related to muscle weakness with impaired mobility, functional limitations and range of motion, newly admitted after prolonged hospitalization, active orders for antidepressant medications, and diagnosis of diabetes mellitus, congested heart failure, asthma, heart disease, depression, and depression, at risk of malnutrition. The goal date is 4/28/2026. The Interventions are:- Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. - educate resident family caregivers of causative factors and measures to prevent skin injury.- encourage good nutrition and hydration in order to promote healthier skin.- implement pressure-reducing devices example: wheelchair cushion, air mattress, offloading heels, etc.- keep skin clean and dry. use lotion on dry skin.- use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. This was initiated on 1/22/26.R47's plan of care was not revised with the onset of a new pressure injury on 1/5/26.R47 Treatment Administration Record documentation for January 2026 documents a coccyx treatment starting on 1/9/2026. There is no documentation of a treatment being administered to R4's coccyx from 1/5/26 to 1/9/26.On 2/10/2026, at 1:15 PM, Surveyor interviewed the facility's Wound Nurse Licensed Practical Nurse (LPN)- G. LPN- G stated they thought there was a Meplix dressing on the coccyx upon R4's readmission 1/5/26. LPN-G stated that the Wound Nurse Practitioner (NP) Consult changed the staging to a 3 on 1/8/26 due to necrosis coming off the wound. LPN-G reviewed R47's medical record during the interview. R47's medical record did not have a treatment order starting on 1/5/26, not a comprehensive assessment of R47's coccyx pressure injury. LPN-G stated the previous Assistant Director of Nursing (ADON) did the care plans and that R47's pressure injury is almost healed now. On 2/10/2026, at 2:33 PM, LPN-G spoke with Surveyor. LPN-G stated they placed a Meplix dressing on R47's coccyx when R47 was readmitted and that it was the same type of dressing as the hospital. LPN-G stated they had staged it differently and LPN-G did not provide documentation of an comprehensive wound assessment for R47's coccyx pressure injury on 1/5/26 or treatment order or hospital orders for the care of R47's coccyx pressure injury.On 2/10/2026, at 3:18 PM, at the facility exit meeting with the Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. Surveyor shared the concerns with R47's wound assessment, treatment and plan of care. At the time, no additional information was provided. On 2/11/2026, at 10:07 AM, Surveyor interviewed the DON-B and NHA-A. The harm concerns for R47 were reviewed, and again there was no additional information provided. On 2/11/2026, at 10:39 AM, Surveyor interviewed RN-H. RN-H stated they spoke to the hospital via telephone and that the hospital stated they were using a foam dressing on the coccyx 3 times a week. RN-H applied a Meplix (foam type) dressing on the area upon readmission and that RN-H told Wound LPN-G about the area. RN-H stated they just take the measurements of the wound and roughly what stage it is when a resident is readmitted . RN-H stated Wound LPN-G does comprehensive assessment and gets the treatment order for any pressure injuries. On 2/11/2026, at 10:48 AM, Surveyor interviewed DON-B. DON-B stated the RN on the floor would be expected to complete a comprehensive wound assessment. Surveyor informed DON-B that R47 was readmitted with a pressure injury on the coccyx on 1/5/26 and at the time the pressure injury was not comprehensively assessed and not provided with treatment until 1/8/26. Surveyor informed DON-B that R47's plan of care was not revised with the new onset of a pressure injury on 1/5/26.No additional information was provided.

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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 in 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 of Medicare and Medicaid Services (CMS).Staffing information for Fiscal Year Quarter 4 2025 (July 1st, 2025 - September 30th, 2025) of the Payroll Based Journal (PBJ) was not accurately submitted to CMS.This deficient practice has the potential to affect all 56 residents residing in the facility.Findings include:The CMS Electronic Staffing Data Submission Payroll-Based Journal, Long-term Care Facility Policy Manual, dated June 2022, documents: Chapter 1: Overview, 1.1 introduction .(U) mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS .1.2 Submission Timelines and Accuracy. Direct care staffing and census data will be collected quarterly and is required to be timely and accurate .Report Quarter: staffing and census data will be collected for each fiscal quarter. Staffing data includes the number of hours paid to work by each staff member each day within a quarter. Census data includes the facility's census on the last day of each of the three months in a quarter. The fiscal quarters are as follows: Fiscal Quarter, Date range: (quarter) 1 October 1-December 31, (quarter) 2 January 1-March 31, (quarter) 3 April 1-June 30, (quarter) 4 July 1-September 30.Surveyor reviewed the PBJ Staffing Data Report, CASPER Report 1705D, for Fiscal Year Quarter 4 2025 (July 1st, 2025 - September 30th, 2025; run date 1/21/2026), documents the facility had excessively low weekend staffing, one star staffing rating, and no registered nurse (RN) hours for the following dates:- 7/5/2025, 7/6/2025, 7/20/2025, 7/2025.- 8/2/2025, 8/3/2025, 8/16/2025, 8/17/2025, 8/30/2025, 8/31/2025.- 9/13/2025, 9/14/2025, 9/27/2025, 9/28/2025.On 2/11/2026, at 9:06 AM, Surveyor requested facility weekend schedules with nurse postings for Quarter 4 2025 (July- September 2025). Director of nursing (DON)-B provided Surveyor an email from Corporate Director of Recruitment (DoR)-Q that documented DoR-Q was inputting information incorrectly into the PBJ Staffing report to CMS and resulted in inappropriate staffing levels being reported. DON-B stated the RN (registered nurse) hours were not reported accurately. Surveyor requested to review the email and look at the requested schedules.Surveyor reviewed the facility's assessment and noted staffing ratios, compared them to the schedules provided. No discrepancies were found between the schedules or RN hours during quarter 4 for 2025. Surveyor noted licensed nurses and certified nursing assistants on each shift and unit per facility assessment. Surveyor noted schedules included call ins and showed the staff that picked up the shift. Surveyor reviewed the email provided that was sent to CMS from DoR-Q on 2/5/2026. The email documents: . (DoR-Q) just confirmed what caused the 1- star in staffing. (DoR-Q) neglected to report the manual updates the facility made to the days that were missing RN hours. Steps have been added to the reporting process to ensure the issue does not happen again. Multiple steps:1. Upload all time clock . data to SimplePBJ.2. Submit that data to CMS3. (DoR-Q) executed and analyzed the report to identify potential missing or inaccurate information, including low or missing RN hours.- If that report identifies missing or inaccurate information, the facility is alerted for accuracy:- If the facility uncovers missing hours from the time clock . the facility manually enters the hours into SimplePBJ.- Once the facility makes the updates, (DoR-Q) is updated. - (DoR-Q) reruns the analyzation report to ensure the manual facility updates were made and taken into effect.- (DoR-Q) resubmits the hours to CMS (THIS WAS THE PART DoR-Q DID NOT COMPLETE. The facility made the manual updates timely on 11/4/2025. On 11/7/2025 the facility confirmed with DoR- Q the manual updates were made. (DoR-Q) did not resubmit the hours to CMS.On 2/11/2026, at 10:17 AM, Surveyor interviewed DoR-Q who stated DoR-Q recalls receiving the information for the facility for the 1-start staffing and no RN (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	hours for selected dates. DoR-Q notified the facility and DOR-B sent the corrects back to DoR-Q. DoR-Q stated, just forgot to resubmit the corrections to CMS, unable to determine why the step was missed, however a step has been added to ensure it does not happen again. DoR-Q stated has been submitting the hours to CMS for about 3 years now and only missed once. Surveyor asked DoR-Q if there was a response from CMS. DoR-Q state did not receive and official email back from CMS, but CMS acknowledged the response with a ?Thumbs up emoji. On 2/11/2026, at 12:54 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and DON-B. DON-B stated when the facility was notified of the low weekend staffing and no RN hours, the facility reviewed the schedule and nurse postings. DOB-B stated during that time the facility did not have many weekend RN's and the facility does not do agency help. DON-B and the previous assistant DON (ADON) would alternate the weekends that did not have an RN on duty. Surveyor reviewed the schedules with DON-B and the dates of concern on the PBJ staffing report. DOB-B or the previous ADON were in the facility on those dates, however because DON-B and the previous ADON are/ were salaried and not paid hourly, they do not get reported like the other workers for PBJ staffing report. DON-B resubmitted the corrections to DoR-Q. DON-B stated the corrections were not submitted to CMS from what DON-B understands. DON-B stated currently the facility has weekend RNs, so it is no longer an issue for reporting the hours or RN coverage. Surveyor shared concern even though the error was noted for submitting hours and has since been corrected, there is still concern that hours were not accurately reported at the time for quarter 4 2025. NHA-A understood the concern and no additional information was provided.

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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 maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility did not have documentation that it implemented an effective water management plan. This deficient practice had the ability to affect all 56 of 56 residents residing at the facility at the time of this recertification survey. * The facility could not provide documentation of weekly temperature testing, weekly flushing logs for the vacant second floor rooms or rooms that were tested on first floor, the infection preventionist was not part of the water management team, and the water management plan did not include diagrams of the analysis of the building water system, control measures and monitoring, and was not included in the Facility Assessment. * Surveyor made observations on 2/9/2026 of staff not wearing appropriate personal protective equipment (PPE) in rooms with signs posted for droplet precautions. Findings include: The facility policy titled Water and Waste Management authorized 4/1/2025 documents: Water Management Plans to Reduce Legionella Growth; Policy- The water management program at [Facility name] will help identify at-risk areas with our water system and help us take the steps needed to minimize the growth and spread of Legionella and other pathogens. Developing and maintaining a water management program is a multi-step process that requires continuous review. [Facility name] is establishing a water management team to work together to identify ways to reduce legionella growth, conduct routine checks and control measures, and to take action if an issue is found. Our water management program includes:- Describing the building water systems using flow diagrams and a written description.- Identifying areas where legionella could grow and spread.- Deciding where control measures should be applied and how to monitor them.- Establishing ways to intervene when control measures are not met.- Ensuring the program is running as designed and is effective.- Documenting and communicating all activities.Several different types of control measures used to control growth of legionella:- Using the correct amount of disinfectant.- Keeping our water at the recommended temperatures.- Operating and maintaining equipment to reduce biofilm and debris.- Preventing stagnation by keeping water flowing.- Awareness of external factors around (such as construction and water main breaks).Our water management team shall regularly monitor water control parameters such as disinfectants, pH, and temperature levels. Surveyor reviewed the Facility's Water Management Program (WMP) Manual that documents: . per the facility's manual the water management program team consists of the director of nursing (DON)-B, maintenance director-D, and nursing home administrator (NHA)-A. The water management program will be championed by maintenance director-D. NHA-A will be responsible to ensure the WMP is maintained and will report at the facility's Quality Assurance and Performance Improvement (QAPI) meeting any findings. DON-B will be responsible for all clinical aspects of the plan . Surveyor noted the infection preventionist was not included as a team member of the facility water management program team. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor noted the WMP manual facility diagram included the path of water flow throughout the facility, however the diagrams do not indicate any points with potential for legionella or other waterborne pathogens to grow, does not include a risk assessment of the water system or analysis of control measures or what the facility is to do in event control measures have not been met. Surveyor noted the facility water flow diagram indicated the second floor is a closed unit. Surveyor reviewed the facility map of their floor plan. Surveyor noted 2nd floor was not included in the facility floor plan. On 2/10/2026, at 10:05 AM, Surveyor walked around the 2nd floor of the facility and noted the following:1. Emergency eye washing station room- - Tape across the toilet seat with writing that documented: No water- DO NOT USE- A little water noted in the toilet bowl with an orange rust stain in the toilet bowl- in the corner of the room was an open shower with calcium build-up around the floor drain. The shower pipe did not have a shower head on it. 2. Rooms 203, 205, 207:- Bathrooms are blocked with walkers, wheelchairs, and other equipment. Surveyors were unable to get into bathroom; bathroom doors were closed. 3. room [ROOM NUMBER] and 210 connecting bathroom:- Water in the toilet bowl with rust stains noted around the toilet bowl. 4. room [ROOM NUMBER]- Sign on toilet documenting: DO not use water, toilet shut off 10/9/2023.- No water in the toilet bowl.- Rust stain noted around the toilet bowl. 5. room [ROOM NUMBER] and 215 connecting bathroom:- Small amount of water in the toilet bowl with rust stains noted around the toilet bowl. 6. room [ROOM NUMBER]:- Toilet bowl dry with rust stains around the toilet bowl.- Sink dry with calcium deposits and rust stains around the sink bowl. On 2/11/2026, at 9:18 AM, Surveyor interviewed Maintenance- D who stated Maintenance-D has been employed with the facility since November 2025 and NHA-A who has been employed with the facility since September 2025. Surveyor asked to review logs for temperatures and flushing. Maintenance-D stated the facility does not keep logs, Maintenance-D just knows what has been flushed and tested. Surveyor asked how often rooms get flushed. Maintenance-D stated on 2nd floor, every sink gets turned on for 2-3 minutes and toilets get flushed 2-3 times biweekly and 1st floor bedrooms get flushed if a resident is not in the bedroom which is discussed at morning meetings so made aware of what rooms are not occupied. Surveyor asked maintenance-D if every room upstairs is flushed. Maintenance-D stated every room on 2nd floor is flushed except the toilets that have tape on them. Maintenance-D and NHA-A were not sure if the water to the toilets was turned off or what was happening with the 2nd floor. NHA-A and Maintenance-D were not sure how long the 2nd floor units have been shut down. NHA-A stated the previous maintenance director threw away all the logs whether they were temperature logs or flushing logs, NHA-A was not sure. Maintenance-D stated there has not been a water management team meeting to go over the facility water management plan and was not sure what parameters to go off of regarding water temperatures or what to do in the instance a control measure was out of range. Maintenance-D stated would bring any concerns to the attention of NHA-A. Surveyor reviewed the water management plan with Maintenance-D, and Maintenance-D was not able to walk Surveyor (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	through the facility water flow diagram or indicate where potential areas on the water flow diagram where potential areas of legionella and other waterborne pathogens growth could occur. Maintenance-D started finding a sheet from 2021 and started using that as a guide to log water temps until Maintenance-D could come up with a more up to date form, as of right now, maintenance-D does not log water temps or room flushes to indicate they are being completed. NHA-A provided a water specimen sheet that indicated the facility was tested for legionella and other waterborne pathogens on 9/8/2025 and results were negative, with some of those locations tested included second floor rooms. The next water testing for the facility will be March 2026. Surveyor shared concerns with NHA-A and Maintenance-D that the facility could not provide documentation of weekly temperature testing, weekly flushing logs for the vacant second floor rooms or rooms that were tested on first floor, the infection preventionist was not part of the water management team, and the water management plan did not include diagrams of the analysis of the building water system, control measures and monitoring. Surveyor shared when reviewing the facility assessment, the water management plan was not included. NHA-A and Maintenance-D understood the concerns. No additional information was provided at the time of this write up. 2.) The facility policy titled Management of Covid-19, Influenza and other ARI (Active Respiratory Infection) Outbreak revised 11/11/25 documents (in part): It is the policy of this facility that influenza or respiratory outbreak measures are instituted whenever there is an incidence above what would normally be expected, considering seasonal variations. Outbreak measures are used to reduce the potential spread of influenza or respiratory virus. Procedure: 3. Guidelines to prevent the spread of the infection: d. Caregivers and visitors should adhere to the appropriate precautions when in the presence of a resident with suspected or confirmed respiratory illness. Transmission-based precautions may be recommended, depending on the type of respiratory virus detected. For Covid-19 outbreak: For confirmed or suspected influenza, residents should remain on droplet and contact precautions for at least ten days after onset of illness or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer. On 2/9/26 at 10:13 AM, during the initial pool review, Surveyor observed a sign outside of R37's room that documented: Droplet precautions. Everyone must clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit. Surveyor noted that there was not a Personal Protective Equipment (PPE) cart outside or inside of R37's room. Surveyor noted that R37 has a roommate (R16). Surveyor observed a staff member inside of the room next to R37's bed. The staff member was wearing only a surgical mask and no other PPE and was placing dirty laundry in a bag. The staff member said to R37 I'll be back later picked up the bag of laundry, left the room and did not wash her hands. Surveyor later identified the staff member as Hospice Aide-K. On 2/9/26 at 10:17 AM, Surveyor observed Hospice Aide-K entering R37's room wearing a surgical mask, but no other PPE. She brought a Styrofoam cup of water, placed it on the bedside table and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	then put gloves on. After gathering garbage in a bag, she went into the bathroom and Surveyor heard water running. The aide then left the room with the garbage bag tied up. On 2/9/26 at 10:23 AM, Surveyor asked Hospice Aide-K about the sign on the door and asked which resident was on precautions. Hospice aide-K reported she did not know, stating, I don't think it's (R37) because she's my resident and I think I would know. On 2/9/2026 at 10:32 AM, Surveyor asked Certified Nursing Assistant (CNA)-E which resident is on droplet precautions and why. CNA-E reported she did not know. Surveyor advised there is not a PPE cart outside of the room. CNA-E stated, Yeah, I don't see one, I don't know which one is on the precautions or why. Surveyor asked CNA-E if she wears PPE when she enters the room. CNA-E stated, I usually do for (R16) because she sits on the side of the bed and pees or poops. On 2/9/26 at 12:31 PM, Surveyor noted the sign outside of R37's room had been removed. On 2/9/26 at 10:59 AM, Surveyor observed a sign outside of R52's room that documented: Special Droplet/Contact precautions. In addition to standard precautions only essential personnel should enter this room. Everyone must, including visitors, doctors and staff: Clean hands when entering and leaving the room. Wear mask (fit tested N-95 or higher recommended when performing aerosol-generating procedures), wear eye protection (face shield or goggles), gown and glove at the door. Surveyor observed a PPE cart outside the room. Surveyor observed Hospice aide-K, CNA-E and CNA-F inside the room, none of whom were wearing any PPE except for Hospice aide-K, who was wearing only a surgical mask. All 3 staff members left the room and were observed standing outside of the room talking to a woman/visitor (unknown name). Surveyor heard the woman ask, Does someone in this room have covid? Hospice Aide-K and CNA-E responded, I don't know. The woman asked, Why do they have this sign on the door? CNA-E stated, I don't know which one the precautions are for. Hospice Aide-K stated, I've been wearing a mask just to be safe. Surveyor heard one of the CNA's (unsure which one) say, When you find out if one of them has Covid would you let us know. On 2/9/26 at 11:07 AM, Surveyor noted the sign outside of R52's room had been removed. Surveyor observed Hospice Aide-K inside the room talking to R52. Upon leaving the room, Surveyor asked Hospice aide-K if she knew the woman who was earlier asking about the sign and precautions. Hospice aide-K reported the woman was from Hospice but was not sure if she is the music person or someone else and could not remember her name. Hospice Aide-K reported the woman was asking if one of the residents in the room have Covid or something. Hospice Aide-K stated, I was like I don't know, no one told me anything. On 2/9/26 at 12:34 PM, Surveyor noted the PPE cart was no longer outside of R52's room and a sign was posted for Enhanced Barrier Precautions. On 2/10/26 at 9:57 AM, Surveyor reviewed R37's medical record and found no evidence of Covid or respiratory infection. A rapid Covid test done on 12/22/25 was negative. Review of R37's roommate (R16) revealed a rapid Covid test done on 12/22/25 was positive. Review of R52's medical record documented a rapid Covid test done on 12/22/25 was positive. On 2/11/26 at 11:12 AM, Surveyor advised Director of Nursing (DON)-B and Assistant Director of Nursing (ADON)-C of observations and concern staff not wearing appropriate PPE in rooms with sign (continued on next page)

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	525490	A. Building B. Wing	02/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aria of Waukesha	1451 Cleveland Ave Waukesha, WI 53186

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	posted for droplet precautions. DON-B reported the residents were not in precautions anymore and the signs should have been removed. Surveyor advised DON-B of concern staff was not aware, signs were still posted for droplet precautions, and observations of staff not following PPE precautions. DON-B reported she understood the concern. No additional information was provided.

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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. Based Observation and interview, the facility did not ensure that 1 (R6) of 16 residents reviewed had clean, comfortable and a homelike environment. *R6 was observed to have mold on the ceiling in R6's room.Findings:The Facility's policy, titled Housekeeping Policy- Safe, Clean, Comfortable Homelike Environment dated 1/2/2026, states PROCEDURE: II. The facility must provide: . b. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; . On 02/09/2026, at 11:12 AM, Surveyor observed mold on the ceiling tiles around the light in R6's room. R6 indicated the facility is aware and said they will be fixing it.On 02/10/2026, at 10:23 AM, Surveyor interviewed Maintenance- D. Maintenance-D informed Surveyor that Maintenance-D was made aware of the issue in R6's room about 1 week ago but does not have any tiles to replace it and would need to go to the store to buy new tiles. Maintenance-D indicated he would be addressing the mold immediately.On 02/10/2026, at 10:26 AM, Chief Innovation Officer-K informed Surveyor that Chief Innovation Officer-K saw it yesterday and Maintenance-D is getting new tiles. Chief Innovation Officer-K indicated mold should immediately be corrected. A work ticket would be put in and addressed immediately.The facility then immediately began fixing the mold issue in R6's room. No additional information was provided.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that discharge planning included documented coordination of services, resident participation, and verification of a safe and appropriate transition for 1 (R32) of 2 residents reviewed.* R32's medical record did not contain documentation of a completed discharge summary, documented care conference discharge meeting and confirmation that the post-discharge needs and services for R32 were fully addressed prior to discharge. Findings:The Facility's policy, titled Discharge Planning, dated 7/17/2024 states the following, . 13. Document, complete on a timely basis on the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. 14. A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. 15.The post-discharge plan of care will indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. R32 was admitted to the facility on [DATE] with diagnoses which include respiratory failure (the lungs cannot properly provide oxygen to the blood or remove carbon dioxide), cognitive communication deficit, heart failure and muscle weakness.R32's admission Minimum Data Set (MDS), dated [DATE], indicates R32 has a Brief Interview for Mental Status (BIMS) score of 14 indicating R32 is cognitively intact. R32 does not use an assistive devices, has functional limitation in upper extremities on one side, has impairment on both side of lower extremities, requires substantial/maximal assistance with sit to stand, requires substantial/maximal assistance with chair/bed to chair transfer, dependent with car transfer and dependent on staff with walking 10 feet.R32's discharge MDS, dated [DATE], indicates R32 was discharged to home/community, has a BIMS score of 13 indicating intact cognition, requires partial/moderate assistance with sit to stand, partial/moderate assistance to chair/bed to chair transfer, car transfer was not attempted due to medical condition or safety concerns, walk 10 feet was not attempted due to medical or safety concerns.The Facility's provided document titled Care Plan Report, indicates R32 would like to discharge home or community, initiate on 12/29/2025. Interventions include encouraging R32 to discuss feelings and concerns with impending discharge, evaluate R32's motivation and ability to safely return to the community and evaluate/record R32's abilities and strengths and determine gaps in abilities which will affect discharge.Surveyor reviewed the Facility provided progress note, dated 1/22/2026 at 9:16 AM, which indicates R32 was discharged home with all paperwork provided by social services and medications sent by the social worker, nursing gave R32 all remaining medications and all belongings. Van transport arrived at the Facility and R32's family member is waiting at destination.On 02/10/2026, at 11:13 AM, Surveyor interviewed Social Services-M who indicated has worked at the Facility for about 7 months. Social Services-M recalled working with R32 and R32's brother regarding discharge and the initial plan when admitted , was to go back to R32's brother's home after rehab. R32's insurance ran out and R32 did not qualify for assistance and did not want to pay privately. R32 is their own person but would include R32's brother in care conferences. Social Services-M indicated R32's first care conference was on 12/31/2025 and the next care conference was 1/6/2026. Surveyor asked Social Services-M if Social Services-M documented the care conferences in R32's medical record or had any documentation of the meetings with R32 regarding discharge planning. Social Services-M informed Surveyor that he usually takes notes in one note and if needed, will reference those notes and deletes them. Social Services-M indicated the notes are only seen by Social Services-M and if any other staff have questions or need the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information the staff will come to Social Services-M.On 02/10/2026, at 11:45 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-N regarding the discharge process and progress note for R32. LPN-N indicated the discharge process is managed by the discharge team which includes the social worker, therapy and management (Assistant Director of Nursing (ADON), Director of Nursing (DON), department heads). The Social Worker manages all home health care if needed, doctors' orders and the medications available to the residents. Nursing has little involvement in the discharge process, just making sure belongings are together and sent along with medication management and being available to answer questions. LPN-N indicated there is a discharge check off list which is done on a piece of paper and is not part of medical record. The nurse is responsible for documenting what time the resident is leaving and what is with them. The discharge assessment is done by the team; nursing can do also. Surveyor asked LPN-N how LPN-N knew R32's brother would be waiting for R32 at the homes, LPN-N indicated R32 was on the phone with R32's brother and they were talking. LPN-N did not go over any discharge instructions with R32 and informed Surveyor that the social worker would have gone over discharge instructions and the secretary would go over appointments. LPN-N indicated R32 was given a discharge summary given as well as a copy of medications. LPN-N stated R32's discharge was really fast and abrupt once insurance ran out. LPN-N indicated LPN-N was not working the floor that day but wanted to document what was going on because there was nothing in the chart.Surveyor noted that R32's discharge occurred without documented evidence that R32's discharge goals were met or that R32's ability to safely transition to the community was fully evaluated and verified.On 02/10/2026, at 12:01 PM, Surveyor interviewed Occupational Therapist (OTR)-O. OTR-O indicated R32's goals were for basic Activities of Daily Living (ADL)'s lower body dressing and toilet transfers (was an assist of 1 w/ 2ww). R32 used a wheelchair on the unit for mobility and there was no change at time of discharge. OTR-O indicated based on R32's evaluation, R32 at time of discharge was not appropriate to live alone and was cut off by insurance. Therapy recommended home health services after discharge from the Facility. Surveyor noted that therapy recommendations for home health services were not implemented prior to R32's discharge. There was no documented evidence that the facility ensured referrals for home health services were completed, confirmed or declined by R32. There was no documentation that R32 was fully informed of the risks and benefits of accepting or declining home health services.OTR-O informed Surveyor R32's brother got R32 an apartment and that therapy gave recommendations to R32 and the social worker. OTR-O informed Surveyor that the Social Worker follows up and will do home health referrals. Surveyor noted that R32's medical record did not contain any documentation that home health referrals were initiated or formally declined by R32. There was no documentation that R32 was informed of therapy's recommendations for home health services or the potential risks of discharging without the services On 02/10/2026, at 1:06 PM, Surveyor interviewed Social Services-M regarding therapy recommendations for R32 at time of discharge. Social Services-M indicated R32's brother was reluctant to allow anyone to come to the home and said he did not want anyone in his home, which was discussed over the phone the day prior day to discharge. Social Services-M indicated R32's brother said 2 family members would be at the residence to assist R32 and set up a time. Social Services-M indicates he was never told R32 has own apartment and the plan was to stay with R32's brother. Social Services-M informed Surveyor that the home services referral was never sent due to conversation with R32's brother but Social Services-M has nothing documented. Surveyor noted that the facility relied on information provided by R32's brother without informing and verifying it with R32, despite R32 having a BIMS score indicating that he was cognitively intact and was identified to be his own person and decision maker. There was no documentation that R32 was informed of therapy's recommendation for home health services or that R32 declined such services after education regarding potential risks. Surveyor noted that the facility failed to verify that adequate support was in place at the discharge location prior to R32's discharge from the facility. The was no documentation confirming the number of caregivers available, their ability to provide the required assistance with (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer and mobility or that the environment was safe and appropriate for R32's functional status.On 02/10/2026, at 3:20 PM, Surveyor interviewed DON-B and NHA-A regarding the discharge process. DON-B informed Surveyor that Social Worker will open the discharge summary in the electronic health record and nursing will review before the resident leaves. Therapy referrals should be followed through and should be documented why it would not have been submitted. NHA-A indicated the Social Worker should be documenting the care conferences and would expect the Social Worker to document all aspects of clinical team discussed in the care conference in the resident's record. DON-B did not provide any information as to why R32's discharge planning failed to ensure that the recommended home health services were arranged or formally declined by R32 or why the facility did not verify that the discharge environment of R32's destination met R32's identified care needs.On 02/11/2026, at 12:16 PM, NHA-A informed Surveyor that the Facility does not have the records regarding R32's discharge summary or recapitulation of stay.No additional information was provided as to why the facility did not ensure that R32's discharge was safe, informed and consistent with R32's assessed needs and discharge goals.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility did not ensure that a resident who is unable to carry out activities of daily living (ADLs) receives the necessary services to maintain good grooming and personal hygiene for 1 of 16 (R23) residents reviewed for ADLs.R23 did not receive showers as requested.Findings include:R23 was admitted to the facility on [DATE] and has diagnoses that include hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, neuralgia and neuritis.The facility policy titled Bathing Policy revised 7/28/25 documents (in part) . It is the policy of this facility to provide residents with a bath or shower in order to cleanse the skin, observe the skin, increase circulation, and prevent infection.1. All residents are offered a bath or shower at least once a week or per resident's preference.4. Documentation of the resident's shower or bath must be completed. If the resident refuses the shower/bath, the nurse needs to be informed for reapproach. If the resident continues to refuse, the refusal must be documented by the licensed nurse.R23's Quarterly Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment.Section GG0130 Self-Care Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair) - Dependent.R23's Care Plan documents: The resident has an ADL self-care performance deficit related to impaired mobility with physical limitations, muscle weakness, recent hospitalization - dated 3/18/25. Interventions include Bathing/Showering: The resident requires assistance by 1 staff with bathing/showering twice a week and as necessary dated 11/3/25. Requires assistance by 2 staff with bathing/showering twice a week and as necessary - Revised 1/27/26.R23's Kardex documents bathing/showering: The resident requires assistance by 2 staff with bathing/showering twice a week and as necessary.On 2/9/26 at 9:43 AM, while interviewing R23, she reported she needs assistance with ADLs. R23 stated. I don't ask a lot, just a diaper change, and get me washed and dressed. I used to get a shower every Monday, but now I don't anymore - I don't know why. R23 reported she thinks her last shower was maybe 2 weeks ago. R23 reported she wants her shower early in the morning, before 10:00 AM.On 2/9/26 at 10:00 AM, Surveyor advised Assistant Director of Nursing (ADON)-C R23's call light was not working for at least an hour, was crying and needed to be changed and she would like some ice water.On 2/9/26 at 10:19 AM, Surveyor observed staff wheeling R23 into her room in the shower chair. Surveyor spoke with R23 after she was dressed and in her wheelchair. R23 reported she received a shower, if that's what you want to call it. It was like 2 minutes; they just rinsed me with water and that was it.Surveyor asked Registered Nurse (RN)-J how the Certified Nursing Assistants (CNAs) know when residents' shower days are. RN-J provided Surveyor a form titled [NAME] Census which listed each resident's name, room number and shower day highlighted in yellow. Surveyor noted the form documents R23's shower day on Monday and Thursday AM.On 2/9/26 at 2:00 PM, Surveyor reviewed the Point of Care (POC) tasks documentation of R23's bathing/showers for the past 30 days (1/12/26 through 2/9/26). The documentation revealed the following:1/12/26, 1/15/26, 1/26/26 and 2/5/26 - Type of Bathing Received: A check mark under not applicable. There was no documentation R23 received a shower on these dates.1/19/26 - a check mark under refused.1/22/26 - a check mark under bed bath. Surveyor found no documentation of why a bed bath was given instead of a shower.1/29/26 and 2/2/26 - there was no documentation on these dates indicating a shower was given.2/9/26 - a check mark under shower. (When Surveyor was in building).On 2/11/26 at 10:32 AM, Surveyor requested and was provided with a printed copy of R23's POC task/shower documentation. Upon reviewing printed copy, Surveyor noted it differed from what surveyor previously viewed in the computer POC. Surveyor viewed documentation in POC again and noted check marks under shower on dates that were not previously there when viewed on 2/9/26. On 2/11/26 at 10:37 AM, Nursing Home (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator (NHA)-A was advised of concern regarding R23 not receiving showers. Surveyor advised NHA-A that the task/shower documentation on the printed copy provided is different than what surveyor viewed on 2/9/26 and asked why it would have been changed. NHA-A reported her boss printed the form and has no knowledge if or why the documentation is different than previously viewed. On 2/13/26 at 5:08 PM, DON-B emailed the state agency additional information regarding R23's showers. The email documented: Documentation attached shows Resident received showers (within last 30 days as reviewed during survey):1/12/20261/15/2026- Refused1/19/20261/22/2026- Refused shower but allowed bed bath1/23/20261/24/20261/26/2026- Refused1/29/2026- Refused2/7/20262/9/2026Surveyor noted that per R23's plan of care, where it documents R23 is supposed to receive showers on Monday and Thursday AM, R23 was supposed to have a total of 9 scheduled shower opportunities between 1/12/26 and 2/9/26. The documentation provided by the facility does not provide evidence that R23 received showers per R23's care plan on 2/2/26 and 2/5/26 nor does it provide an explanation as to why the documentation provided was not the same as the documentation viewed by surveyor during the on site survey. No additional information was provided as to why R23, who is unable to carry out activities of daily living, received the necessary services to maintain good grooming and personal hygiene.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure that based on the comprehensive assessment of a resident, 1 (R4) of 5 residents reviewed, received treatment and care in accordance with professional standards of practice.*R4 has diabetes mellitus and receives scheduled insulin. R4's blood glucose was being obtained 3 times a day without any parameters and without order for treatment for variances in R4's blood glucose. Findings include:R4 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus. R4 receives scheduled insulin 3 times a day.R4's physician orders documents: Insulin Lispro inject 5 units subcutaneously three times a day. Do not give if R4 doesn't eat.R4's Medication Administration Record since 10/3/25 documents that blood sugars were obtained three times a day while R4 was administered scheduled insulin.R4's physician order summary does not document blood glucose orders with parameters nor does it give any hyperglycemia or hypoglycemia protocols if R4 experiences variances in blood glucose levels.On 2/10/2026, at 3:44 PM, Surveyor interviewed the Director of Nursing (DON)-B. DON-B is covering the nursing units. Surveyor requested blood glucose orders and parameters for R4.On 2/11/2026, at 7:24 AM, DON-B informed Surveyor that the facility does not have blood glucose orders with parameters for R4. DON-B provided physician blood sugar orders with parameters for R4 dated 2/10/26. The physician orders include parameters for blood sugars with interventions for hypoglycemia and hyperglycemia.No additional information was provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the accurate and safe administration of medication for 1 Resident (R5) of 16 reviewed.R5 returned from the hospital with an order for an antibiotic on 12/16/25 and it was not available until 12/18/25, three doses were not provided. Findings include:The Facility Policy titled Unavailable Medications revised January 2018 documents (in part): Policy: Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to ensure that medications are available to meet the needs of each resident.Procedures.B. Nursing staff shall:1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available.a. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or direction.2) Obtain a new order and cancel/discontinue the order for the non-available medication.3) Notify the pharmacy of the replacement order.R5 was admitted to the facility on [DATE] with pertinent diagnoses that include end stage renal disease (your kidneys no longer work as they should to meet your body's needs), type 1 diabetes mellitus with diabetic chronic kidney disease (high blood sugar causes damage to the kidney's nephrons, impairing their ability to filter blood and potentially leading to end-stage renal disease), and dependence on renal dialysis (refers to the mandatory, long-term reliance on artificial blood filtration, hemodialysis or peritoneal dialysis, because the kidneys have permanently failed, usually due to end-stage renal disease).R5's Annual/Medicare 5 day Minimum Data Set (MDS) with an assessment reference date of 12/19/25, documents a Brief Interview for Mental Status (BIMS) score of 13 indicating R5 is cognitively intact. The MDS documents R5 was assessed to have no behaviors exhibited during the look back period and can make self understood and understands others. The MDS documents that an antibiotic was given.R5's physician order dated 12/16/25 documents Vancomycin HCl Oral Suspension 50 MG/ML, Give 2.5 ml by mouth every morning and at bedtime for c diff (Clostridioides difficile)(C. diff) is a bacterium causing severe, watery diarrhea, fever, and abdominal pain, usually following antibiotic use that disrupts healthy gut flora) prophylaxis for 14 Days.R5's Medication Administration Record (MAR) documents that the bedtime dose was not given on 12/16/25, and the morning and bedtime doses were not given on 12/17/25. Surveyor noted this is three doses missed.R5's progress note written on 12/16/2025, at 8:19pm, documents: Administration Note Text: Vancomycin HCl Oral Suspension 50 MG/ML.on order.R5's progress note written on 12/17/2025, at 02:14am, documents Resident Vancomycin was temporary out of stock and will send as soon as available per pharmacy no ETA date given.R5's progress note written on 12/17/2025 at 1:55pm, documents Administration Note Text: Vancomycin HCl Oral Suspension 50 MG/ML.Medication on order.On 02/10/2026, at 1:24 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-L and asked why the vancomycin was not available, LPN-L replied per notes it was temporarily out of stock at the pharmacy, and they sent it when available. Surveyor asked if R5's physician was contacted, LPN-L replied that they did not see a note indicating that.On 02/10/2026, at 3:40 PM, and on 02/11/2026, at 7:56 AM, Surveyor asked if Director of Nursing (DON)-B had any information about the vancomycin and was told they were looking at documentation.On 02/11/2026, at 10:05 AM, Surveyor interviewed DON-B regarding the concern that the prescription was started late, not given for 14 days, and no documentation was provided that the physician was contacted.On 02/11/2026, at 11:55 AM, DON-B provided an email dated 2/11/2026, at 11:04am, documenting that the Nurse Practitioner (NP) wrote I was in the building on 12/17/25 and (continued on next page)

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	525490	A. Building B. Wing	02/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aria of Waukesha	1451 Cleveland Ave Waukesha, WI 53186

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was made aware that R5's Vancomycin was not available from the pharmacy. He was returned from the hospital on 12/16 and was placed on vancomycin prophylaxis for a hx (history) of C-diff. No signs of symptoms of C-diff was reported from nursing. Therefore his vancomycin course was not extended.On 2/13/26 at 5:08 PM, DON-B emailed the state agency providing additional information regarding R5's Vancomycin availability. The email documents: Order for prophylactic vancomycin was obtained on 12/16/2025Pharmacy informed facility that medication was out of stock, but was delivered to the facility at 0200 on 12/18Medication was administered 12/18Facility nurse practitioner was in facility morning of 12/17 and was notified of vancomycin not being available in facility (see attached email from nurse practitioner).Nurse practitioner did not wish to extend vancomycin course since medication was prophylactic and resident had no signs or symptoms of infection (as described in email attached)Surveyor informed DON-B there is still a concern that the pharmacy did not provide a physician ordered medication on time, as the NP was not consulted until the next day and documentation of the consultation was obtained during the survey. There was no evidence provided that R5's bedtime dose was given on 12/16/25, and the morning and bedtime doses were given on 12/17/25. Surveyor noted that despite the additional documentation that was provided, R5 still missed three doses missed of Vancomycin as originally ordered. No additional information was provided regarding the antibiotic not being available for administration as ordered.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility did not ensure pharmacy irregularity reports were maintained in the medical record, and acted upon promptly, by the primary care provider. This was observed with 2 (R10 and R42) of 5 resident pharmacy record reviews. * R10 and R42, had a Medication Regimen Review (MMR) completed by the pharmacist and a separate recommendation report was written for R10 and R42. The recommendation reports were not discovered in the medical record, nor acted upon promptly by the primary care provider. Findings include: The facility policy and procedure Consultant Pharmacist Reports undated. The Procedures section documents:G. Recommendations are acted upon and documented by the facility staff and/or the prescriber.G.1) Prescriber accepts and acts upon suggestion or rejects and provides an explanation for disagreeing. Findings include: 1.) R10 medical record was reviewed for Medication Regimen Review (MMR) by the Pharmacist. On 12/6/25 there was a Pharmacist MMR completed by the Pharmacist-I. This document stated: Pharmacist Statement: Medication regimen review completed. Recommendations are documented in a separate, written report. R10's medical record did not contain the written report that was completed by the pharmacist. On 2/10/2026, at 12:18 PM, Surveyor interviewed the Director of Nurses (DON)-B and Nursing Home Administrator (NHA)-A. DON-B stated they are unable to locate the written reports by the pharmacist and that the reports were not sent and that the facility does not have them. On 2/10/2026, at 3:18 PM, at the exit meeting with NHA-A and DON-B, NHA-A stated the old NHA would print off the written reports by the pharmacist and that DON-B was getting a duplicate copy but that the pharmacy written report for R10 could not be located. On 2/10/2026, at 1:48 PM, Surveyor interviewed Pharmacist -I. Pharmacist-I stated they send written reports to the facility management and that pharmacy sends them electronically. They were not aware that the facility could not locate the reports and Pharmacist-I stated they will find out. O 2/11/2026, at 8:46 AM, The DON-B provided Surveyor with R10 written pharmacist report from 12/6/25. This recommendation was implemented on 2/9/26 due to survey query. The recommendation for the written report is: Midodrine 5 mg (milligram) by mouth every 8 hours as needed for systolic blood pressure (SBP) less than 100 PRN (as needed). Metoprolol tartrate 12.5 mg by mouth twice daily for atrial fibrillation [give midodrine if SBP is less than 100].Please consider clarification of metoprolol administration parameters: metoprolol tartrate 12.5 mg by mouth twice daily related to history of atrial fibrillation [hold if SBP less than 120 and pulse less than 60. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted that the pharmacy recommendation was not followed up on promptly for R10 by the medical care provider. No additional information was provided. 2.) R42 was admitted to the facility on [DATE] with pertinent diagnoses that include chronic diastolic (congestive) heart failure (occurs when the heart's left ventricle becomes stiff and doesn't relax properly, hindering its ability to fill with blood), cognitive communication deficit (difficulty with communication that stems from impaired thinking skills, such as memory, attention, and problem-solving, rather than from physical speech problems), dementia, with anxiety, and hallucinations. R42's Quarterly Minimum Data Set (MDS) with an assessment reference date of 12/4/25, documents a Brief Interview for Mental Status (BIMS) score of 03, indicating that R42 has severe cognitive impairment. The MDS documents R42 is understood and understands others. R42 exhibited no behaviors during the look back period of the MDS assessment. R42's Pharmacy Review progress notes, dated 12/6/25, 11/5/25, 10/1/25, 9/3/25, 8/6/25, document a recommendation was made to the facility regarding medications. On 02/11/2026, at 11:55 AM, Surveyor interviewed Director of Nursing (DON)-B who provided a Prescriber Recommendations Pending a Response form from the pharmacy. Per DON-B, the same recommendation had been made for all of the above mentioned dates. On 2/9/26, the Nurse Practitioner signed off to discontinue the two PRN medications the pharmacy was recommending due to lack of utilization. Per DON-B, nothing was done about the prior pharmacy recommendations until 2/9/26. No additional information regarding R42's repeated pharmacy recommendations not being acted upon in a prompt matter was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview and record review, the facility did not ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles and included the expiration date when applicable for 1 of 2 medication carts reviewed.Insulin pens and vials were not dated when opened.Findings include:The facility policy titled Storage of Medications (which is not dated) documents (in part): Medications and biologicals are stored safely, securely and properly, following the manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.Expiration Dating (Beyond-use dating)A. Expiration dates (beyond-use date) of dispensed medications shall be determined by the pharmacist at the time of dispensing.C. Certain medications or package types, such as multiple dose injectable vials, require an expiration date shorter than the manufacturer's expiration date to ensure medication purity and potency.D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated.1. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date or expiration. The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating.On 2/10/26 at 9:30 AM, Surveyor observed the medication cart on the west unit. The bottom drawer of the medication cart contained a plastic bin containing residents insulin pens and vials. Surveyor review of the insulin pens and vials revealed the following:A Lispro insulin Kwik pen belonging to R4 which was open and used but not dated when opened. The label documented: Discard after 28 days.A Lantus vial belonging to R26 which was open and used but used not dated when opened. The label documented: Discard after 28 days.A Glargine insulin pen belonging to R39 which was open and used but not dated when opened. The label documented: Discard after 28 days.A Lispro insulin vial belonging to R39 which was open and used but not dated when opened. The label documented: Discard after 28 days. On 2/10/26 at 9:45 AM, Surveyor informed Registered Nurse (RN)-J of the observed resident insulins that were opened and used but not dated of when they were opened.On 2/10/26 at 11:11 AM, Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were advised of the above insulins that were open and used but not dated of when they were opened. DON-B expressed frustration stating, Pharmacy just did an audit like 2 weeks ago.No additional information was provided.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not ensure it was adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside for 1 of 16 (R23) rooms observed.R23 needed to be changed for incontinence and her bedside call light was not functioning.Findings include:R23 was admitted to the facility on [DATE] and has diagnoses that include hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, neuralgia and neuritis.R23's Quarterly Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment.Section GG0130 Self-Care Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement - Dependent.R23's Care Plan documents: The resident has bladder incontinence r/t (related to) activity intolerance, muscle weakness - revised 3/18/25. Interventions include clean peri-area with each incontinent episode.The resident has an ADL (Activity of Daily Living) self-care performance deficit related to impaired mobility with physical limitations, muscle weakness, recent hospitalization - revised 3/18/25. Interventions include: The resident requires assistance by 1 staff to turn and reposition in bed as necessary with right sided bed rail - revised 11/3/25. The resident is dependent on staff for toileting. Bed pan/check and change - revised 1/27/26. Encourage the resident to use bell to call for assistance - revised 4/9/25.On 2/9/26 at 9:00 AM, Surveyor observed R23 lying in bed on her back. Surveyor observed her call light next to her bed was on (illuminated), but was not on above the door outside of the room.On 2/9/26 at 9:43 AM, Surveyor observed R23's call light remained on next to her bed but was not on outside of her room. Surveyor noted the call board at the nurse's station was illuminated for R23's room to indicate her call light was on. Surveyor interviewed R23 who reported she needs assistance with ADLs. R23 stated, I don't ask a lot, just a diaper change, and get me washed and dressed. R23 reported her call light has been on for 45 minutes because she needs to be changed for incontinence. R23 began crying and tried to reposition herself. R23 appeared frustrated and stated, I can't, I just need someone. Can I please have some ice water?On 2/9/26 at 10:00 AM, Surveyor left the room to look for assistance for ice water. Surveyor noted the call light was still not on outside of her room. Surveyor asked Assistant Director of Nursing (ADON)-C, who was in the hall outside of R23's room if she could get R23 some ice water. ADON-C entered R23's room and R23 asked her for ice water. Upon leaving the room, Surveyor asked ADON-C how staff would know if the residents' call light were on. ADON-C looked up at the light above R23's door and reported it should light up. Surveyor advised R23's call light is illuminated on the wall next to her bed, but not outside the room. ADON-C stated, I noticed that; I don't know why it's not on. Surveyor asked R23's roommate (R40) to put her call light on to see if it was working. R40 pushed the button, which lit up on the wall next to her bed, but did not light up outside of the room. ADON-C reported she will let maintenance know. On 2/9/26 at 10:19 AM, Surveyor observed Maintenance-D standing on a ladder outside of R23's room reaching for the light above the door.On 2/9/26 at 12:14 PM, Surveyor tested R23's call light, which now turned on both the wall and outside of the room. On 2/11/26 at 9:18 AM, Surveyor spoke with Maintenance-D about R23's call light. Maintenance-D reported it was the bulb, it was out, and he replaced it.On 2/11/26 at 11:30 AM, Surveyor advised Nursing Home Administrator (NHA)-A of concern R23 needed to be changed for incontinence, turned her call light on, however it was not functioning outside the room for at least 1 hour until Surveyor advised ADON-C. NHA-A reported R23 was provided a bell to ring for assistance and the call light has since been fixed. No additional information was provided.