STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525494	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Spring Senior Living at Scandia Village	10560 Applewood Rd Sister Bay, WI 54234

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 3 residents (R) (R25, R7, and R22) of 5 sampled residents or their legal representatives were thoroughly informed in advance of the risks and benefits of prescribed psychotropic medication. R25 was prescribed lorazepam (an anti-anxiety medication), duloxetine (an antidepressant medication), trazodone (an antidepressant medication), and quetiapine (an antipsychotic medication). The facility did not ensure written consents were thoroughly reviewed and completed with R25's Power of Attorney for Healthcare (POAHC). R7 was prescribed venlafaxine (an antidepressant medication) and bupropion (an antidepressant medication). The facility did not ensure written consents were thoroughly reviewed and completed with R7's POAHC. R22 was prescribed citalopram (an antidepressant medication). The facility did not ensure a written consent was thoroughly reviewed and completed with R22's POAHC. Findings include: The facility's Psychotropic Medication policy, revised July 2022, indicates: .13. Residents (and/or resident representatives) will be informed of the recommendation, risks, benefits, purpose, and potential adverse consequences of antipsychotic medication use. Residents (and/or representatives) may refuse medications of any kind. Resident/Power of Attorney (POA) or Guardian will review and sign psychotropic medication consents. 1. From 5/5/25 to 5/7/25, Surveyor reviewed R25's medical record. R25 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia with behavioral disturbance, anxiety, insomnia, and depression. R25's Minimum Data Set (MDS) assessment, dated 10/17/24, had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R25 had severe cognitive impairment. R25 was deemed incapacitated on 11/5/24 and had an activated POAHC to assist with healthcare decisions. R25's physician orders included the following medications with a black box warning (the strictest warning on the label of prescription drugs or drug products by the Food and Drug Administration (FDA) when there is reasonable evidence of an association of a serious hazard with the drug): (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ Lorazepam oral tablet 0.5 milligrams (mg). Give 0.5 mg by mouth every 6 hours as needed for anxiety. ~ Lorazepam oral tablet 0.5 mg. Give 0.5 mg by mouth three times a day related to anxiety. ~ Trazodone oral tablet. Give 25 mg by mouth one time a day related to insomnia. ~ Duloxetine oral capsule delayed release particles 30 mg. Give 30 mg by mouth one time a day for anxiety. ~ Quetiapine fumarate oral tablet 50 mg. Give 50 mg by mouth two times a day for behaviors related to dementia with other behavioral disturbance. R25's medical record contained medication consent forms for lorazepam, quetiapine, trazodone, and duloxetine that noted only verbal consent was obtained, as documented on the signature page by staff. There was no documentation to indicate written consent or an attempt to obtain written consent was made. The consent forms did not contain initials on all 12 pages and only 4 pages were dated with 12/17/24 to indicate R25's POAHC reviewed and understood the risks and benefits of the medications, including side effects, adverse reactions, and alternatives to treatment. 2. From 5/5/25 to 5/7/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including hypertension, depression, and history of a stroke. R7's MDS assessment, dated 4/18/25, had a BIMS score of 8 out of 15 which indicated R7 had moderate cognitive impairment. R7 had an activated POAHC. R7's physician orders included the following medications with a black box warning: ~ Venlafaxine HCL ER oral tablet extended release 24 hour 150 mg for depression ~ Buproprion HCL ER (XL) oral tablet extended release 24 hour 150 mg for depression R7's medical record contained medication consent forms for venlafaxine and bupropion. R7's consent for venlafaxine did not include how the medication would be administered, the reason/benefits for the medication, alternative modes of treatment other than/in addition to the medication, and probable consequences of not receiving the medication. R7's consent for bupropion did not include alternative modes of treatment other than/in addition to the medication, probable consequences of not receiving the medication, or a staff signature. 3. From 5/5/25 to 5/7/25, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] and had diagnoses including fracture, anemia, and depression. R22's MDS assessment, dated 4/19/25, had a BIMS score of 13 out of 15 which indicated R22 had intact cognition. R22's physician orders included the following medication with a black box warning: ~ Citalopram hydrobromide oral tablet 10 mg for depression (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's medical record contained a medication consent form for citalopram. R22's consent for citalopram did not include alternative modes of treatment other than/in addition to the medication and probable consequences of not receiving the medication. On 5/7/25 at 10:24 AM, Surveyor interviewed Registered Nurse (RN)-N who indicated the facility's protocol is for the Social Worker (SW) to obtain the resident/POA's consent for psychotropic medication. RN-N indicated if verbal consent is obtained from the resident's POA, a written signature should be obtained within 10 days On 5/7/25 at 10:29 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated the SW goes over the medication forms and obtains the resident/POA's signature upon admission. DON-B indicated since the SW is no longer at the facility, DON-B obtains the medication consents. DON-B indicated after verbal consent is received from a resident's POA, written consent should be obtained within 10 days by mail or e-mail. DON-B reviewed R25's consent forms and indicated R25's POAHC should have signed the forms already. DON-B also indicated all pages should be initialed and dated.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure grievances were thoroughly investigated and resolved for 1 resident (R) (R28) of 13 sampled residents. The facility did not document, investigate, and follow-up with R28 after R28 reported seven missing articles of clothing. Findings include: The facility's resident grievance policy was not provided during the survey. From 5/5/25 to 5/7/25, Surveyor reviewed R28's medical record. R28 was admitted to the facility on [DATE]. R28's Minimum Data Set (MDS) assessment, dated 2/13/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R28 was not cognitively impaired. R28 made R28's own healthcare decisions. On 5/5/25 at 11:08 AM, Surveyor interviewed R28 who indicated R28 had informed several staff members, including housekeeping/laundry staff, about seven missing articles of clothing. R28 stated R28 was missing a yellow and tan t-shirt, a striped over-shirt, a matching top and bottom (missing since last year), a pair of navy blue sweatpants, and a green 1/4 zip sweatshirt. R28 indicated the clothes were labeled prior to when they went missing. R28 indicated grievance forms were not filled out. Surveyor reviewed the facility's grievance file which did not contain grievances for R28's missing items. On 5/6/25 at 12:06 PM, Surveyor interviewed Housekeeper (HK)-K who also works in laundry. HK-K indicated some of R28's missing clothing was addressed last year with the previous Social Worker (SW). HK-K indicated R28 informed HK-K about the most recent missing t-shirts approximately four weeks ago. HK-K recalled seeing R28's missing clothing in the laundry in the past but stated at this point the clothes were probably missing. HK-K indicated HK-K did not fill out a grievance form or notify Nursing Home Administrator (NHA)-A or Director of Nursing (DON)-B. HK-K indicated if residents inform HK-K of missing items, HK-K lets the SW know and a grievance form is filled out. HK-K did not let NHA-A know because HK-K was hoping the missing items would show up. On 5/6/25 at 2:08 PM, Surveyor interviewed NHA-A who indicated R28 was admitted to the facility last August and had issues with missing clothes. NHA-A indicated HK-K had taken R28 to find the missing clothes. NHA-A indicated staff should fill out a grievance form for any items that are reported missing.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not monitor the effectiveness of psychotropic medication for 1 resident (R) (R25) of 5 sampled residents. R25 had an order for lorazepam (an anti-anxiety medication) 0.5 milligrams (mg) as needed (PRN) every 6 hours for anxiety disorder/irritability and anger with a start date of 2/25/25. The medication was not discontinued or reviewed after 14 days. Findings include: The facility's Psychotropic Medication Use policy, revised July 2022, indicates: .Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: .c. Anti-anxiety medications .12. Psychotropic medications are not prescribed or given on an as needed (PRN) basis unless the medication is necessary to treat a diagnosed specific condition .a. PRN orders for psychotropic medications are limited to 14 days. 1. For psychotropic medications .If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. From 5/5/25 to 5/7/25, Surveyor reviewed R25's medical record. R25 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia with behavioral disturbance, and anxiety disorder. R25's Minimum Data Set (MDS) assessment, dated 10/17/24, had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R25 had severely impaired cognition. R25 had an activated Power of Attorney (POA) as of 11/5/24. R25 was prescribed lorazepam 0.5 mg PRN every 6 hours for anxiety disorder/irritability and anger with a start date of 2/25/25 and no end date. Surveyor also noted an order for lorazepam oral tablet 0.5. Give 0.5 mg by mouth every 6 hours as needed for anxiety until 5/19/25 (which was entered on 5/6/25). Surveyor reviewed R25's Medication Administration Record (MAR) and noted lorazepam was administered once in March 2025, eight times in April 2025, and twice in May 2025. On 5/6/25 at 3:00 PM, Surveyor and Director of Nursing (DON)-B reviewed R25's lorazepam orders. DON-B verified the order started on 2/25/25 was still active and did not contain an end date. DON-B requested to look at the order again on DON-B's computer. On 5/6/25 at 3:15 PM, DON-B approached Surveyor and indicated DON-B entered a new order on 5/6/25 for lorazepam PRN with a stop date of 5/19/25 but forgot to discontinue the previous PRN order. DON-B indicated the PRN lorazepam order that started on 2/25/25 should have been discontinued after 14 days. DON-B verified DON-B discontinued the previous PRN lorazepam order on 5/6/25 at 3:10 PM.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based staff interview and record review, the facility did not ensure their abuse policy was implemented for 5 (Certified Nursing Assistant (CNA)-F, CNA-H, Dietary Aide (DA)-J, CNA-G, and Registered Nurse (RN)-I) of 8 employees reviewed for background checks. CNA-F was hired and started work on 2/24/25. CNA-F's Background Information Disclosure (BID) form was completed on 3/1/25 and Department of Justice (DOJ) report was run on 3/28/25. CNA-F did not have an Integrated Background Information System (IBIS) report. CNA-H and DA-J's background checks did not contain IBIS reports. CNA-G did not have a background check completed within the last 4 years. RN-I's DOJ and IBIS reports were completed before RN-I signed a BID form. Findings include: The facility's undated Employee Screening policy indicates: Employee screening will be respected in terms of state law and facility policy. Background screening: It is a condition of employment that every employee successfully completes a background screening. Program eligibility checks: We are required by law to do pre-employment and then ongoing period checks with various government sites and databases. Wisconsin State Statute at 50.065 - Criminal history and patient abuse record search. Outlines (b) Every entity shall obtain all of the following with respect to a caregiver of the entity: 1. A criminal history search from the records maintained by the Department of Justice. 2. Information that is contained in the registry under s. 146.40 (4g) regarding any findings against the person. (d) Every entity shall maintain, or shall contract with another person to maintain, the most recent background information obtained on a caregiver under par. (b). The information shall be made available for inspection by authorized persons, as defined by the department by rule. 3(b) Every 4 years or at any other time within that period that an entity considers appropriate, the entity shall request the information specified in sub. (2)(b) 1. to 5. for all caregivers of the entity. 1. Between 5/5/25 and 5/7/25, Surveyor reviewed background check information for CNA-F who was hired on 2/24/25. Surveyor noted CNA-F did not complete a BID form until 3/1/25. CNA-F's DOJ form was not completed until 3/28/25. In addition, the facility did not provide an IBIS report for CNA-F. On 5/6/25, Surveyor reviewed CNA-F's time card and noted CNA-F had worked 3 shifts prior to filling out the BID form and had worked 17 shifts prior to the facility obtaining CNA-F's DOJ report. 2. Between 5/5/25 and 5/7/25, Surveyor reviewed background check information for CNA-H who was hired on 4/1/24. Surveyor noted the facility did not provide CNA-H's IBIS report. 3. Between 5/5/25 and 5/7/25, Surveyor reviewed background check information for DA-J who was hired on 3/3/25. Surveyor noted the facility did not provide DA-J's IBIS report. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Between 5/5/25 and 5/7/25, Surveyor reviewed background check information for CNA-G who was hired on 12/28/11. The facility provided a BID form, DOJ report, and IBIS report dated 2/14/20. The facility did not provide a more recent background check for CNA-G. 5. Between 5/5/25 and 5/7/25, Surveyor reviewed background check information for RN-I and noted RN-I's DOJ and IBIS reports were run on 12/31/24. RN-I's BID form (that gives permission for DOJ and IBIS information to be obtained) was completed on 1/9/25. On 5/6/25 at 12:15 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the facility did not have a Business Office Manager at that time. NHA-A indicated NHA-A was completing the state background check information and the corporate office was completing the national search. NHA-A confirmed IBIS reports were not completed for CNA-F, CNA-H, and DA-J. NHA-A was not aware that the background check information NHA-A completed did not contain all the required forms. NHA-A also confirmed CNA-F's BID form and DOJ letter were completed after CNA-F started working at the facility. NHA-A confirmed BID forms should be completed prior to the DOJ and IBIS reports and background checks should be completed every 4 years.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on staff and resident interview and record review, the facility did not ensure 1 resident (R) (R11) of 1 resident reviewed for hospitalization received the proper notice of transfer, reason for transfer, location of transfer, appeal rights, and name and address (mailing and email) with telephone number of the Office of the State Long-Term Care Ombudsman. In addition, the facility did not ensure R11 received written information on the duration of the bed hold policy, the reserve bed payment policy, and the right to return to the facility. R11 was transferred to the Emergency Department (ED) on 5/1/25. R11 was not provided with a written transfer or bed hold notice. Findings include: The facility's Bed-Holds and Returns policy, revised October 2022, indicates: .Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies .1. All residents .are provided written information regarding the .bed-hold policies, which address holding or reserving a resident's bed during periods of absence. Residents, regardless of payer source, are provided written notice about these policies at least twice .b. Notice 2: at the time of transfer (or if the transfer was an emergency, within 24 hours) . On 5/5/25, Surveyor reviewed R11's medical record and noted R11 was transferred to the ED on 5/1/25 due to a fall with head injury. R11's Minimum Data Set (MDS) assessment, dated 3/28/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R11 was not cognitively impaired. R5's medical record included a Notice of Transfer and Bed-Hold Form, dated 5/1/25, that documented verbal consent was obtained on 5/1/25 and signed by staff. The form did not contain appeals information, the daily rate, or Ombudsman contact information and was not thoroughly filled out. On 5/7/25 at 10:56 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding R11's transfer/bed hold notice. When Surveyor indicated R11's transfer/bed hold notice did not contain Ombudsman information or appeals rights, NHA-A showed Surveyor the facility's admission packet which contained the facility's transfer/bed hold policy. NHA-A indicated residents are aware and sign admission paperwork. When Surveyor informed NHA-A that Ombudsman information and appeals rights should be a part of the transfer/bed hold notice each time a resident is transferred out of the facility, NHA-A indicated NHA-A needed to consult with Director of Operations (DO)-L and would get back to Surveyor. NHA-A indicated R11's form was verbal in the moment of transfer and NHA-A did not know if the form was sent with R11. When Surveyor asked NHA-A about the facility's transfer/bed hold notice process, NHA-A indicated when a resident is transferred to the hospital, the facility sends a medication list, code status, and activated power of attorney paperwork. Surveyor showed NHA-A a copy of R11's transfer/bed hold notice from 5/5/25 and asked if the form that was provided to Surveyor on 5/6/25 had the daily rate and location of transfer recently added. NHA-A indicated NHA-A would ask DO-L. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 11:15 AM, Surveyor interviewed DO-L who indicated DO-L knew R11's original copy of the transfer/bed hold notice was not thoroughly filled out, however, the nurse did attempt to fill it out. DO-L indicated residents are educated upon admission on transfer/bed hold notices and who to contact for appeals. DO-L indicated DO-L understood the notices were supposed to be sent and indicated the nurses were trying hard. DO-L was unsure if appeals rights and Ombudsman information were already given to the residents. When Surveyor asked if the information was documented anywhere, DO-L indicated staff would look for documentation and get back to Surveyor. The information was not provided at the time of survey exit. On 5/7/25 at 12:31 PM, Surveyor interviewed R11 and showed R11 the facility's Notice of Transfer and Bed-Hold Form. When Surveyor asked if R11 was given a copy of the form, R11 indicated R11 was not given the form when R11 was transferred to the ED and did not see the form until yesterday when someone put it on the table next to R11's recliner.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a Pre-admission Screening and Resident Review (PASRR) Level I Screen was updated to initiate a PASRR Level II Screen when a newly evident mental disorder and/or change in medication was identified for 1 resident (R) (R22) of 5 sampled residents. R22 received new diagnoses and orders for psychotropic medication, including an antipsychotic medication. The facility did not update R22's PASRR Level I Screen and submit for PASRR Level II reevaluation. Findings include: R22 was admitted to the facility on [DATE] and had diagnoses including fracture, anemia, hypertension, depression, and mood disorder. R22's most recent Minimum Data Set (MDS) assessment, dated 4/19/25, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R22 had intact cognition. R22's PASRR Level I Screen was completed by the facility on 1/11/24. The Level I Screen indicated R22 did not have any diagnoses or medications prescribed that would indicate a Level II evaluation was needed. R22's physician orders indicated R22 was prescribed citalopram (an antidepressant medication) 10 milligrams (mg) for depression on 2/19/25. R22's medical record contained diagnoses of a mood disorder on 9/24/24 and depression on 2/19/25. R22's medical record did not contain an updated PASRR Level I or Level II Screen for the initiation of new psychotropic medication and changes in R22's diagnoses. On 5/6/25 at 1:37 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified an updated Level I and Level II screen were not completed with R22's new medication and diagnoses. NHA-A stated it is the responsibility of the Social Worker (SW) to complete PASRR Screens.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not revise a care plan in accordance with current care needs for 1 resident (R) (R34) of 4 sampled residents. R34 fell on 3/20/25 and fractured R34's left wrist. R34's care plan was not updated after the fall and did not include interventions to prevent future falls. Findings include: The facility's Falls-Clinical Protocol policy, revised March 2018, indicates: .Treatment/Management: 1. Based on the preceding assessment, the staff .will identify pertinent interventions to try to prevent subsequent falls and address the risks of clinically significant consequences of falling .2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation . Monitoring and Follow-up: 1. The staff .will follow-up on any fall with associated injury until the resident is stable and delayed complications .2. The staff .will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling .3. If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed . The facility's Care Plans, Comprehensive Person-Centered policy, revised March 2022, indicates: .9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas .11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly . From 5/5/25 to 5/7/25, Surveyor reviewed R34's medical record. R34 was admitted to the facility on [DATE] and had diagnoses including dementia with other behavioral disturbance, Alzheimer's disease, and diabetes. R34's admission Minimum Data Set (MDS) assessment, dated 2/18/25, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R34 had moderately impaired cognition. R34 did not have an activated Power of Attorney (POA). R34's medical record indicated R34 had a fall on 3/20/25 that resulted in a left wrist fracture. A fall risk assessment, dated 3/21/25, indicated R34 was a moderate fall risk. R34's care plan (initiated on 2/11/25) did not indicate R34 had a fall and did not contain fall interventions. On 5/5/25 at 12:06 PM, Surveyor observed R34 with a brace on R34's left wrist. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Spring Senior Living at Scandia Village	10560 Applewood Rd Sister Bay, WI 54234

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 at 9:55 AM, Surveyor interviewed Registered Nurse (RN)-N who indicated R34 fell in the hallway on 3/20/25 and fractured the left wrist. RN-N verified R34's care plan did not contain fall interventions. RN-N indicated management updates residents' care plans. On 5/6/25 at 11:10 AM, Surveyor reviewed R34's medical record and noted a new fall care plan with interventions was initiated on 5/6/25. On 5/6/25 at 11:18 AM, Surveyor interviewed Regional Nurse Consultant (RNC)-M and Assistant Director of Nursing (ADON)-C. RNC-M confirmed R34 had a fall with injury. RNC-M indicated R34 should have had a fall care plan, however, it was missed. ADON-C indicated staff education to update residents' care plans after a fall was not completed.

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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 staff interview and record review, the facility did not ensure 1 resident (R) (R18) of 4 sampled residents received care and treatment based on the resident's needs and hospital discharge instructions. R18 had a fall with a head laceration on 1/5/25. R18 was transferred to the emergency room (ER) and received staples to repair the laceration. R18's hospital discharge instructions stated to apply Neosporin or bacitracin ointment to the wound. The order was not implemented until two days after R18 returned to the facility. Findings include: From 5/5/25 to 5/7/25, Surveyor reviewed R18's medical record. R18 was admitted to the facility on [DATE] and had diagnoses including adult failure to thrive, chronic low back pain, peripheral neuropathy, and depression. R18's Minimum Data Set (MDS) assessment, dated 3/5/25, had a Brief Interview for Mental Status (BIMS) score of 7 out of 15 which indicated R18 had severe cognitive impairment. R18 had an activated Power of Attorney for Healthcare (POAHC) to assist with healthcare decisions. R18's medical record indicated R18 had an unwitnessed fall and sustained a laceration to the left side of the head on 1/5/25. R18 was transferred to the hospital and diagnosed with a closed head injury and laceration of the scalp which was repaired with staples. R18 returned to the facility on 1/5/25 with instructions to wash the wound gently with soap and water or shampoo, gently pat dry, and apply Neosporin or bacitracin to the laceration. The staples were to be removed in 10 days. Surveyor noted a fax to the provider, sent on 1/7/25 by Director of Nursing (DON)-B, that indicated R18 was seen in the emergency room (ER) on 1/5/25, received staples for a head laceration, and the discharge paperwork had wound care instructions to wash the area with soap/water, pat dry, and apply Neosporin or bacitracin. DON-B asked the provider if wound care as described should be done daily to which the provider responded yes. On 5/6/25 at 11:43 AM, Surveyor interviewed DON-B about the R18's wound care order for Neosporin or bacitracin which was not ordered upon R18's return to the facility on 1/5/25. DON-B was unsure why the order was not started on 1/5/25 and indicated DON-B thought the nurse looked at R18's discharge orders. On 5/6/25 at 3:16 PM, Surveyor interviewed DON-B who indicated there was no documentation that the physician orders from the ER were reviewed on 1/5/25 upon R18's return to the facility. R18 did not receive the Neosporin or bacitracin treatment until the order was obtained via fax on 1/7/25. DON-B agreed the order for Neosporin or bacitracin should have been ordered upon R18's return on 1/5/25.

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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 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** 2. From 5/5/25 to 5/7/25, Surveyor reviewed R33's medical record. R33 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure, renal insufficiency, diabetes, and malnutrition. R33's most recent MDS assessment, dated 2/10/25, had a BIMS score of 13 out of 15 which indicated R33 had intact cognition. On 5/6/25 at 9:17 AM, Surveyor observed medication administration for R33 with LPN-O. While in R33's room, Surveyor observed a bottle of lubricating eye drops on R33's bedside table. Surveyor noted the eye drops were not labeled or dated. LPN-O removed the eye drops from R33's room. On 5/6/25 at 9:22 AM, Surveyor interviewed LPN-O who indicated LPN-O was not sure where the eye drops came from and was not sure if R33 had a self-administration of medication assessment. On 5/6/25 at 2:24 PM, Surveyor interviewed DON-B regarding the eye drops at R33's bedside. DON-B indicated a box of Systane eye wipes and a tube of triple antibiotic ointment were also found in R33's beside drawer. DON-B indicated DON-B was not sure where the medications came from but they were not from the facility's pharmacy. DON-B verified R33 did not have orders for the medication or a self-administration of medication assessment. On 5/7/25 at 3:15 PM, DON-B informed Surveyor that a self-administration of medication assessment was completed for R33 and indicated R33 was not able to self-administer the medications. DON-B stated DON-B would notify R33's family to ensure they don't bring medication without consulting with staff first. DON-B verified the medications should not have been left at R33's bedside. 3. On 5/6/25 at 8:50 AM, Surveyor observed medication administration for R29 with LPN-O. While preparing R29's medications, LPN-O dropped one of R29's pills on top of the medication cart. LPN-O picked up the pill with a bare hand and placed the pill in a medication cup. LPN-O then administered R29's medications. On 5/6/25 at 8:58 AM, Surveyor interviewed LPN-O who verified LPN-O should have disposed of the pill and obtained a new pill. On 5/7/25 at 9:31 AM, Surveyor interviewed DON-B who verified LPN-O should have disposed of the pill when it fell on the medication cart and should not have touched the pill with an unwashed bare hand. Based on observation, staff and resident interview, and record review, the facility did not provide pharmacy services to ensure the accurate and safe administration of medication for 3 residents (R) (R20, R33, and R29) of 13 sampled residents. A bottle of Refresh Tears and multivitamins were observed on R20's bedside table. R20 did not have a self-administration of medication assessment that indicated R20 could self-administer the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A bottle of lubricating eye drops, a box of Systane eye wipes, and a tube of triple antibiotic ointment were observed at R33's bedside. R33 did not have orders for the medication or a self-administration of medication assessment that indicated R33 could self-administer the medications. During medication administration for R29, Licensed Practical Nurse (LPN)-O dropped one of R29's pills on the medication cart, picked up the pill with a bare hand, and administered the pill to R29. Findings include: The facility's Self-Administration of Medications Policy indicates: Residents have the right to self-administer medications if the Interdisciplinary Team (IDT) has determined that it is clinically appropriate and safe for the resident to do so .1. As part of the evaluation/comprehensive assessment, the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. 2. The IDT considers the following factors when determining whether self-administration of medications is safe and appropriate for the resident: a. The medication is appropriate for self-administration; b. The resident is able to read and understand medication labels; c. The resident can follow directions and tell time to know when to take the medication; d. The resident comprehends the medication's purpose, proper dosage, timing, signs of side effects, and when to report these to staff; e. The resident has the physical capacity to open medication bottles, remove medications from a container, and ingest and swallow (or otherwise administer) the medication; and f. The resident is able to safely and securely store the medication. The facility's Administering Oral Medications policy, revised October 2010, states: Do not touch the medication with your (staffs') hands. 1. From 5/5/25 to 5/7/25, Surveyor reviewed R20's medical record. R20 was admitted to the facility on [DATE] and had diagnoses including acute panmyelosis with myelofibrosis (a rare blood cancer affecting the bone marrow), osteopathic, and dry eyes. R20's Minimum Data Set (MDS) assessment, dated 2/4/25, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R20 had moderate cognitive impairment. R20 made R20's own healthcare decisions. During an interview with R20 in R20's room on 5/6/25 at 10:53 AM, Surveyor observed a 1 ounce bottle of Refresh Tears labeled with R20's name on the bedside table. R20 indicated R20 self-administered Refresh Tears whenever R20 thought about it. R20's physician orders included an order (dated 1/10/25) for Refresh Plus Ophthalmic Solution 0.5%, instill 1 drop in both eyes 2 times daily for dry eyes unsupervised self-administration. Surveyor noted R20's medical record did not contain a self-administration of medication assessment. On 5/6/25 at 2:24 PM, Surveyor interviewed Director of Nursing (DON)-B who checked R20's room and found the Refresh eye drops and a bottle of One a Day complete multivitamins at R20's bedside. DON-B indicated DON-B needed to complete a self-administration of medication assessment before R20 could continue to keep and self-administer medication at the bedside. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 at 3:02 PM, Surveyor interviewed DON-B who indicated DON-B completed a self-administration of medication assessment that indicated R20 was appropriate to self-administer medication. DON-B also obtained an order and updated R20's care plan. DON-B agreed a self-administration of medication assessment should have been completed prior to 5/6/25.

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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 staff interview and record review, the facility did not ensure monthly medication reviews were completed for 2 residents (R) (R7 and R25) of 5 sampled residents. R7 did not have a monthly medication review (MMR) documented for November 2024, January 2025, or March 2025. R25 did not have a monthly medication review (MMR) documented for April 2025. Findings include: 1. From 5/5/25 to 5/7/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including hypertension, depression, and history of a stroke. R7's Minimum Data Set (MDS) assessment, dated 4/18/25, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R7 had moderate cognitive impairment. R7 had an activated Power of Attorney for Healthcare (POAHC). On 5/7/25 at 12:28 PM, Surveyor reviewed R7's MMRs from November 2024 through April 2025. R7's medical record did not contain an MMR for November 2024, January 2025, or March 2025. 2. From 5/5/25 to 5/7/25, Surveyor reviewed R25's medical record. R25 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia with behavioral disturbance, anxiety, insomnia, and depression. R25's MDS assessment, dated 10/17/24, had a BIMS score of 4 out of 15 which indicated R25 had severe cognitive impairment. R25 was deemed incapacitated on 11/5/24 and had an activated POAHC to assist with healthcare decisions. On 5/7/25 at 1:30 PM, Surveyor reviewed R25's MMRs from November 2024 through April 2025 and noted R25's medical record did not contain an MMR for April 2025. On 5/7/25 at 2:13 PM, Surveyor interviewed Director of Nursing (DON)-B who verified the facility could not locate the missing MMRs and/or pharmacist recommendations for R7 or R25. DON-B verified medication reviews are completed monthly by the pharmacist and all recommendations are emailed to DON-B to ensure follow up with the physician.

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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, staff interview, and record review, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to affect all 40 residents residing in the facility. The deep fryer was stored uncovered and had food debris along the sides and in the oil. In addition, there was no cleaning schedule for the deep fryer. Butter was observed in an uncovered container in the prep area. Equipment in the kitchen was not in clean condition. The hood vent above the deep fryer and oven contained a greasy black substance. The stove top had dried food debris. The microwave in the kitchen contained dried food on the inside. Fifteen boxes were observed on the floor in the freezer. Findings include: On 5/5/25 at 9:54 AM, Surveyor interviewed [NAME] (CK)-D who indicated the facility follows the Wisconsin Food Code. Deep Fryer/Uncovered Food Items: The Wisconsin Food Code documents at 3-305.11 Food Storage: Food shall be protected from contamination by storing the food: .(2) Where it is not exposed to splash, dust, or other contamination. The user manual for the facility's commercial 70 pound fryer indicates: Care and Maintenance/Cleaning: Clean your fryer interior daily with the tank brush along with a damp cloth, and polish with a soft dry cloth. If regular cleaning is neglected, grease will be burned on and discolorations may form. Boil Out Procedure: Perform a boil out at least once a week, or as needed. 1. Drain the tank as described under draining the tank. Once the oil has been drained, flush out scraps and sediment with a small amount of warm oil, using the tank brush. Allow the tank to drain thoroughly .3. Close the drain valve and fill tank with non-corrosive, grease-dissolving commercial cleaner .4. Add commercial boil-out solution .5. Set thermostat to the temperature recommended for the solution being used. Allow solution to simmer for about 15 to 20 minutes. 6. Drain the cleaning solution from the tank and refill the tank with water. Add 1 cup (1/4 liter) of vinegar to neutralize alkaline left by the cleaner .8. Bring the solution to a simmer only, turn the thermostat off. Allow to stand for a few minutes. 9. Drain the tank .Rinse thoroughly with clear, hot water .Dry the tank thoroughly. 10. Close the drain valve and add oil. Follow the filling tank with oil procedure .Filter oil at least once a day . Use the tank brush to help clear sides and tubes of debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the initial kitchen tour with CK-D on 5/5/25, Surveyor observed the deep fryer. CK-D indicated there was not a schedule to change the oil or clean the deep fryer and stated the oil is changed when it is dirty. CK-D indicated CK-D would be using the fryer for lunch that day but stated the fryer is not used daily. When Surveyor asked if there is a cleaning schedule that staff follow, CK-D indicated there used to be a cleaning schedule but there was no paperwork. CK-D indicated the facility was between Dietary Managers and schedules had not been put out since the previous manager left. During a return visit to the kitchen on 5/6/25 at 1:09 PM, Surveyor observed the deep fryer and noted there was not a cover on the deep fryer which left the oil potentially exposed to contaminants. Surveyor also noted food debris floating on top of the oil and food debris stuck to the side of the fryer walls. During the same observation, Dietary Aid (DA)-E indicated there was no cover for the oil and confirmed the floating debris in the deep fryer. During the initial kitchen tour with CK-D on 5/5/25, Surveyor also observed a container of butter on the prep table next to the steam table. The butter was uncovered and exposed to potential contaminants. CK-D confirmed the butter was uncovered. Cleanliness of Equipment: The Wisconsin Food Code documents at 4-601.11 Equipment, Food: .(B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. During the initial kitchen tour with CK-D on 5/5/25, Surveyor observed the stove top burners and noted they contained dried food and splatter. CK-D confirmed the burners should be cleaned. Surveyor also observed a black, greasy substance between the stove and hood vent. CK-D indicated the substance had been there for a while. CK-D indicated maintenance staff attempted to clean the substance that morning, however, debris started falling and food needed to be prepped so they could not clean it at that time. Microwave Cleanliness: The Wisconsin Food Code documents at 4-602.12 Cooking and Baking Equipment: .(B) The cavities and door seals of microwave ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning procedure. During the initial kitchen tour with CK-D on 5/5/25, Surveyor observed the inside of the microwave which contained dried food splatter on the top and sides. CK-D indicated the microwave could use a cleaning. Boxes on the Floor: The Wisconsin Food Code documents at 3-305.11 Food Storage: Food shall be protected from contamination by storing the food: .(3) At least 15 centimeters (cm) (6 inches) above the floor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the initial kitchen tour with CK-D on 5/5/25, Surveyor observed fifteen boxes on the floor in the freezer. CK-D indicated the delivery arrived on 5/1/25. CK-D indicated the cook who was supposed to put the delivery away quit and staff had not gotten to it yet.