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	06/03/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, staff, resident, represenatative interview, and record review, the facility did not ensure the resident enviornment was as free of accident hazards as possible for 2 residents (R) (R10 and R15) of 3 sampled residents. In addition, the facility did not ensure 2 residents (R6 and R18) of 2 sampled residents had behavioral interventions and were adequately supervised. R10 had a fall with injury on 4/24/26. The facility did not update R10's care plan post-fall. R15 had a fall with injury on 6/2/26. The facility did not complete post-fall assessments, provide prompt or appropriate medical care, implement falls interventions, or notify the required parties. R6 and R18 were known to wander into other residents' rooms uninvited. R6 and R18's care plans did not contain interventions to address wandering or appropriate levels of supervision. Findings include: The facility's Care Planning-Interdisciplinary Team policy, revised January 2026, indicates: The Interdisciplinary Team (IDT) is responsible for the development of resident care plans .Comprehensive, person-centered care plans are based on resident assessments and developed by the IDT. The IDT includes but is not limited to: the resident's attending physician; a registered nurse with responsibility for the resident; a nursing assistant with responsibility for the resident; a member of the food and nutrition services staff; to the extent practicable, the resident and/or the resident's representative; and other staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident. The resident, the resident's family, and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan . The facility's Goals and Objectives, Care Plans policy, revised January 2026, indicates: Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence .Care plans will be modified accordingly. Care plan goals and objectives are .resident oriented; behaviorally stated and measurable; and contain timetables to meet the resident's needs .Goals and objectives are reviewed and/or revised: when there has been a significant change in the resident's condition; when the desired outcome has not been achieved; when the resident has been readmitted to the facility from a hospital/ rehabilitation stay; and at least quarterly. The facility's Assessing Falls and Their Causes policy, revised January 2026, indicates: The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall .Review the resident's care plan to assess any special needs of the resident .Residents must be assessed upon admission and regularly afterward for potential risk of falls. Relevant risk factors must be addressed promptly .After a fall: If a resident has just fallen or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities. Obtain and record vital signs as soon as it is safe to do so .Notify the resident's attending physician and family in an appropriate time frame. When a fall results in a significant injury or condition change, notify the practitioner immediately by phone. When a fall does not result in significant injury or a condition change, notify the practitioner routinely (e.g., by fax or by phone the next office day). Observe for delayed complications of a fall for approximately 48 hours after an observed or suspected fall and document findings in the medical record. Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of (continued on next page)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	responsiveness/consciousness and overall function .Complete an incident report for resident falls no later than 24 hours after the fall .Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident .and/or whether there is a pattern of falls for this resident .When a resident falls, the following information should be recorded in the resident's medical record: The condition in which the resident was found; assessment data, including vital signs and any obvious injuries; interventions, first aid, or treatment administered .Completion of a falls risk assessment. Appropriate interventions taken to prevent future falls . 1. R10 had diagnoses including Alzheimer's disease, dementia, and repeated falls. R10's Minimum Data Set (MDS) assessment, dated 3/22/26, stated R10 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severely impaired cognition. R10 had an activated Power of Attorney (POA). A care plan, revised 3/27/26, indicated R10 was at high risk for falls related to immobility, history of falls, dizziness, and giddiness. The last intervention added to the care plan indicated the blinds should be closed when dark outside and open when light outside (dated 11/4/25). A progress note, dated 4/24/26, indicated staff found R10 found face down on the floor of the bathroom with a bedside toilet seat caught in R10's brief and pajamas. R10 was bleeding from a gash on the left side of the forehead. R10's left eye was swollen and bruised and R10 had skin tears to both elbows. The bed alarm did not sound but was in place and working properly. Immediate interventions were to encourage R10 to use the call light for assistance and ensure the bed alarm was functioning properly. (Of note: There were no fall interventions added after R10's care plan follwing the fall.) A fall report, dated 4/24/26, contained the same information as the progress note above and also indicated an assessment was completed, 911 was called, and R10 was sent to the Emergency Department (ED). Injuries reported post incident - none identified. Predisposing environmental factors - none identified. Predisposing physiological factors identified were confusion, gait imbalance, impaired memory, and incontinence. Predisposing situation factors were identified as a walker. Other information indicated R10's wheelchair was in front of the bed and walker was in front of the sink in the bathroom. A Hospital After Visit Summary, dated 4/24/26, indicated R10 had a laceration on the left forehead, skin tears on the forearm and upper left arm, a hemorrhage on the inside of the eye, and a contusion on the face. On 6/1/26 at 12:09 PM, Surveyor observed R10 in the dining room with a bandage on the left side of their forehead. On 6/1/26 at 12:38 PM, Surveyor interviewed Power of Attorney (POA)-R who expressed concern that a bed alarm did not sound when R10 got out of bed and fell. POA-R indicated R10 might have gotten up to use the bathroom and required assistance with ambulation. POA-R indicated R10's facial injuries were extensive and R10 was heavily bruised. POA-R did not know what the facility was doing to prevent future falls or injury. POA-R indicated staff tested R10's bed alarm and stated it was functioning properly. On 6/3/26 at 10:34 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated falls are reviewed by the IDT and interventions are reviewed and revised in a residents's care plan following a fall. DON-B confirmed a fall intervention was not added to R10's care plan following the fall on 4/24/26. 2. R15 had diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, difficulty walking, and delirium due to known physiological condition. R15's MDS assessment, dated 4/23/26, stated R15 had a BIMS score of 6 out of 15, indicating severely impaired cognition. R15 had an activated POA. A care plan, dated 7/22/25, indicated R15 was at high risk for falls related to delirium and forgetfulness and right-sided weakness from cerebral infarction (stroke). The care plan contained interventions to follow the facility's fall protocol, review information on past falls and attempt to determine cause of falls, record possible root causes, and alter or remove potential causes if possible. The care plan indicated R15 had chair and bed alarms and staff should ensure they were in place and working correctly. On 6/2/26 at approximately 7:45 AM, Surveyor observed Certified Nursing Assistant (CNA)-Q push R15 in a wheelchair down the hallway. CNA-Q informed Registered Nurse (RN)-V that R15 required RN-V's attention. Surveyor observed RN-V provide wound care for R15's left arm and elbow. Surveyor interviewed R15 who stated, I slipped. After completing wound care, RN-V left R15 without further assessment to continue with medication (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pass. On 6/2/26 at 1:11 PM, Surveyor interviewed POA-S who expressed concern related to follow-up for R15's fall on the morning of 6/2/26. POA-S arrived at the facility at 10:40 AM and observed R15 at the nurses' station with a bandage on the left forearm. When POA-S asked what occurred, RN-V stated R15 must have bumped it. POA-S indicated RN-V just brushed it off. POA-S stated RN-T completed wound care for R15's left forearm and assessed R15. RN-T observed rug burn on R15's left knee and applied a bandage. POA-S indicated R15 could not accurately report what occurred due to cognitive deficit. POA-S attended an activity with R15 during which an activity aide told POA-S that R15 fell before breakfast. POA-S asked Regional Registered Nurse (RRN)-U about the fall. RRN-U indicated R15 fell near the front entrance of the facility and had likely gotten up and continued to walk to the dining area for breakfast. CNA-Q found R15 and informed RN-V that R15 needed assistance. There was blood on R15's arm and knee and a trail of blood from the dining area to the front entrance. POA-S was frustrated that the fall was not addressed properly and R15 did not receive adequate care following the fall. POA-S indicated R15's forearm and knee were not addressed until POA-S arrived hours later and noted the injuries. POA-S was also frustrated that RN-V did not tell POA-S the truth right away. On 6/3/26, Surveyor reviewed R15's medical record which did not contain a fall report, assessment, investigation, or neurological assessments for the unwitnessed fall that occurred on 6/2/26. Surveyor noted two progress notes, dated 6/2/26 and written by RN-T, that indicated R15's wounds were assessed and dressed and a progress note that indicated POA-S would speak with DON-B regarding the injuries. On 6/3/26 at 10:34 AM, Surveyor interviewed DON-B who indicated administration discussed the fall and concluded RN-V did not look into the fall or handle the fall correctly per policy. DON-B verified there was not a fall investigation, appropriate wound care, or notification. DON-B indicated a grievance was filed immediately for POA-S regarding notification of fall with injuries. On 6/3/26 at 1:31 PM, Surveyor interviewed CNA-Q who discovered R15 in the dining room with blood on the left arm and observed a trail of blood from R15 to the hallway. CNA-Q indicated R15 stated they had fallen. CNA-Q assisted R15 to their bedroom and informed RN-V that R15 had fallen and needed assistance. CNA-Q also informed Licensed Practical Nurse (LPN)-M and Social Services Director (SSD)-C of the incident. CNA-Q indicated LPN-M and SSD-C stated they believed that was where the blood by the front door came from. CNA-Q indicated R15 would have been able to get off the floor independently and stated if staff had noticed R15 on the floor, they would have provided assistance immediately. On 6/3/26 at 1:45 PM, Surveyor interviewed Regional Director of Clinical Services (RDCS)-W verified staff did not follow the facility's fall protocol for R10 and R15. 3. On 6/1/26 at 10:47 AM, Surveyor interviewed R38 who expressed concern that R6 frequently entered R38's room uninvited. R38 stated R6 entered their room at 12:30 AM that morning (6/1/26), turned on the light while R38 was sleeping, and stated the room belonged to R6. R38 indicated R6 entered their room approximately five times last week, including once in the middle of the night, and stated it was R6's daughter's room and R6 needed to get her up. R38 indicated R6 threated to call the police on R38 last week and in another incident indicated they needed to use R38's bathroom. R38 tried to redirect R6 to their room next door to use their own bathroom. R38 stated R6 used R38's bathroom instead and urinated all over the toilet and floor. R38 indicated their sleep is disrupted at night and they are in a private room and should have privacy. R38 stated staff remove R6 from the room, however, the incidents continue to occur and R38's privacy and personal space is not respected. (Of note: R38's MDS assessment, dated 5/14/26, indicated R38 had intact cognition.) R6's medicdal record indicated R6 had diagnoses including dementia, insomnia, and unspecified mood disorder. R6's MDS assessment, dated 5/20/26, stated R6 had a BIMS score of 14 out of 15, indicating intact cognition. A care plan, revised 2/3/25, indicated R6 had behavior problems, refused assistance, and did not use a call light appropriately due to dementia and poor safety awareness. The care plan indicated R6 liked to wander the facility freely and had a WanderGuard on the left ankle (initiated 2/19/25). The care plan contained an intervention to monitor behavior episodes and attempt to determine underlying cause .consider location, time of day, persons involved, and situations and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	document behavior and potential causes. A progress note, dated 5/17/26, indicated R6 had visual hallucinations, periods of anger and harm to others with a walker, and many attempts to exit the building. Surveyor did not observe any progress notes that indicated R6 wandered into others' rooms and required redirection or that the IDT discussed behavioral interventions and/or care plan updates/interventions for behavioral concerns and wandering. During a Resident Council meeting at 1:00 PM on 6/2/26, R7 expressed concern that R6 entered their room uninvited. R7 indicated it happened at least three times and they changed rooms due to the disturbances. (Of note: R7's MDS assessment, dated 5/6/26, indicated R7 had moderately impaired cognition.) On 6/2/26 at 1:21 PM, Surveyor interviewed CNA-Q who stated R6 pulls clothing out of their closet during the day and requires assistance with putting the clothing back in. CNA-Q indicated R6's behavioral concerns have increased during the evening and night hours, including entering other residents' rooms uninvited. CNA-Q indicated R18 enters other residents' rooms all the time and there really isn't much we can do. CNA-Q indicated when R6 enters other residents' rooms, staff redirect R6. CNA-Q was not aware of any other interventions to prevent the behavior. (See additional interview under example 4.) 4. On 6/2/26, Surveyor reviewed the facility's grievance file and noted R33 submitted a grievance on 4/1/26 that indicated R33 was asleep in a dark room and awoke to find (R18) standing in the room with what appeared to be a candy wrapper in their hand. R33 yelled for (R18) to get out of room. (R18) began to leave and then came back. R33 activated the call light for assistance and again told (R18) to leave. (R18) left the room prior to staff arriving. The grievance form indicated R18 entered another resident's room the day prior (3/31/26). The resolution indicated staff would continue to redirect R18 from entering others' rooms and the facility would look into stop signs to prevent residents from entering other residents' rooms. The date completed was 4/25/26. R18's medical record indicated R18 had diagnoses including frontotemporal neurocognitive disorder (umbrella term for a group of progressive brain diseases that damage the frontal and temporal lobes, affecting personality, behavior, language, and sometimes movement) and panic attacks. R18's MDS assessment, dated 5/7/26, stated R18 had a BIMS score of 2 out of 15, indicating severely impaired cognition. A care plan, revised 11/26/25, indicated R18 was an elopement/wander risk and had a history of putting themself in other residents' rooms/beds when wandering (dated 9/21/25). The care plan contained an intervention to identify pattern of wandering and intervene as appropriate (dated 8/1/25). On 6/2/26 at 10:10 AM, Surveyor interviewed R33 who indicated they submitted a formal grievance due to R18 entering their room. R33 recalled the incident and stated it scared me. R33 stated the incident occurred in the early morning while it was still dark and R33 awoke to find R18 standing over them and staring at them with a candy wrapper in hand. R33 shouted twice at R18 to get out of the room, however, R18 left and came back. R33 used the call light the second time when R18 didn't leave but stated R18 eventually left before staff arrived. R33 indicated R18 frequently enters others' rooms uninvited. R33 stated staff are aware and redirect R18, however, nothing is done to prevent it. R33 stated R18 is calm and quiet during the day, roams the halls, and does not enter others' rooms until late afternoon or later. R33 indicated R18 chases people around. R33 thought R18 follwed R33 in common areas of the facility after the incident which frightened R33 to the point that R33 does not like to come out of R33's room at all due to feeling watched and pursued by R18. R33 indicated staff told them R18 has a mind of a child and is harmless. R33 stated the incidents have made them more secluded and they do not feel safe to freely move about the facility. R33 indicated there aren't stop signs on doors or other deterrents to keep others from entering rooms aside from staff redirection. R33 indicated the incident felt like an invasion of my privacy. R33 stated the incidents are not handled appropriately and R33 was told R18 had a right to move freely in the facility and outside of R18's room. R33 stated they have a right to feel safe in their home which they feel is not being considered. R33 stated the facility should do something before something bad happens to someone. (Of note: R33's MDS assessment, dated 3/19/26, indicated R33 had moderately impaired cognition.) During a Resident Council meeting at 1:00 PM on 6/2/26, R23 stated R18 is constantly in and out of my room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R23 state it is scary and indicated residents who wander were previously on a secured unit and did not have access to other units without assistance. (Of note: R23's MDS assessment, dated 5/28/26, indicated R23 had intact cognition.) On 6/3/26 at 10:05 AM, Surveyor conducted an abbreviated tour of the facility and did not observe stop signs on residents' doors or in hallways. On 6/3/26 at 10:34 AM, Surveyor interviewed DON-B who was not aware R6 and R18 frequently entered other residents' rooms which was a concern for other residents. DON-B indicated concerns are addressed in IDT meetings and interventions are discussed and implemented. DON-B reviewed R6 and R18's care plans and confirmed they did not contain updated interventions for supervision or to assist in the prevention of entering other residents' rooms. DON-B indicated the grievance form filled out by R33 would need follow-up by the IDT. DON-B indicated if the incident occurred, the resolution should be in R33's care plan and R18's behavior should be monitored through behavioral tracking which was not occurring for R6 or R18. DON-B stated DON-B would investigate further to find updated care plan interventions and IDT notes. (Of note: Surveyor did not receive updated care plan interventions or IDT notes for R6 or R18.)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 2 residents (R) (R7 and R23) of 3 sampled residents were offered the opportunity to create or obtain Power of Attorney for Healthcare (POAHC) paperwork. R7 was admitted to the facility on [DATE]. The facility did not obtain R7's POAHC document or offer R7 the chance to fill out a new document prior to 6/1/26. R23 was admitted to the facility on [DATE]. The facility did not obtain R23's POAHC document or offer R23 the chance to fill out a new document prior to 6/1/26. Findings include: The facility's Advanced Directive policy and procedure, dated January 2026, indicates: .1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so .8. If the resident indicates that he or she has not established advance directives, facility staff will offer assistance in establishing advance directives . 1. R7 was admitted to the facility on [DATE]. R7's medical record did not contain a POAHC document with witness signatures or a POAHC refusal document. (See interview under example 2.) 2. R23 was admitted to the facility on [DATE]. R23's medical record did not contain a POAHC document or a POAHC refusal document. On 6/2/26 at 3:34 PM and 6/3/26 at 12:47 PM, Surveyor interviewed Social Services Director (SSD)-C who indicated if a POAHC document does not contain witness signatures, the document is not valid. SSD-C verified R7's POAHC document was not valid and indicated SSD-C would work with R7 to complete a new document. SSD-C indicated the facility did not have a POAHC document on file for R23. SSD-C indicated advance directives are discussed at the time of admission and if a resident wants to fill one out, assistance is provided. SSD-C indicated they do not provide follow-up to verify completion. On 6/3/26 at 10:53 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated staff should obtain a copy of a resident's POAHC document or offer the resident the opportunity to create a new POAHC document upon admission.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure an allegation of misappropriation was thoroughly investigated for 1 resident (R) (R14) of 1 sampled resident. R14's wallet went missing after 4/15/26. The facility did not thoroughly investigate the allegation of misappropriation or report the findings to the State Agency (SA). Findings include: The facility's Abuse, Neglect, Exploitation, and Misappropriation Policy, revised April 2021, indicates: Residents have the right to be free from .misappropriation of resident property .the facility will implement policies and protocols to prevent and identify .theft, exploitation, or misappropriation of resident property .identify and investigate all possible incidents of .misappropriation of resident property .investigate and report any allegations within the timeframes required by federal requirements. R14 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, insomnia, and history of stroke. R14's Minimum Data Set (MDS) assessment, dated 4/14/26, stated R14 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderately impaired cognition. On 6/3/26 at 9:38 AM, Surveyor asked Certified Nursing Assistant (CNA)-D if any residents were missing a wallet. CNA-D indicated CNA-D heard R14 was missing a wallet a few weeks ago. CNA-D was not sure if the wallet was found. On 6/3/26 at 9:45 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who confirmed they heard R14 was missing a wallet with money. LPN-E stated R14 sometimes misplaced things but staff always find them. LPN-E was not sure if R14's wallet was found. On 6/3/26 at 10:07 AM, Surveyor interviewed Staffing Coordinator (SC)-F who indicated R14's wallet was reported missing to Social Services Director (SSD)-C a few weeks ago by a CNA or housekeeper. SC-F regularly worked with R14 and stated R14 misplaced things often, however, the items were always found in R14's room. When SC-F was told by SSD-C that R14's wallet was missing, SC-F went to R14's room to search for the wallet. On 6/3/26 at 10:27 AM, Surveyor interviewed SSD-C who indicated a staff member reported that R14's wallet was missing. SSD-C asked R14 to describe the wallet and if there was any money in it. SSD-C stated R14 indicated the wallet contained between $100 and $900. SSD-C asked if R14 wanted to file a grievance, however, R14 declined. SSD-C did not have documentation to show evidence of an investigation. On 6/3/26 at 10:36 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated they became aware of R14's missing wallet a couple weeks ago and was aware that R14 often misplaced items. NHA-A indicated any documentation/investigation was SSD-C's responsibility. On 6/3/26 at 1:19 PM, Surveyor interviewed R14 who verified the wallet was missing and contained $900 which was now gone. R14 believed the money was stolen. On 6/3/26 at 1:22 PM, Surveyor interviewed Personal Care Worker (PCW)-G who visited R14 every week to assist with errands and appointments. PCW-G stated they brought R14 to the bank on 4/15/26 to withdraw $1000. PCW-G indicated R14 liked to stash things but always put things in the same few spots. On 6/3/26 at 1:25 PM, PCW-G found R14's wallet in a dresser drawer. Surveyor observed a receipt in the wallet from a local bank for a withdrawal of $1000. Surveyor did not observe any money in the wallet or dresser drawer. R14 verified the wallet was R14's and the money was missing.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure proper discharge procedures and/or a written transfer or bed hold notice was provided to 3 residents (R) (R43, R8, and R41) of 3 sampled residents. R43 discharged from the facility on 4/10/25. R43's medical record did not contain a recapitulation of stay, confirmation of discharge against medical advice (AMA), indicate discharge orders were received from R43's primary care physician, or indicate education and further services were offered prior to discharge.R8 was transferred to the hospital on 2/23/26 and 4/29/26. R8's medical record did not contain written transfer or bed hold notices.R41 was transferred to the hospital on 4/5/26. R41's medical record did not contain a written transfer or bed hold notice. Findings include: The facility's policy Bed-Holds and Return policy, revised January 2026, indicates: .All residents/representatives are provided with written information regarding facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice. Notice 1: Well in advance of any transfer (e.g., in the admission packet); and Notice 2: At the time of transfer (or, if the transfer was an emergency, within 24 hours) .Multiple attempts to provide the resident representative with notice 2 should be documented in cases where staff are unable to reach and notify the representative timely. Written bed-hold notices provided to residents/representatives explain in detail: The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; the reserve bed payment policy as indicated by the state plan (for Medicaid residents); the facility policy regarding bed-hold periods; the facility per-diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the state bed-hold period (for Medicaid residents); and the facility's return policy, the requirement that residents be permitted to return to the facility following hospitalization or therapeutic leave applies to all residents regardless of payer source . The facility's Discharge Summary policy, revised January 2026, indicates: The discharge summary includes a recapitulation of the resident's stay and a final summary of the resident's status at the time of the discharge .Every resident is evaluated for his/her discharge needs and has an individualized post-discharge plan. The post-discharge plan is developed by the care planning/Interdisciplinary Team (IDT) with the assistance of the resident and his/her family and includes: where the individual plans to reside; arrangements that have been made for follow-up care and services; a description of the resident's stated discharge goals; the degree of caregiver/support person availability, capacity, and capability to perform required care; how the IDT will support the resident or representative in the transition to post-discharge care; what factors may make the resident vulnerable to preventable readmission; and how those factors will be addressed . 1. R43 was admitted to the facility on [DATE] for rehabilitation and had diagnoses including sepsis, gross hematuria, and congestive heart failure. R43's Minimum Data Set (MDS) assessment, dated 4/21/26, stated R43 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. R43 was their own decision maker. R43's medical record indicated R43 discharged from the facility on 4/10/25. (continued on next page)

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	525494	A. Building B. Wing	06/03/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 4/10/26, indicated R43 left the facility AMA at 5:30PM with their belongings. R43's medical record did not contain a recapitulation of stay, services offered prior to discharge, confirmation if R43 was discharged AMA, if discharge orders were received from primary care physician (PCP)-O, or if education was offered prior to discharge. On 6/3/26 at 10:01 AM, Surveyor interviewed Hospital Social Worker (HSW)-N who indicated PCP-O sent orders for R43 to be seen at the emergency room (ER) on 4/9/26 because R43 had shortness of breath and an oxygen saturation level of 87%, however, R43 did not go to the ER. HSW-N indicated there was concern when R43 did not go to the ER and PCP-O's office contacted the facility for follow-up. HSW-N indicated R43's medical record at the physician's office indicated the facility informed PCP-O's office on 4/17/26 that R43 left the facility, however, the facility did not know what day R43 left and thought R43 left AMA. HSW-N indicated R43's medical record at the physician's office did not contain an order from PCP-O to discharge R43 from the facility. Surveyor requested R43's medical record from PCP-O's office. On 6/3/26 at 11:46 AM, Surveyor interviewed Social Services Director (SSD)-C who indicated R43 was admitted to the facility on [DATE] from the hospital for rehabilitation. SSD-C was not working the day R43 left and recalled being told the discharge was a really weird situation and R43 indicated they were leaving the facility, R43 indicated to nursing staff that R43 did not need to be at the facility. Licensed Practical Nurse (LPN)-M obtained discharge orders from PCP-O. A discharge progress note was entered which indicated R43 left AMA. SSD-C indicated if a resident leaves AMA, the facility has the resident sign AMA paperwork. SSD-C confirmed R43's medical record did not contain signed AMA paperwork or signed discharge orders. On 6/3/26 at 11:59 AM, Surveyor interviewed LPN-M who called PCP-O's office and received a telephone order to discharge R43 from the facility on 4/10/26 otherwise R43 was going to leave the facility AMA. LPN-M indicated R43 was homesick and was visiting with family at the facility when R43 stated R43 no longer needed to be at the facility and requested family take them home. LPN-M showed Surveyor an order in R43's medical record, dated 4/10/26 and entered 4/13/26, from PCP-O to discharge R43 from the facility. LPN-M was not sure why the order was dated 4/10/26 but was entered on 4/13/26. LPN-M verified the order was a phone order and there was not a signed discharge order in R43's medical record. On 6/3/26 at 1:30 PM, Surveyor reviewed R43's medical record from Hospital (HSP)-Y and noted the following: ~ A summary note, dated 4/9/26, indicated PCP-O's office received a call from the facility at 11:10 AM that R43 was short of breath and had a low oxygen (O2) saturation level of 87%. PCP-O gave an order for R43 to be seen in the ER. The order was hand-delivered to Former Director of Nursing (FDON)-P. ~ Phone log documentation from PCP-O's office indicated PCP-O called the facility on 4/17/26 to follow-up on why R43 did not go to the ER. PCP-O's office phone log indicated the facility stated R43 left AMA but were unsure when R43 left. PCP-O's office called R43 at home. R43 stated they left the faciity on 4/9/26. On 6/3/26 at 3:26 PM, Surveyor interviewed FDON-P who indicated R43 experienced shortness of breath and a low O2 saturation level on 4/9/26 and refused to be seen in the ER. FDON-P indicated R43 was visiting with family the next day and indicated R43 was leaving the facility and did not need (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be there for care. FDON-P indicated LPN-M received a phone order from PCP-O to discharge R43. FDON-P indicated R43 indicated they were going to leave AMA prior to LPN-M receiving phone order. FDON-P indicated a phone order was received for discharge and PCP-O was updated at that time. FDON-P was unsure what documentation or discharge processes were conducted following the phone order for discharge. 2. R8 had diagnoses including gastrointestinal bleeding and cellulitis. R8's MDS assessment, dated 5/28/26, stated R8 had a BIMS score of 15 out of 15, indicating intact cognition. R8 was their own decision maker. R8's medical record indicated R8 was transferred to the hospital on 2/23/26 for concerns of abnormal vital signs post-fall and possible gastrointestinal bleeding. R8 was also transferred to the hospital on 4/29/26 for chest pain. R8's medical record did not contain a written transfer or bed-hold notice for either transfer. On 6/3/26, Surveyor requested a copy of R8's written transfer and bed-hold notices for 2/23/26 and 4/29/26 from Nursing Home Administrator (NHA)-A. On 6/3/26 at 9:54 AM, NHA-A confirmed R8 was not provided a written transfer or bed-hold notice for the hospital transfers on 2/23/26 and 4/29/26. 3. R41 was admitted to the facility on [DATE] and had diagnoses including heart disease, atrial fibrillation, panic disorder, and post-traumatic stress disorder (PTSD). R41's MDS assessment, dated 1/25/26, stated R41 had a BIMS score of 15 out of 15, indicating intact cognition. R41 was their own decision maker. R41's medical record indicated R41 was transferred to the hospital on 4/5/26. A progress note, dated 4/7/26, indicated R41 was admitted to the hospital. R41's medical record did not contain a written transfer or bed-hold notice for the hospital transfer. On 6/3/26 at 1:32 PM, Surveyor interviewed NHA-A who indicated NHA-A could not provide written transfer or bed hold notices for R43, R8, or R41. NHA-A recognized there was a process concern with transfers/discharges and stated NHA-A would educate staff on the proper procedure.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a comprehensive care plan was developed and implemented for 1 resident (R) (R7) of 14 sampled residents. R7 had orders for oxygen use and Hospice care. R7's care plan did not contain goals or interventions to address R7's dependence on oxygen and potential for airway disturbance or need for Hospice care. Findings include: The facility's Individual Care Plans-Baseline policy, dated 1/2026, indicates: .The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident, including but not limited to, the following: .b. Physician orders . R7 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD), acute and chronic heart failure, and pressure ulcers. R7's Minimum Data Set (MDS) assessment, dated 5/18/26, stated R7 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. R7 had an activated Power of Attorney for Healthcare (POAHC). R7's medical records contained the following orders: ~ Change oxygen (O2) tubing and nasal cannula every night shift, every Thursday (dated 5/28/26)~ 2 liters/minute (LPM) oxygen via nasal cannula to maintain O2 saturation level greater than 90% as needed for hypoxia (dated 4/24/26)~ Admit to Hospice care (dated 5/8/26) On 6/1/26 at 10:13 AM, Surveyor observed R7 in bed using oxygen at 2 LPM via nasal cannula. R7 indicated they used oxygen at all times. On 6/2/26, Surveyor reviewed R7's care plan which didn't contain goals or interventions to address R7's dependence on oxygen and potential for airway disturbance or R7's need for Hospice care. On 6/3/26 at 11:48 AM and 1:38 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R7's care plan should include interventions for oxygen use and Hospice care. DON-B stated the facility was aware care plans needed to be updated and would work to complete the updates.

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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 observation, staff and resident interview, and record review, the facility did not ensure physican orders were followed and appropriate wound care and treatment was provided for 1 resident (R) (R35) of 4 sampled residents.R35 was seen in the wound clinic on 5/8/26 for non-pressure right anterior and posterior leg wounds. New treatments were ordered. The facility did not update R35's orders until 5/14/26. R35 was seen in the wound clinic again on 5/22/26. The physician ordered a wound vac and transitioned R35 from non weight-bearing to weight-bearing status. The facility did not order the wound vac, update R35's weight-bearing status, or update R35's care plan and Kardex (an abbreviated care plan used by nursing staff). Findings include:On 6/2/26, 6/3/26, and 6/16/26, Surveyor requested the facility's policy for obtaining, transcribing, and/or following physician orders. A policy was not provided. R35 was admitted to the facility on [DATE] and had diagnoses including dementia, displaced unspecified condyle fracture of lower end of right femur, initial encounter for closed fracture, contusion of right lower leg, and laceration of right lower leg. R35's Minimum Data Set (MDS) assessment, dated 5/4/26, stated R35's Brief Interview for Mental Status (BIMS) score was 7 out of 15, indicating severely impaired cognition.A care plan, initiated on 4/29/26, indicated R35 had self-care deficits related to recent trauma to the right leg. The care plan contained an intervention, dated 4/29/26, to transfer with the assistance of 1 staff and a walker and indicated R35 was non weight-bearing on the right leg. R35's medical record contained the following wound care orders:~ Anterior right calf: Wash with Vashe, apply 1-2 layers of Aquacel AG to wound bed, apply ABD pad, wrap leg with Kerlix, and apply size E Tubigrips once daily on odd days (ordered 5/1/26; discontinued 5/13/26)~ Posterior right calf: Wash with Vashe, remove sloughing skin gently with normal saline soaked gauze, apply oil emulsion over blistered area, and an ABD pad. Wrap with Kerlix and apply Tubigrips to bilateral legs every other day on odd days (ordered 5/1/26; discontinued 5/13/26)Surveyor reviewed wound clinic orders following R35's appointment on 5/8/26 and noted the following:~ Wound care orders: TO BE DONE AT WOUND CLINIC ONLY! Remove dressing, cleanse the right anterior and posterior calf with Vashe and pat dry. Cover the eschared area ulcerations of right posterior/lateral calf with oil emulsion gauze, and an ABD pad. Cover the right anterior calf ulcer with 1-2 layers of Aquacel AG, 2 layers of Drawtex, and an ABD pad. Place the right leg in a dual layer of 3M light compression wrap from toes to knee. Seen weekly in wound clinic (ordered 5/14/26; discontinued 5/20/26)~ Right anterior calf wound and other minor wounds: Cleanse with Dakins or Vashe solution. May perform a dry gauze rub to remove any superficial slough. Cover open areas with oil emulsion gauze/adaptic and ABD pads. Wrap leg with a layer of Kerlix that extends from the base of the toes to just below the bend of the knee to ensure Coban does not touch the skin. The outer Coban wrap should be placed from the base of the toes to the bend of the knee at 50% overlap and 50% stretch. Once daily (ordered 5/20/26)~ Right posterior calf wound: Remove dressings, clean with Dakins or Vashe. May perform dry gauze rub to remove superficial slough. Fill the entire wound, including undermining anteriorly and distally with Dakins or Vashe dampened Kerlix and cover with dry gauze. Cover with ABD pad and wrap with generous amount of Kerlix from base of toes to just below the bend of the knee. Wrap with Coban which should not touch the skin. Place Coban from base of toes to bend of knee with 50% stretch and 50% overlap. Once daily. May change more than once daily if loose or excessive drainage noted (ordered 5/22/26)A progress note, dated 5/11/26 at 12:01 PM, indicated staff found paperwork from the wound clinic on a table in R35's room. The paperwork indicated dressings were only to be changed at the wound clinic. R35's right leg dressing was changed on 5/9/26. Staff notified the wound clinic on 5/11/26. A wound clinic appointment was scheduled for 5/12/26 at 10:30 AM.Surveyor reviewed wound clinic orders following R35's 5/22/26 appointment and noted the following:~ Negative pressure therapy is ordered to accelerate granulation tissue formation which cannot be achieved by other topical wound treatments. The skilled nursing (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility is going to attempt to source a negative pressure wound therapy system to begin utilizing it as soon as possible.Surveyor verified with wound clinic staff that the orders were faxed to the facility on 5/22/26. (Of note: R35's medical record did not contain an order for a wound vac.)A wound clinic note, dated 5/22/26, indicated orthopedics recommended weaning R35's immobilizer and allowing R35 to bear weight. On 6/3/26 at 11:00 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who indicated R35 walked independently in their room. LPN-E was unsure if R35 was weight-bearing or non-weight-bearing status. LPN-E indicated a physical therapy document in R35's closet indicated R35 was weight-bearing, however, R35's care plan stated R35 was non weight-bearing on the right leg. LPN-E verified R35's medical record did not contain an order for weight-bearing status. LPN-E stated LPN-E needed to confirm R35's status with Unit Manager/LPN-M.At 6/3/26 at 11:33 AM, Surveyor observed R35 walking independently in their room. A therapy communication document in R35's closet, dated 5/27/26, indicated: Independent in room. Walking to/from meals only. The document was signed by Physical Therapist (PT)-Z. Surveyor interviewed R35 who indicated R35 walked independently and was not in pain. Surveyor observed a shadow of drainage on the outside of the sock that coverd R35's right lower leg dressing.On 6/3/26 at 1:11 PM, Surveyor interviewed LPN-M who verified R35 did not have an order for weight-bearing status. LPN-M indicated R35's Hospital After Visit Summary, dated 4/27/26, indicated R35 was non weight-bearing on the right leg. LPN-M verified R35's care plan indicated R35 was non weight-bearing on the right leg and R35's Kardex indicated R35 required the assistance of one staff with a gait belt and walker and was non weight-bearing on the right leg.At 6/3/26 at 2:10 PM, Surveyor interviewed PT-Z who received documentation from R35'snclinic visit on 5/22/26 transitioning R1 to weight-bearing status. PT-Z posted an update in R35's room on a therapy communication document and placed the updated documentation in DON-B's mailbox.On 6/3/26 at 2:13 PM, Surveyor interviewed Director of Nursing (DON)-B who started employment at the facility on 5/28/26 and did not observe updated documents or orders regarding R35's weight-bearing status.On 6/3/26 at 1:11 PM, Surveyor interviewed LPN-M who indicated the facility received an order from the wound clinic on 5/22/26 regarding the need for wound vac for R35. LPN-M indicated the facility had not received the wound vac as of 6/3/26. LPN-M did not know who was responsible for ordering the wound vac.On 6/3/26 at 2:00 PM, Surveyor interviewed LPN-E who received a call on the 5/22/26 PM shift from Hospital Registered Nurse (RN)-BB who told LPN-E that R35 was seen in the wound clinic and the physician ordered a wound vac. RN-BB advised LPN-E the facility needed to obtain a wound vac. LPN-E was not familiar with the process of ordering a wound vac and indicated management was gone for the day. LPN-E put a note under DON-B and LPN-M's door regarding the need for a wound vac. On 6/3/26 at 1:40 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated Housekeeper (HSK)-AA ordered all medical and wound supplies.On 6/3/26 at 2:05 PM, Surveyor interviewed HSK-AA who indicated nursing staff did not inquire about ordering a wound vac for R35. HSK-AA did not know which supplier to contact to obtain a wound vac and had not previously ordered a wound vac.On 6/3/26 at 3:21 PM, Surveyor observed LPN-EE complete R35's right anterior and posterior leg dressing change and noted R35 did not have a wound vac.On 6/4/26 at 9:16 AM, Surveyor interviewed Hospital Quality Director (QD)-GG who indicated the facility reported to wound clinic staff that they were not receiving orders. QD-GG indicated orders from the clinic are sent to the facility via fax. QD-GG indicated Hospital (HSP)-Y's IT department investigated the issue and verified faxes were being transmitted successfully on the clinic side. QD-GG indicated the clinic has not had issues with faxes being received at other clinics or providers. On 6/4/26 at 9:20 AM, Surveyor interviewed Hospital Director (DIR)-CC who verified RN-BB spoke to LPN-E on 5/22/26 at 3:40 PM regarding R35's wound clinic appointment on 5/22/26 and the order for a wound vac. RN-BB advised the facility to order the wound vac and stated the clinic does not order wound vacs for residents in skilled nursing facilities. DIR-CC verified RN-BB faxed the wound vac order to the facility on 5/22/26 and stated R35 was seen in the wound clinic on 5/29/26 without a wound vac. DIR-CC indicated (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 2 residents (R) (R23 and R3) of 4 sampled residents received the necessary care and services to promote healing and/or prevent pressure injuries from worsening.R23 was seen in the wound clinic on 5/28/26 for right dorsal foot, left fifth dorsal toe, and right hallux bunion wounds. New treatments were ordered. The facility was not aware of the updated orders which resulted in a missed dressing change for R23's right dorsal foot on 5/31/26. R3 had a stage 4 pressure injury on the left heel and an order for a dressing change every other day. R3's Treatment Administration Record (TAR) indicated the dressing change was not completed on 5/20/26.Findings include:The facility's Wound Care policy, revised January 2026, indicates: The purpose of the policy is to provide guidelines for the care of wounds to promote healing .Documentation: The following information should be recorded in the resident's medical record: .2. The date and time wound care was given .1. R23 was admitted to the facility on [DATE] and had diagnoses including pressure ulcers to calf and foot, malignant neoplasm of sigmoid colon, and protein calorie malnutrition. R23's Minimum Data Set (MDS) assessment, dated 3/17/26, stated R23 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. R23's medical record contained the following wound care orders:~ Ensure wound dressings are clean, dry, and intact. Every shift for wound care (dated 4/28/26)~ Wound Care: (Right) Dorsal Foot: Remove dressing down to the Mepilex Transfer, but DO NOT remove the white Mepilex Transfer foam as R23 has Grafix underneath. Reapply the outer dressing including part of an ABD pad held in place with a few turns of Kerlix. Change just the outer portion of the dressing on Tuesday, Thursday, and Sunday once daily every Tuesday, Thursday, Sunday for wound care (dated 5/21/26)~ Wound Care: Left Hallux Bunion: Cleanse with saline, pat dry. Paint with Betadine and keep covered with protective Band-Aids changed every 2 days. Every day shift every other day for wound care (dated 5/21/26)~ Wound Care: Left Hallux Bunion: Cleanse with saline, pat dry. Paint with Betadine and keep covered with protective Band-Aids changed every 2 days. Every 24 hours as needed for wound care (dated 5/21/26 On 6/2/26 at 10:28 AM, Surveyor observed Registered Nurse (RN)-X provide wound care for R23's left hallux bunion wound with observation/instruction from RN-T. During wound care, R23 indicated to RN-X that at R23's last appointment at the wound clinic on 5/28/26, the provider changed the orders for the right dorsal foot. RN-T indicated the facility would call the provider for updated orders. On 6/2/26, Surveyor reviewed orders written by the wound clinic following R23's appointment on 5/28/26 which indicated the following:~ (R23) to wear heel raiser/heel protector boot to right foot at all times, except showering. Check skin surrounding area twice daily. Two times a day for wound care. (Of note: The order was dated 5/28/26 and transcribed 6/2/26.)~ Wound Care: Right Dorsal Foot: Remove dressing and cleanse with Vashe or normal saline. May perform a dry gauze rub to remove any superficial slough/bioburden. Cover the open area with UrgoClean AG then cover with an ABD pad held in place with a few turns of Kerlix. R23 may continue to use foam heel pads placed beneath the Tubigrip as before. Change 3 times per week (once in the wound clinic on Thursdays). One time a day every Tuesday and Sunday. (Of note: The order was dated 5/28/26 and transcribed 6/2/26.)~ (R23) to plan for surgery on 6/19/26. Podiatry will call 2 days prior with the time of surgery. (Of note: The order was dated 5/28/26 and transcribed 6/2/26.) On 6/2/26, Surveyor reviewed R23's Medication Administration Record (MAR)/TAR and noted a missed dressing change for the right dorsal foot on 5/31/26.On 6/3/26 at 11:33 AM, Surveyor interviewed Director of Nursing (DON)-B who verified the updated orders were not obtained after R23's wound clinic appointment on 5/28/26 which resulted in a missed treatment on 5/31/26. 2. R3 was admitted to the facility on [DATE] and had a diagnosis of pressure ulcer to left heel. R3's MDS assessment, dated 3/27/26, stated R3 had a BIMS score of 15 out of 15, indicating intact cognition. R3's medical record contained the following order: ~ Left Heel: Remove dressing. Cleanse with Vashe (may substitute saline if (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vashe is not available). May perform a dry gauze rub to remove any superficial slough. May apply emollient cream (dated 5/13/26) On 6/3/26, Surveyor reviewed R3's TAR and noted wound care was not completed on 5/20/26. On 6/3/26 at 1:17 PM, Surveyor interviewed DON-B who verified R3's wound treatment was not documented as completed on 5/20/26. DON-B indicated staff should complete wound treatments and document completion.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not maintain acceptable parameters of nutritional status, including usual body weight range for 1 resident (R) (R39) of 1 sampled resident. R39 experienced a weight gain of greater than 5 pounds (lbs) in one week. The facility did not update the dietitian or R39's physician as ordered. Findings include: The facility's Weight Assessment and Intervention policy, dated 2026, indicates: Resident weights are monitored for undesirable or unintended weight .gain .Any weight change of 5 pounds (lbs) (or at the discretion of the dietitian) or more since the last weight assessment is retaken the next day .undesirable weight change is evaluated by the treatment team .and will include the resident's target weight range, caloric, protein, and other nutrient needs, relationship between current medical condition/clinical situation, recent fluctuations in weight, and to what extent weight stabilization can be anticipated. R39 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, depression, hypertension, and vitamin D deficiency. R39's Minimum Data Set (MDS) assessment, dated 4/7/26, stated R39 had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating severely impaired cognition. R39 had an activated Power of Attorney for Healthcare (POAHC). R39's comprehensive care plan, dated 4/7/26, indicated R39 had a potential nutritional problem related to dementia and confusion. The care plan contained a goal to maintain adequate nutrition as evidenced by weight stability. The care plan contained an intervention for staff to obtain weights per protocol and notify the physician/dietitian of significant weight changes (loss or gain) per protocol/physician order. On 6/3/26, Surveyor reviewed R39's physician orders. R39's medical record contained an order, dated 5/14/26, to complete weekly weights and notify the physician of weight gain of more than 5 lbs in one week. On 6/3/26, Surveyor reviewed R39's weekly weights and noted the following: ~ On 5/14/26, R39 weighed 167.9 lbs (mechanical lift)~ On 5/21/26, R39 weighed 176.4 lbs (mechanical lift) (which was an 8.5 lb weight gain)~ On 5/28/26, R39 weighed 181.8 lbs (mechanical lift) (which was a 5.4 lb weight gain) R39's medical record did not indicate the physician or dietitian was notified of the weight gains. On 6/3/26 at 2:48 PM, Surveyor interviewed Director of Nursing (DON)-B who could not provide documentation that R39's physician or the dietitian were notified of R39's weight gains.

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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. Based on staff interview and record review, the facility did not ensure the provision of pharmacy services to meet the needs of 1 resident (R) (R6) of 5 sampled residents.A urinalysis and culture was ordered for R6 for a possible urinary tract infection. The facility did not promptly follow-up on the results or an antibiotic order which caused a delay in R6's treatment.Findings include: The facility's Guidelines for Notifying Physicians of Clinical Problems policy, revised January 2026, indicates: These guidelines are intended to help ensure .medical care problems are communicated to medical staff in a timely, efficient and effective manner and .all significant changes in resident status are assessed and documented in the medical record .The charge nurse or supervisor should contact the attending physician if a clinical situation appears to require immediate discussion and management . R6 had diagnoses including dementia, unspecified mood disorder, displaced fracture of the right femur due to a fall without routine healing, and insomnia. R6's Minimum Data Set (MDS) assessment, dated 5/20/26, stated R6 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. A behavioral note, dated 5/25/26, indicated the physician was notified and requested a urinalysis and culture and lab work to assess for possible underlying infection or metabolic/electrolyte abnormalities contributing to a change in condition due to an acute increase in R6's behaviors and altered mentation. (Of note: R6's medical record did not contain urinalysis and culture results, lab results, or a progress note indicating any new orders.) On 6/3/26, Surveyor reviewed the facility's infection surveillance line list for May 2026 and noted R6 was not listed as having signs or symptoms of an infection, labs orders/results, or any antibiotics prescribed. On 6/3/26 at 10:43 AM, Surveyor interviewed Director of Nursing (DON)-B who confirmed the behavioral note indicated lab orders were received. DON-B verified R6's medical record did not contain the lab results or any new orders. DON-B stated DON-B would obtain the lab results and any new orders. On 6/3/26 at 11:29 AM, DON-B provided R6's urinalysis and culture results to Surveyor. The results indicated a urinalysis on 5/28/26 was abnormal with white blood cells, blood, leukocytes, and mucus and was positive for nitrites. R6's physician reviewed the results and added an order on 5/29/26 (Friday) to culture the sample and treat with cefpodoxime (an antibiotic medication) 200 milligrams (mg) by mouth twice daily for seven days. The order was sent to the pharmacy. DON-B indicated the results and orders were emailed to the facility but floor nurses do not have access to emails. DON-B confirmed administration (who had access to the email containing the results) did not follow-up with the orders on 6/1/26 (Monday). DON-B indicated the facility requested floor nurses have access to faxes to prevent further delays in treatment of residents with lab or medication orders. DON-B also confirmed R6 was not added to the infection surveillance line list for monitoring.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 2 residents (R) (R21 and R15) of 7 sampled residents. R21 was on contact precautions which required staff to don a gown and gloves prior to room entry. Registered Nurse (RN)-L did not don a gown and gloves prior to entering R21's room to provide medication. RN-L did not complete hand hygiene in accordance with the facility's policy during wound care for R15. Findings include: The facility's Handwashing/Hand Hygiene policy, indicates: .This facility considers hand hygiene the primary means to prevent the spread of infections .2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap .and water for the following situations: .Before and after direct contact with residents; Before preparing or handling medications; Before performing any non-surgical invasive procedures; .Before handling clean or soiled dressings, gauze pads, etc.; Before moving from a contaminated body site to a clean body site during resident care; After contact with a resident's intact skin; After contact with blood or bodily fluids; After handling used dressings, contaminated equipment, etc.; After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; After removing gloves; Before and after entering isolation precaution settings .Hand hygiene is the final step after removing and disposing of personal protective equipment .The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. 10. Single-use disposable gloves should be used: Before aseptic procedures; When anticipating contact with blood or body fluids; and When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions . The facility's Isolation-Initiating Transmission-Based Precautions policy indicates: Transmission-Based Precautions (TBP) are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents .When TBP is implemented, the Infection Preventionist (or designee): a. Clearly identifies the type of precautions, the anticipated duration, and the personal protective equipment (PPE) that must be used; .Determines the appropriate notification on the room entrance door and on the front of the resident's chart so personnel and visitors are aware of the need for and type of precautions: 1. Signage informs the staff of the type of precautions, instructions for use of PPE, and/or instructions to see a nurse before entering the room .Ensures protective equipment is maintained outside the resident's room so anyone entering the room can apply the appropriate equipment .Ensures protective equipment and supplies needed to maintain precautions during care are in the resident's room; . R21 was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes mellitus and C-difficile (highly contagious bacterium that causes diarrhea and colitis). According to a Centers for Disease Control and Prevention (CDC) Contact Precautions sign posted at the entrance to R21's room: Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. On 6/2/26 at 7:39 AM, Surveyor observed RN-L prepare R21's medications and noted a contact precautions sign at the entrance to R21's room. Next to R21's room was a personal protective equipment (PPE) cart that contained gowns, gloves, and masks. RN-L entered R21's room without donning a gown or gloves. After entering R21's room, RN-L handed a medicine cup with pills to R21. RN-L elevated the head of the bed and handed R21 a cup of water. R21 took the medication and handed the water cup back to RN-L who threw it in the garbage. RN-L exited the room, walked across the hall into R15's room, and washed hands with soap and water. R15 was in the room waiting (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for RN-L to tend to a bleeding wound on R15's left elbow. R15 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis following a stroke. R15's medical record contained an order for contact precautions due to C-difficile (dated 6/1/26 at 12:56 PM and entered by Infection Preventionist (IP)-M). On 6/2/26 at 7:54 AM, Surveyor observed RN-L exit R15's room and don a gown and gloves from a PPE cart. RN-L washed R15's arm with soap and water. R15's arm contained blood from the elbow to the hand and was actively bleeding. RN-L removed their gown and gloves and exited the room without completing hand hygiene. RN-L opened two doors to get to a storage room with medical supplies. RN-L took a package of steri-strips, again exited through the two doors, and removed a pair of bandage scissors from a cloth bag. RN-L entered R15's room without completing hand hygiene, donned a gown and gloves, and opened the steri-strips. RN-L then removed the gown and gloves and exited the room without completing hand hygiene. RN-L retured to the supply room, retrieved a package of gauze, and returned to R15's room without completing hand hygiene. R15 donned a gown and gloves and used gauze and wound cleanser to clean R15's arm. While attempting to put steri-strips on the wound, RN-L dropped a set of steri-strips on the floor. RN-L picked the steri-strips off the floor with a gloved hand and put the steri-strips on a table. Without changing gloves and completing hand hygiene, RN-L picked up another set of steri-strips and applied three steri-strips over the wound. RN-L then dated and initialed an adhesive bandage placed over the wound. RN-L disposed of all garbage and washed hands with soap and water. On 6/2/26 at 8:14 AM, Surveyor interviewed RN-L who did not know RN-L should wear a gown and gloves when entering the room of a resident on contact precautions if only administering medication. RN-L acknowledged the missed hand hygiene opportunities during R15's wound care. On 6/2/26 at 11:30 AM, Surveyor interviewed IP-M who verified staff should don a gown and gloves prior to entering the room of a resident on contact precautions, even when the intent is to pass medication. IP-M also stated staff should complete hand hygiene and change gloves after soiled tasks and prior to clean tasks. IP-M stated after Surveyor's observation of wound care with RN-L, R15's wound care was redone by the consulting wound nurse.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure vaccines were offered for 2 residents (R) (R2 and R7) of 5 sampled residents.R2 was not offered the influenza vaccine in accordance with the facility's policy.R7 was not offered the PCV20 vaccine in accordance with the facility's policy.Findings include: The facility's Influenza Vaccine policy, revised January 2026, indicates: All residents .who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza .between October 1st and March 31st each year, the influenza vaccine shall be offered to residents. The facility's Pneumococcal Vaccine policy, revised Janauary 2026, indicates: All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections .upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series and when indicated, are offered the vaccine series within 30 days of admission to the facility unless medically contraindicated. 1 . R2 was admitted to the facility on [DATE] and had diagnoses including dementia, hand fracture, and anxiety. R2's Minimum Data Set (MDS) assessment, dated 4/16/26, stated R2 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderately impaired cognition. R2 was their own healthcare decision maker. On 6/3/26, Surveyor reviewed R2's immunization records and noted R2 signed consent to receive the pneumococcal vaccine on 4/15/25. Surveyor reviewed R2's immunizations in the facility's electronic health record as well as the Wisconsin Immunization Registry (WIR) and did not see any pneumonia vaccinations provided. (See interview under example 2.) 2. R7 was admitted to the facility on [DATE] and had diagnoses including femur fracture, diabetes, and pressure injuries. R7's MDS assessment, dated 3/24/26, stated R7 had a BIMS score of 15 out of 15, indicating intact cognition. R7 was their own healthcare decision maker. On 6/3/26, Surveyor reviewed R7's immunization records and noted R7 signed consent to receive the influenza vaccine on 12/17/25. Surveyor reviewed R7's immunizations in the facility's electronic health record as well as the WIR and did not see any influenza vaccinations provided during the 2025-2026 influenza season. On 6/3/26 at 10:04 AM, Surveyor interviewed Director of Nursing (DON)-B who could not provide documentation/evidence that R2 received a pneumococcal vaccine or R7 received an influenza vaccine in accordance with the facility's policy.

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on staff and resident interview and record review, the facility did not have a process to ensure mail was delivered on Saturdays. This practice had the potential to affect all 37 residents (R) residing in the facility. The facility did not have a process to deliver mail on weekends. Mail delivered to the facility on Saturdays was not provided to residents until the following Monday. Findings include: The facility's Mail and Electronic Communication policy indicates: .4. Mail and packages will be delivered to the resident within twenty-four hours of delivery on premises or to the facility's post office box (including Saturday deliveries). The facility's admission Agreement indicates: .Your mail will be delivered to your room within 24 hours of receipt at the center. On 6/2/26 at 1:03 PM, Surveyors conducted a Resident Council meeting. R7, R1 , R23 , R24, R36, and R38 were in attendance. R7 stated residents do not receive mail on Saturdays. When Surveyor asked the other residents if they receive mail on Saturdays, all residents indicated they receive mail Monday through Friday but not on Saturday. (Of note: R7's medical record contained a Minimum Date Set (MDS) assessment, dated 5/6/26, that stated R7 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderately impaired cognition.) On 6/2/26 at 1:54 PM, Surveyor interviewed Recreation Director (RD)-I who stated activity staff do not deliver mail. RD-I stated maintenance staff deliver mail Monday through Friday. RD-I was unsure if mail is delivered on Saturdays. On 6/3/26 at 11:13 AM, Surveyor interviewed Maintenance staff (MS)-J who stated Transportation Driver (TD)-K delivers mail in-between transports Monday through Friday, however, TD-K does not work on the weekend.