STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525495	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Living - Lakeshore at Siena	5643 Erie Street Racine, WI 53402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility did not ensure 2 (R4, R41) of 3 residents with allegations of resident-to-resident abuse and injuries of unknown origin were reported to the State Agency.*On 10/1/2025, a resident-to-resident incident occurred. R41 entered R4's room, grabbed R4's forearm causing R4 to scream in fear and feel pain in R4's forearm.*On 11/8/2025, R41 was discovered to have an injury of unknown origin which was an abrasion to the head.Findings:Review of the facility policy titled Abuse Investigation and Reporting, last approved 12/2024, indicates, Reporting: A. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported to the Administrator or designee and to the following other officials or agencies: . B. Alleged violations involving abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported: 1. Abuse or Serious Bodily Harm - immediately but not later than 2 hours. [sic] If the alleged violation involves abuse or results in serious bodily injury. 2. No Serious Bodily Injury - As soon as practical, but not later than 24 hours*. [sic] If the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property; does not result in serious bodily injury. C. Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone.On 01/20/2026, at 11:38 AM, Surveyor interviewed R4. R4 informed Surveyor of an incident that occurred, stating, R41 came into R4's room, R4 told R41 to leave and then R41 grabbed R4's forearm. (cross reference F744)Surveyor reviewed R4's Electronic Health Record and noted a nursing progress note, dated 10/01/2025, at 23:20:09 (11:20 PM) hours, indicates, during pm shift, a confused resident entered R4's room and grabbed R4's forearm, resident screamed, staff intervened and separated residents, noted, and leadership notified.Surveyor reviewed the Facility provided Facility Reported Incident investigations and noted there were no Facility Reported investigations regarding this incident.On 01/21/2026, at 3:07 PM, Surveyor asked Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B for the facility investigation related to the resident-to-resident (R4 and R41) incident. On 01/22/2026, at 3:44 PM, NHA-A informed Surveyor NHA-A was not employed at the Facility during the time of the incident and was unable to locate an investigation that would have been done prior to NHA-A. Surveyor was provided with an investigation of the injury of unknown origin by the Facility. Surveyor reviewed a document, titled R41's Abrasion Investigation, with no date, indicates Skin abrasion and marks of unknown origin. Fall protocol reviewed. Statements colluded from staff. Skin assessment completed. Appropriate parties notifi9ed. Skin tear found 11/8/25 to forehead. Shower sheet reviewed and attached. Resident monitored and Neuro checks completed Surveyor noted, the Certified Nursing Assistant and Licensed Practical Nurse who first identified the injury on the shower sheet and wrote the progress note were not interviewed as part of the investigation. Factual discoveries section on the investigation is blank.On 01/26/2026, at 9:55 AM, Surveyor interviewed Director of Nursing (DON)-B and NHA-A. DON-B indicated to Surveyor (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that staff informed DON-B of the resident-to-resident incident involving R4 and R41. DON-B deferred to former NHA at that time and indicated the NHA would have handled the whole investigation. NHA-A informed Surveyor, NHA-A's expectation is for staff to immediate intervene, maintain safety, preform assessment, provide first aid, send out if needed, document and notify on call, DON , Provider, NHA and NHA-A would get the reportable in. skin assessment, pain assessment, notify POA, collect staff statements, resident statements, try to determine cause, determine what was happening prior, as a team, discuss, review care plans for both individuals, notify Police department, then continue working on 5 day. Surveyor asked DON-V about R41's injury of unknown origin, DON-B indicated she does not know where it came from. NHA-A indicated an injury of unknown origin is an injury that cannot be determined on what happened and the injury is in a suspicious location. NHA-A indicated R41's injury to the head would be considered an injury of unknown origin and would expect to look at past falls, history and obtain resident interviews, staff interviews and review interventions. Surveyor asked DON-B why the investigation into R41's injury started 3 days after the injury was found, DON-B indicated she was not sure and would need to investigate it. NHA-A informed Surveyor the expectation is for the investigation to have started immediately, staff is to notify the unit manager, on call nurse and/or NHA immediately upon finding the injury and to notify the State Agency.No further information provided at time of write up.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interviews, the facility did not ensure a thorough investigation was completed for 2 (R4 and R41) of 3 Residents reviewed for allegations of abuse/neglect and injury of unknown origin investigations.*On 10/1/2025, a resident-to-resident incident occurred. R41 entered R4's room, grabbed R4's forearm causing R4 to scream in fear and feel pain in R4's forearm.*On 11/8/2025, R41 was discovered to have an injury of unknown origin which was an abrasion to the head. The investigation was not started until 11/11/2025, 3 days later, and was not thorough. The investigation did not include statements from staff who first identified the injury and does not include determination of possible cause. Findings include: The Facility policy, titled, Abuse Investigation and Reporting, with a last approved date of 11/2024, documents in part, . Role of the Administrator or designee:A. If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown sources reported, the Administrator or designee will assign the investigation to an appropriate individual.C. The administrator or designee will keep the resident and his/her representative informed of the progress of the investigation.Role of the Investigator:The individual conducting the investigation will, at a minimum:Review the completed documentation forms; . 7. Interview associate members (on all shifts) who have had contact with the resident during the period of the alleged incident; .10. Review events leading up to the alleged incident. On 01/20/2026, at 11:38 AM, Surveyor interviewed R4, during the interview R4 informed Surveyor of an incident that occurred, indicating, R41 came into R4's room, R4 told R41 to leave and then R41 grabbed R4's forearm. (Cross reference F744)Surveyor reviewed R4's Electronic Health Record and noted a nursing progress note, dated 10/01/2025, at 23:20:09 (11:20 PM) hours, indicates, during pm shift, a confused resident entered R4's room and grabbed R4's forearm, resident screamed, staff intervened and separated residents, noted, and leadership notified.Surveyor reviewed R41's Electronic Health Record, and noted a progress note on 11/8/2025, indicating during a skin check R41 was identified to have a skin tear to R41's head.Surveyor noted there is no Facility Reported Incident (FRI) investigation regarding this incident.On 01/21/2026, at 3:07 PM, Surveyor asked Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B for the resident-to-resident altercation investigation for R4 and R41 and the injury of unknown origin investigation for R41. On 01/22/2026, at 3:44 PM, NHA-A informed Surveyor NHA-A was not employed at the Facility during the time of the resident-to-resident incident and was unable to locate an investigation that would have been done prior to NHA-A. Surveyor was provided with an investigation of the injury of unknown origin by the Facility. Surveyor reviewed a document, titled R41's Abrasion Investigation, with no date, indicates Skin abrasion and marks of unknown origin. Fall protocol reviewed. Statements collected from staff. Skin assessment completed. Appropriate parties notified. Skin tear found 11/8/25 to forehead. Shower sheet reviewed and attached. Resident monitored and Neuro checks completed. Surveyor noted, the Certified Nursing Assistant and Licensed Practical Nurse who first identified the injury on the shower sheet and wrote the progress note were not interviewed as part of the investigation. Surveyor notes the factual discoveries section on the investigation is blank.On 01/26/2026, at 9:55 AM, Surveyor interviewed Director of Nursing (DON)-B and NHA-A. DON-B indicated to Surveyor staff informed DON-B of the resident-to-resident incident involving R4 and R41. DON-B deferred to former NHA at that time and indicated the NHA would have handled the whole investigation. NHA-A informed Surveyor, NHA-A's expectation is for staff to immediately intervene, maintain safety, preform assessment, provide first aid, send out if needed, document and notify on call, DON , Provider, NHA and NHA-A would get the reportable in. skin assessment, pain assessment, notify POA, collect staff statements, resident statements, try to determine cause, determine what was happening prior, as a team, discuss, review care plans for both (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	individuals, notify Police department, then continue working on 5 day. Surveyor asked DON-V about R41's injury of unknown origin, DON-B indicated she does not know where it came from. NHA-A indicated an injury of unknown origin is an injury that cannot be determined on what happened and the injury is in a suspicious location. NHA-A indicated R41's injury to the head would be considered an injury of unknown origin and would expect to look at past falls, history and obtain resident interviews, staff interviews and review interventions. Surveyor asked DON-B why the investigation into R41's injury started 3 days after the injury was found, DON-B indicated she was not sure and would need to investigate it. NHA-A informed Surveyor the expectation is for the investigation to have started immediately, staff is to notify the unit manager, on call nurse and/or NHA immediately upon finding the injury.No further information provided at time of write up.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not comprehensively assess residents to ensure residents receive treatment and care in accordance with professional standards of practice for 5 (R2, R66, R62, R38, and R5) of 14 sampled residents. *R2 developed maceration in the gluteal fold on 1/20/2026 that was not comprehensively assessed and Certified Nursing Assistant (CNA)-H stated CNA-H had been applying an antifungal powder; R2 did not have an order for antifungal powder. *R66 was admitted to the facility with cellulitis to the right lower leg. The right lower leg cellulitis was not comprehensively assessed and documented. Treatment orders were entered into the Treatment Administration Record without documenting where the treatment was to be applied. *R62 had an unwitnessed fall on 1/26/2026. R62 hit their head, had altered mental status, and was taking an anticoagulant. R62 was moved from the floor to the bed with observed injury and a private ambulance service was called for transport rather than 911 being initiated. *R38 had an unwitnessed fall on 12/8/2025. Neurological assessments were not completed as per facility protocol. *R5 developed a skin wound on 12/24/2025 that was not comprehensively assessed for etiology, along with appropriate interventions to promote healing. R5 had a Nurse Practitioner (NP) order for a wound consult on 12/24/25 and this was not completed. *R5 had a fall on 12/16/2025 that was unwitnessed. R5 was not able to communicate if they hit their head and is receiving blood thinning medication. R5 did not have a thorough neurological assessment completed post fall. Findings include: The facility policy and procedure titled Falls dated 9/2025 documents: A Licensed Nurse shall observe clinical status for 72 hours after an observed or suspected fall, and document findings in the resident clinical record. In an interview on 1/22/2026 at 3:11 PM, Surveyor asked Director of Clinical Operations (DCO)-F if the timing documented on the Neuro Assessment flow sheet was the facility protocol for how often neurological assessments should be completed after a resident has an unwitnessed fall. DCO-F stated yes, that is how often neuro checks should be done. The form documents neurological assessments are to be completed every 15 minutes for the first hour, every 30 minutes for the next hour, every hour for the next 2 hours, every 2 hours for the next 8 hours, every 4 hours for the next 12 hours, and every shift for the next 48 hours. 1.) R2 was admitted to the facility on [DATE] with a urinary tract infection for which R2 was receiving intravenous (IV) antibiotics. R2's admission Minimum Data Set (MDS) assessment dated [DATE] documented R2 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15, had an indwelling urinary catheter, was frequently incontinent of bowel, and had no skin concerns. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/20/2026 at 10:49 AM, Surveyor asked R2 if R2 had any open areas or sores on the skin. R2 stated R2's bottom was red and raw from having diarrhea which was caused by being on antibiotics. Surveyor asked R2 if the facility staff were putting anything on the raw skin. R2 stated they put on a cream which helps it feel better. On 1/20/2026 at 10:01 PM, on R2's Skin Evaluation Record, a Licensed Practical Nurse (LPN) documented R2's buttock had maceration in the gluteal fold. The macerated area was not measured and did not have any descriptors of the tissue type. The treatment documented was to cleanse and dry the area and then apply antifungal powder. No order for antifungal powder was entered into R2's medical record. No documentation was found showing a physician or Nurse Practitioner were notified of the new skin breakdown. On 1/22/2026 at 3:42 PM, on R2's Skin Evaluation Record, an LPN documented a general skin check: existing wounds noted and no changes. The LPN did not document what existing wounds were present and did not document any descriptors of the wounds. On 1/22/2026 at 3:30 PM, R2 had an unwitnessed fall and was sent to the hospital for evaluation due to hitting the head and being on blood thinners. R2 was admitted to the hospital with chronic obstructive pulmonary disease exacerbation, new onset atrial fibrillation, and cellulitis to the left leg. On 1/26/2026 at 10:19 AM, Surveyor entered R2's room and observed miconazole nitrate 2% topical powder with the instructions to apply to redness and rash on penis, groin, inner thighs, and buttocks twice daily. Surveyor notes the pharmacy label was dated 12/5/2025 and had been provided to R2 while in the hospital prior to admission to the facility. R2 did not have a current order for the antifungal powder. Surveyor asked LPN-G if R2 had been receiving antifungal powder. LPN-G stated R2 was currently in the hospital and LPN-G had not worked with R2 prior to R2 going to the hospital so did not know if R2 had been getting antifungal powder. Certified Nursing Assistant (CNA)-H overheard the question from Surveyor to LPN-G and stated CNA-H puts the antifungal powder on R2. Surveyor noted R2 did not have an order for antifungal powder, and it was not being administered by a licensed nurse. On 1/26/2026 at 1:55 PM, Surveyor shared with Director of Nursing (DON)-B the concern R2 had maceration to the gluteal fold that was not comprehensively assessed and was getting an antifungal powder treatment with no order, and it was being applied by a CNA and not a nurse. In an interview on 1/26/2026 at 2:34 PM, Surveyor shared with Wound Registered Nurse (WRN)-I R2 had maceration to the gluteal fold that was discovered on 1/20/2026 that was not comprehensively assessed. RN-I is the facility wound nurse who is Wound Care Certified. WRN-I stated WRN-I should be notified of a new wound, but the orders do not go right to WRN-I. WRN-I stated WRN-I needs to be told directly of any new wounds either through text, the 24-hour board, or email. Surveyor asked WRN-I if WRN-I was aware R2 had maceration. WRN-I stated no. Surveyor asked WRN-I what would you expect the floor nurse to do when a new skin concern or open area is found. WRN-I stated the nurse should get measurements and document a description of the wound. WRN-I stated WRN-I and the wound physician would include that resident on wound rounds. Surveyor shared with WRN-I the observation of R2's antifungal powder and the statement by CNA-H of CNA-H applying the medicated powder. WRN-I stated sadly, that is an example of what is happening in the facility with wounds. WRN-I stated WRN-I used to spend a day with new employees to teach them wound care and charting and now that is not done. 2.) R66 was admitted to the facility on [DATE] with diagnoses of cellulitis to the right lower (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	limb, diabetes, diabetic foot ulcers, chronic non-pressure ulcers to the feet, and peripheral vascular disease. R66's admission Minimum Data Set (MDS) assessment dated [DATE] documented R66 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15, had an infection of the foot and a diabetic foot ulcer. R66 had multiple wounds on admission: rash to the groin, pressure injury to the left outer heel, diabetic ulcer to the right foot, diabetic ulcer to the left second toe, diabetic ulcer to the right second toe, diabetic ulcer to the right fourth toe, diabetic ulcer to the left fifth toe, and a callous to the ball of the right foot. No documentation was found of an assessment of the right lower leg cellulitis. Nursing documented in the progress notes that R66 was being monitored for the cellulitis, but there were no descriptions or measurements documented in R66's medical record to determine if the cellulitis was improving or declining. On 1/7/2026, R66 had an order to cleanse with normal saline or wound cleanser and apply betadine daily. The order did not specify where the treatment was to be applied On 1/26/2026 at 10:15 AM, Surveyor observed R66 sitting up in a wheelchair in R66's room. R66 had heel boots on both feet. The right shin was observed to be discolored and dark. In an interview on 1/27/2026 at 12:53 PM, Surveyor shared with Wound Registered Nurse (WRN)-I, who is the facility wound nurse, the concern no documentation was found of R66's right lower leg cellulitis. WRN-I stated WRN-I would expect the floor nurses to chart about the cellulitis with a description of the area. WRN-I stated WRN-I and the wound physician do not monitor or assess non-pressure wounds, but the floor nurse or Unit Manager should be assessing those areas. Surveyor shared with WRN-I the treatment order that did not specify where the treatment was to be applied. WRN-I stated WRN-I noticed that as well and changed the orders after WRN-I did the first assessment of the multiple wounds with the wound physician. In an interview on 1/27/2026 at 1:41 PM, Surveyor asked Certified Nursing Assistant (CNA)-J if R66 had any open wounds on the legs. CNA-J stated R66's legs have spots of discoloration but was not sure if there were any open areas. 3.) R62 was admitted to the facility on [DATE] with diagnoses of diabetes, orthostatic hypotension, cirrhosis with ascites, compression fracture of L1, osteopenia, and atrial flutter. R62's admission Minimum Data Set (MDS) assessment dated [DATE] documents R62 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 and needed extensive assistance with activities of daily living (ADLs). R62 had an order for Xarelto 15 mg (milligrams) (a blood thinner) every evening on admission. R62's ADL Care Plan was initiated on 1/13/2026 and revised on 1/21/2026 with the intervention: extensive assistance with one person, no devices for bed mobility. On 1/13/2026 at 6:42 PM, in the progress notes, nursing documented R62 was alert and oriented to person and place. At 9:45 PM in the progress notes, nursing documented R62 was observed and monitored for the condition of a compression fracture of L1. R62 was alert, speech was clear, and R62 was pleasant and cooperative. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/14/2026 at 10:07 AM, in the progress notes, nursing documented R62 was able to make needs known. On 1/20/2026 at 2:00 PM, in the progress notes, nursing documented R62 was alert and oriented and able to make needs known. R62 denied any pain or discomfort. On 1/21/2026 at 4:58 AM, in the progress notes, nursing documented R62 was observed and monitored for the orthopedic condition of a compression fracture. R62 was alert, speech was clear and R62 was cooperative and tearful. R62 was being seen by skilled services of PT (Physical Therapy), OT (Occupational Therapy), and was declining to participate with the plan of treatment. R62's balance and gait were unsteady. At 5:51 AM in the progress notes, nursing documented R62 did not eat dinner the prior shift and wanted to be in bed for the remainder of the shift. R62 was repositioned throughout the shift. R62 slept most of the night with no complaints of pain or discomfort and was awake for toileting. On 1/22/2026 at 2:40 PM, in the progress notes, nursing documented R62 told the nurse R62 wants to be a full body mechanical lift due to having a hard time using the sit to stand lift. At 11:19 PM in the progress notes, nursing documented R62 was having a hard time standing with the sit to stand lifts, both manual and electric. The nurse talked to the Quality Manager and was told R62 would be moving to another unit on 1/23/2026. On 1/23/2026 at 1:35 PM, in the progress notes, nursing documented R62 refused to get out of bed with three attempts. At 2:19 PM in the progress notes, nursing documented they spoke to R62's family regarding the room change due to increased care needs. On 1/25/2026 at 11:01 PM, in the progress notes, nursing documented R62 was alert and denied any complaints of pain or discomfort. R62 was adjusting well to the new room. On 1/26/2026 at 6:06 AM in the progress notes, nursing documented R62 was yelling out earlier in the shift. R62 complained of pain and pain medication was administered. No other issues were noted after that. On 1/26/2026 at 4:35 PM in the progress notes, Registered Nurse Unit Manager (RNUM)-C documented at approximately 9:00 AM, RNUM-C was called to R62's room due to R62 was on the floor. R62 was face down with the face resting on the bottom of the bedside table. The bedside table was removed while the Certified Nursing Assistant (CNA) held R62's head. The CNA brought in a full body mechanical lift and R62 was gently rolled onto the back and onto the lift sling. R62 was transferred to bed. R62's vital signs were, blood pressure 86/57, temperature 98.1, pulse 98, respirations 16, and oxygenation 100%. R62 had an abrasion to the right forehead, an abrasion to the nose, and an abrasion to the right knee. RNUM-C received an order from the Nurse Practitioner to send R62 to the emergency room for evaluation. Surveyor notes R62's average blood pressure during R62's admission at the facility was 124/66 and pulse was 68. The private Ambulance Report documented on 1/26/2026 at 8:00 AM, they were notified R62 fell in the facility at 7:50 AM. The ambulance emergency medical services (EMS) arrived at R62's bedside at 8:22 AM. EMS documented the fall occurred 30 minutes prior to arrival. R62 had altered mental status and the acuity was emergent. EMS documented they arrived on scene, donned personal protective (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	equipment, and was directed to R62's room. On arrival, EMS was met by the facility RN who stated R62 had a fall 30 minutes prior to EMS's arrival. R62 fell approximately 2 feet from the bed. EMS was informed the fall was unwitnessed and was unsure if R62 lost consciousness. R62 was found in bed. R62 was alert and oriented times one (to person only) with a Glasgow Coma Scale score of 11 (indicating a moderate level of brain injury, suggesting the resident is conscious but may have impaired responsiveness). EMS noticed R62 had a one-inch abrasion located just above the right eye. Bleeding was controlled. R62 was unable to answer questions appropriately. EMS obtained a blood sugar reading of 155. Nursing staff informed EMS R62 was on blood thinners and takes Xarelto. EMS obtained a set of vitals. R62's blood pressure was extremely difficult to auscultate due to R62's pulse being extremely weak. EMS agreed, due to R62's altered mental status and weak pulses, they would run lights and sirens to the hospital. EMS documented enroute to the hospital R62 remained altered and continued to not be able to answer questions appropriately. EMS was unable to obtain a second blood pressure reading as the pulse was extremely weak. The emergency room (ER) report on 1/26/2026 documented R62 had a history of dementia and was brought to the ER after a fall. R62 had a history of atrial flutter and was on Xarelto. R62 was brought in by ambulance after falling out of bed. R62 did strike the head and appeared to have struck the right knee. Per report, R62 was alert and oriented times one at baseline. R62 does not provide any reliable history. Surveyor noted R62 did not have a history of dementia and R62's baseline was not alert and oriented times one. R62, along with R62's family, decided to change from a full code status to a Do Not Resuscitate status and opted to sign onto hospice services. R62 passed away on 1/27/2026 at 3:45 AM at the hospital. The Fall Scene Investigation Form from the facility for R62's fall on 1/26/2026 was completed by RNUM-C and documented the fall happened at 9:00 AM. Surveyor noted EMS was called at 8:00 AM for the fall at 7:50 AM. R62's statement, when asked how they fell, was I don't know. R62's fall was unwitnessed and was found face down on the floor after rolling out of bed. R62 had been sleeping prior to the fall. R62's vital signs were documented as in the progress notes after the fall. RNUM-C documented the root cause of the fall to be R62 sleeping too close to the edge of the mattress. The CNA Post Fall Report was blank. On the Incident Statement Form, CNA-J documented before the incident, CNA-J was walking towards the dining room for breakfast and was approached by the housekeeper about R62 being on the floor. CNA-J informed the nurse and another CNA and assisted with helping R62. On the Incident Statement Form, RNUM-C documented RNUM-C was called R62's room due to R62 being on the floor. R62 was lying face down with the face resting on the bottom of the bedside table. R62 had an abrasion to the right forehead, nose, and right knee. The bedside table was removed while the CNA held R62's head. The CNA brought in the mechanical lift and they gently rolled R62 onto the back and transferred R62 to bed. RNUM-C got an order to send R62 to the ER due to R62 hitting their head and being on Xarelto. In an interview on 2/5/2026 at 9:46 AM, Surveyor asked CNA-J if CNA-J could recall the events on 1/26/2026 with R62's fall. CNA-J stated CNA-J was taking care of R62 that morning and had gone into R62's room before 7:30 AM to ask R62 if R62 wanted to eat breakfast. R62 said no and CNA-J told R62 CNA-J was going to bring R62 breakfast anyway and did not have to eat it, but it was CNA-J's job to give R62 breakfast. CNA-J stated R62 was just waking up, the bed was in a low position, and R62 was in the middle of the bed. CNA-J stated the overbed table was next to the bed because when the bed is all the way down, the table won't go under the bed. CNA-J stated residents like the table next to them because then they can reach what they need, like their phone or tablet. CNA-J stated R62 looked flushed or red in the face, but CNA-J did not know if that was typical for R62. CNA-J stated CNA-J was with another CNA assisting with another resident when the housekeeper yelled out that someone was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on the floor. CNA-J yelled for the nurse and at the same time another CNA was pushing a resident to the dining room, so they all went into R62's room. CNA-J stated RNUM-T was the nursing supervisor and was doing rounds and heard CNA-J call for help. CNA-J stated the fall had to have happened between 7:30 and 8:00 AM because it was around breakfast time. CNA-J stated R62 was lying face down with the face on the floor. CNA-J stated it was awkward the way R62 was lying on the floor and had no idea how R62 got into that position. CNA-J stated R62 was on top of the bottom bracket of the overbed table with the body draped over the metal legs, the forehead on the floor, and the cheek on the metal leg/bracket. CNA-J stated CNA-J did not want to move R62. CNA-J asked R62 if they had any pain and R62 said they had pain on the head. CNA-J stated RNUM-C was the nurse working on the floor that day because the nurse that was scheduled to work called in. CNA-J stated RNUM-C came to R62's room and told them they had to remove the table from under R62. CNA-J stated CNA-J and another CNA helped get the table away from R62 by CNA-J picking up R62's head and the other CNA picking up R62's torso. CNA-J stated CNA-J went and got the mechanical lift and they gently rolled R62 back and forth to get R62 onto the lift sling and then put R62 in bed. Surveyor asked CNA-J if RNUM-C did any assessment of R62. CNA-J stated RNUM-C talked to R62 when R62 was on the floor, but RNUM-C could not do vital signs on the floor because R62 was face down. CNA-J stated RNUM-C did vital signs after R62 was in bed. Surveyor asked CNA-J if R62 could move their arms or legs. CNA-J stated R62 was unable to move anything; R62 was limp. CNA-J stated this was after they moved R62 to bed. CNA-J was not sure if R62 could not move or if R62 did not want to move because R62 kept moaning. Surveyor asked CNA-J if R62 was able to talk. CNA-J stated R62 kept moaning and may have mumbled when the nurse asked questions. CNA-J stated R62 did say R62 had pain in their head before R62 was moved but was not sure if R62 said any words after that, just moaning. CNA-J stated RNUM-T said R62 hit their head on metal and needed to go to the hospital. CNA-J stated R62 had a red mark on the forehead, like a scrape, and a couple of skin tears on the arm. CNA-J stated there was not a lot of blood, but the mark on the forehead looked like it was ready to bruise up because it was getting purple. Surveyor asked CNA-J what are staff told to do when a resident has a fall. CNA-J stated they tell you to yell for help and call 911. Surveyor asked CNA-J if CNA-J would have called 911 when R62 was still on the floor. CNA-J stated yes, CNA-J would have called 911 because you don't know the extent of the internal injuries because R62 fell on a metal table. CNA-J stated RNUM-T said right from the beginning that R62 needed to be sent out, but their main priority was to get R62 off the floor and into bed. In an interview on 2/5/2026 at 1:03 PM, Surveyor asked RNUM-C if RNUM-C could recall the events on 1/26/2026 with R62's fall. RNUM-C stated RNUM-C was passing medications when the CNA came and said R62 was on the floor. R62 was on their stomach with their head resting on the leg of the overbed table. RNUM-C stated R62's head was towards the head of the bed, R62's body was on the floor and R62's face was on the metal bottom leg of the table. RNUM-C stated there was an abrasion to the right forehead, nose, and knee with no bleeding. RNUM-C stated it was a group effort trying to move the table and rolling R62 over; it took two CNAs and RNUM-C and RNUM-T to move R62. RNUM-C stated one CNA was at the bottom of R62 and one CNA was at the top; they tucked R62's arm under the side and gently rolled R62 over. RNUM-C stated the CNA that was at the top held R62's head so it did not hit the ground. RNUM-C stated RNUM-C did a head-to-toe assessment after R62 was rolled over and R62 was alert and talking. RNUM-C stated R62 did not yell out in pain at any time they were moving R62. RNUM-C stated RNUM-T said R62 complained their stomach hurt 3 out of 10 when RNUM-C went to call the ambulance. RNUM-C stated they got R62 onto the mechanical lift and when they were putting R62 into bed, RNUM-C went to call the ambulance. Surveyor asked RNUM-C if RNUM-C got R62's vital signs when R62 was still on the floor or after (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents received adequate supervision and assessments after falls to determine the cause of the fall to implement an intervention to prevent future falls for 5 (R58, R62, R38, R5, R41, and R46) of 9 residents reviewed for falls. *R58 had an unwitnessed fall on 8/10/2025 in the bathroom self-transferring off the toilet. The Falls Care Plan was revised to include R58 being educated to call for assistance to ambulate to the bathroom and a Call No Fall sign was placed in R58's room two days later. R58 had an unwitnessed fall out of bed on 12/27/25 and fractured the distal end of the right fibula requiring surgical repair. The fall was not thoroughly assessed, and no revisions were made to R58's falls care plan to prevent future falls. There was no documented evaluation of R58's bladder incontinence, urgency, frequency, or toileting patterns as a potential contributing factor to either fall. *R62 had a witnessed fall on 1/17/2026 during a transfer. R62's transfer status had not been updated on 1/14/2026 in the Activities of Daily Living Care Plan to address what type of assistance was needed. R62 was a sit to stand mechanical lift transfer and was transferred with a pivot transfer with the assistance of one sustaining a fall. *R38 had an unwitnessed fall on 12/8/2025 and the fall was not thoroughly assessed to determine the root cause of the fall. R38's Falls Care Plan was not revised for eight days. *R5 had unwitnessed falls in the facility on 11/19/2025, 11/30/2025, 12/4/2025, 12/16/2025, 12/26/2025 and 12/28/2025 that were not thoroughly assessed. This would include possible etiology, risk factors and preventative measures, to prevent further falls. *R41 had a witnessed fall on 1/1/2026 and an unwitnessed fall on 1/18/2026. The falls were not thoroughly assessed, interventions were not updated after the fall and the interventions did not address the root cause of the fall. Observations were made of inconsistencies with the use of a fall mat and gripper socks. *R46 had a witnessed fall on 12/25/2025 and an unwitnessed fall on 1/4/2026. The falls were not thoroughly assessed, and immediate interventions were not put in place to prevent future falls. Findings include: The facility policy and procedure titled Falls dated 9/2025 documents: Policy Statement/Overview – The purposes [sic] of this procedure is to provide guidelines for evaluation of a resident in the event a fall occurred and to assist associates in identification of potential causes of the fall. Policy Detail – 1. The [NAME] Fall Risk Assessment form (or similar fall risk evaluation) should be utilized to complete the evaluation of the residents' potential for falls during the admission process. The [NAME] Fall Risk Assessment form (or similar fall risk evaluation) should be completed quarterly, with significant change MDS Assessment and after every fall. 2. If a resident sustains a fall, or is found on the floor without a witness to the event, associates shall evaluate for possible injuries and provide first aid or treatment as indicated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Direct care associates shall evaluate the area where the fall occurred for possible contributors. A Licensed Nurse shall notify the resident's Attending Physician and implement any new orders and notify the Resident Representative of the event. The Licensed Nurse shall document the fall in the resident's clinical record. The documentation of the identified interventions should be maintained in the resident clinical record and available to the direct care associates. A Licensed Nurse shall observe clinical status for 72 hours after an observed or suspected fall, and document finding in the resident clinical record. An incident report shall be completed for resident falls by a Licensed Nurse after the fall occurs. 1.) R58 was admitted to the facility on [DATE] after hospitalization for fractures to the upper and lower end of the right fibula after a fall at home. R58 had diagnoses of diabetes, chronic obstructive pulmonary disease, and osteoarthritis. R58's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R58 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14. R58 was occasionally incontinent of bladder and did not have a toileting program (scheduled toileting, prompted voiding, or bladder training). R58 needed partial/moderate assistance with toileting hygiene, bed mobility, and transfers. There was no documentation that R58's occasional bladder incontinence was assessed as a fall risk factor or incorporated into the Falls Care Plan. R58's Falls Care Plan was initiated on 4/24/2025 with the following interventions: -Keep pathways clear and provide adequate lighting. -Keep bed at the appropriate height. -Keep personal items within reach. -Transfer per intake information until seen by therapy, then follow therapy recommendations/plan of treatment. -Orient to room and call light. Surveyor noted there was no clarification as to what the appropriate height for the bed should be. On 8/10/2025 at 4:40 PM in the progress notes, nursing documented R58 was found in the bathroom with the left knee on the floor, the right leg in a crouch holding on to the arms of the wheelchair, trying to pull themselves up into the wheelchair. R58 was assisted to a lying position, and a mechanical full body lift was used to put R58 back into the wheelchair. R58 stated R58 was trying to get off the toilet and into the wheelchair when R58 lost balance and fell into the wall hitting the right shoulder and landed on the left side of the face. R58 stated R58 then tried getting up independently, then pulled the call light. R58 had an injury at the time of the fall: bright red bruising and swelling to the left side of the face with scant blood smear. The nurse was unable to locate where the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	blood came from on the left cheek. The nurse believed R58's glasses cut R58 due to the glasses being askew on R58's face. The Nurse Practitioner was made aware of the fall at 7:04 AM. R58 initially refused to go to the hospital for evaluation, but after conversation with R58's son at 7:40 AM, R58 agreed to transfer to the hospital for evaluation and treatment. At 7:23 PM in the progress notes, R58 returned to the facility with no new orders. There was no documentation evaluating whether urgency, frequency, or incontinence contributed to R58 attempting to self-transfer from the toilet. R58's Falls Care Plan was revised on 8/10/2025 with the intervention R58 was reeducated to call for assistance to ambulate to the bathroom. R58 did not have a care plan that addressed toileting needs, such as a scheduled toileting program, prompted voiding, or bladder training. Despite documentation of bladder incontinence and the location of the first fall being the bathroom during toileting, no bladder-related interventions were initiated. On 8/12/2025 at 10:12 AM in the progress notes, nursing documented staff continued to encourage R58 to call for assistance to the bathroom and a Call No Fall sign was placed in the room as a visual reminder. R58 assisted with the placement of the sign, R58 read the sign, and R58 stated R58 understood. R58's Falls Care Plan was revised on 8/12/2025 with the intervention of the Call No Fall sign placed in room. Surveyor noted no toileting program was initiated or incontinence addressed. No Interdisciplinary Team (IDT) note was documented on the root cause of the fall. There was no evidence the IDT analyzed whether bladder incontinence increased R58's urgency to toilet independently, contributing to the fall. On 12/28/2025 at 12:10 AM in the progress notes, nursing documented R58 was observed at 4:30 PM (on 12/27/2025) on the left side in R58's room on the floor. R58 stated R58 had rolled out of bed and did not know what happened. A head-to-toe assessment was completed and R58's right leg was broken and actively bleeding. 911 was called and R58 was transported to the hospital for evaluation. R58 was admitted to the hospital. The Fall Scene Investigation Form was completed by nursing staff. The unwitnessed fall occurred on 12/27/2025 at 4:30 PM in R58's room. R58 stated R58 rolled out of bed and did not know what happened. The form documented handwritten notations of positioned towards center of bed during rounds, body pillow/sheets, soft touch (call light), BIMS 14 on 12/1/2025, and wider bed. Surveyor was unable to determine if the handwritten notations were what was present at the time of the fall or what interventions would be appropriate. Footwear at the time of the fall was gripper socks. The intervention implemented at that time was to put bed in the lowest position and call light within reach. Surveyor noted R58's bed was not in the lowest position at the time of the fall. The Certified Nursing Assistant (CNA) statement on the Post Fall Report documented R58 was given fluids at 2:45 PM and was visually observed at 4:15 PM. The CNA documented R58's toileting schedule as as needed. The CNA documented R58 was incontinent of bladder at the time of the fall, the room light was on, the bed was locked, and R58 was barefoot. Surveyor noted the information about what R58 had on their feet was contradictory. The IDT Follow Up/Review/Summary page of the packet had Root Cause Analysis/Review section that was blank and the form was not signed. Despite documentation that R58 was incontinent of bladder at the time of the fall, there was no documented evaluation of whether incontinence, urgency, or (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	attempts to toilet independently contributed to R58 rolling out of bed. On 1/5/2026 at 9:49 PM in the progress notes, nursing documented R58 was admitted to the facility at 3:40 PM for skilled nursing care/rehab for a closed fracture of the distal end of the right fibula. No revisions to R58's Falls Care Plan were made. No toileting program was evaluated or implemented. There was no documented reassessment of bladder incontinence as a fall risk factor following the fracture and hospitalization. On 1/13/2026 at 3:32 PM in the progress notes, Director of Nursing (DON)-B documented R58 had a fall on 12/27/2025 at 4:30 PM. R58 had stated R58 rolled out of bed and did not know what happened. R58 sustained a leg fracture and was sent to the emergency room for further evaluation. Surveyor noted DON-B's progress note did not identify a root cause of the fall or document any interventions to prevent future falls. The progress note did not address R58's documented bladder incontinence or evaluate whether toileting needs required structured intervention. On 1/22/2026 at 8:52 AM, Surveyor observed R58 lying in bed with a meal tray on the overbed table, eating breakfast. Surveyor noted the height of the bed to be at mid-thigh height, or about 2-1/2 feet from the floor, not in the lowest position. Surveyor asked R58 if R58 had any falls. R58 stated R58 fell and broke the leg but did not know how they fell or why. R58 was not sure what the facility was doing to prevent future falls. On 1/26/2026 at 10:19 AM, Surveyor asked Licensed Practical Nurse (LPN)-G what the facility protocol was when a resident has a fall. LPN-G stated there is a fall packet at the desk that tells you everything that you need to do. LPN-G stated the nurse gets vital signs, assesses the resident from head to toe for injuries, and if the resident hit their head, they would be sent out right away to the hospital for evaluation, especially if they are on blood thinners. LPN-G stated the unit manager is called and the resident is kept on the floor until the ambulance comes. LPN-G stated if the resident is not hurt, they will use a full body mechanical lift to get the resident off the floor and do neurological checks as written on the flow sheet. LPN-G stated everyone working makes a statement and it does not matter if they saw the fall or not. LPN-G stated the Director of Nursing (DON) and Nursing Home Administrator (NHA) along with management have a meeting every morning to go over the stuff that is on the checklist. Surveyor asked LPN-G if the floor nurse would update the care plan after a fall with an intervention to address the cause of the fall. LPN-G was not sure if an LPN could update a care plan stating LPN-G had never done that. LPN-G thought the unit managers would update any care plans. On 1/27/2026 at 1:36 PM, Surveyor observed R58 sitting in the wheelchair in R58's room visiting with a guest. The bed was at hip height and a Call Don't Fall sign was on the wall across from the bed. Surveyor asked CNA-D if R58 had any interventions to prevent falls. CNA-D stated the only fall prevention for R58 was just had to keep the bed lower to the floor. CNA-D did not identify any toileting-related interventions or bladder management strategies in place for R58. On 1/27/2026 at 2:39 PM, Surveyor asked Registered Nurse Unit Manager (RNUM)-C what the facility protocol was for following up after a resident has a fall. RNUM-C stated the nurse on the floor does an assessment and tries to figure out why the fall happened and immediately implement an intervention to address the cause. RNUM-C stated all falls are discussed in the morning huddle where the IDT (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	reviews what the floor nurse implemented to see if it is an appropriate intervention, look at past interventions, and review the care plan and see if they can come up with something better to address the fall. RNUM-C stated the IDT consists of the DON, the Nursing Home Administrator (NHA), the unit managers, physical therapy, activities sometimes, and the MDS nurse. RNUM-C stated therapy is really good at coming up with interventions. RNUM-C stated about a week ago the IDT discussed they needed to meet to do a root cause analysis because that had not been done; the facility did not have any unit managers for a while. On 1/27/2026 at 3:51 PM, Surveyor shared with NHA-A and RNUM-C the concern R58 had a fall on 8/10/2025 that did not address R58's bladder incontinence and toileting as part of the root cause of the fall. R58 had a second fall on 12/27/2025 where R58 was incontinent of bladder and rolled out of the bed that resulted in a fractured leg and hospitalization. No root cause analysis was done to determine how the fall occurred and there was no revision to R58's Falls Care Plan to prevent future falls. The facility was unable to provide documentation that bladder incontinence, toileting frequency, urgency, or need for scheduled toileting were assessed or incorporated into fall prevention interventions after either fall. No additional information was provided. 2.) R62 was admitted to the facility on [DATE] with diagnoses of diabetes, orthostatic hypotension, cirrhosis with ascites, compression fracture of L1, osteopenia, and atrial flutter. R62's admission Minimum Data Set (MDS) assessment dated [DATE] documents R62 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 and needed extensive assistance with activities of daily living (ADLs). R62 had an order for Xarelto 15 mg, a blood thinner, every evening on admission. R62's ADL Care Plan initiated on 1/13/2026 had the intervention: TRANSFER: I need <no/supervision/limited/extensive/total> assistance with <no/set up/1 person/2 person> staff support. I use <no/sit to stand lift/pivot/transfer pole/slide board> assistive device. Surveyor noted all types of transfers were listed with no individualization for R62. On 1/14/2026 at 10:07 AM in the progress notes, nursing documented R62 was able to make needs known and was pending evaluation by therapy. R62's Therapy Recommendations form dated 1/14/2026, therapy documented that R62 required maximum assistance of two to transfer with the use of a non-motorized stand aid (Sara Steady) and use of a gait belt to and from the bed and wheelchair, and to and from the toilet. R62's ADL Care Plan was not revised with the transfer recommendation. On 1/17/2026 at 10:47 AM in the progress notes, Licensed Practical Nurse (LPN)-EE documented LPN-EE was called into R62's room by a Certified Nursing Assistant (CNA) because R62 had been lowered to the floor when R62 became weak during a transfer. R62 had a skin tear to the right elbow and a red area on the left side of the face under the eye/cheek bone area. R62 was able to move all extremities and had generalized weakness. First aid was applied to the right elbow and left cheek. A call was placed to the Nurse Practitioner and was told to monitor R62 and follow the facility fall protocol. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Fall Scene Investigation Form documented R62 was in their room trying to get into the wheelchair with assistance from a CNA and got weak. R62 was lowered to the floor sustaining a skin tear to the right elbow and a red cheek bone to the left side of the face. CNA-R provided a statement of the incident. The statement documented CNA-R was starting to transfer R62 when R62 got weak. CNA-R assisted R62 to the floor. The wheelchair was locked and R62 had bare feet. CNA-R documented R62 was assisted to the floor to keep R62 from falling. On 1/19/2026, R62's ADL Care Plan was revised with the intervention: TRANSFER: I need extensive assistance with 2 person staff support. I use sit to stand lift assistive device. In a phone interview on 2/5/2026 at 8:49 AM, Surveyor asked CNA-R what CNA-R could recall of R62's fall on 1/17/2026. CNA-R stated the CNA worksheet at the nurses' station listed how all the residents transfer and CNA-R saw that it said R62 transferred with the assistance of one person. CNA-R stated R62 was standing up and R62's legs got weak so they both were about to go down to the ground, so CNA-R slid R62 down and R62's head scrubbed the floor a bit. CNA-R stated CNA-R tried to assist R62 to the floor. CNA-R stated the CNA worksheet said R62 was an assist of one and the nurse told CNA-R that, too. CNA-R stated CNA-R heard the nurse tell another CNA at the change of shift what happened and that CNA said R62 uses a Sara Steady. CNA-R stated the nurse said it was not CNA-R's fault that R62 fell because the CNA worksheet had three different ways R62 was to transfer. CNA-R stated CNA-R recalled the CNA worksheet said two different ways to transfer R62, a one assist and a two assist. CNA-R stated CNA-R did not go back to the CNA worksheet after R62 fell to see what the transfer was supposed to be. In an interview on 2/5/2026 at 9:36 AM, Surveyor asked Director of Rehab (DOR)-DD how a new resident is assessed for transfers and how does that recommendation get put in the ADL Care Plan. DOR-DD stated if the resident comes in and nursing needs to transfer them, they go off of the hospital paperwork. DOR-DD stated once physical therapy (PT) and occupational therapy (OT) goes in and assesses them, this goes on their evaluations and a paper form gets filled in to be given to nursing. DOR-DD stated the transfer box would be checked on the form and then it would explain the transfer level and equipment recommendations. DOR-DD stated the form is put on the nurses' desk with a copy to DOR-DD and the Director of Nursing (DON). DOR-DD stated if a resident had a change in status, then the form would be filled out again and redistributed. DOR-DD stated therapy does not do anything with the care plan, nursing would update the care plan based off the recommendation sheet. Surveyor confirmed with DOR-DD R62's therapy evaluation documented R62 was dependent and DOR-DD provided a copy of the therapy recommendation dated 1/14/2026 documenting R62 should be transferred with a Sara Steady and gait belt. On 2/5/2026 at 10:08 AM, Clinical Coordinator (CC)-V, who was working in the status of CNA, stated there is a care plan printed out for all residents on the unit on the clipboard at the nurses' station. CC-V showed Surveyor the CNA worksheet on the clipboard. CC-V stated the CNA worksheet comes from the computer care plan for each resident. CC-V was not sure who updates or prints out the CNA worksheet. Surveyor observed all residents on the unit were on the CNA worksheet and had individual ADL assistance needed for each care area. In a phone interview on 2/5/2026 at 11:30 AM, Surveyor asked LPN-EE what LPN-EE could recall of R62's fall on 1/17/2026. LPN-EE stated the CNA told LPN-EE that the CNA lowered R62 to the ground during a transfer; the CNA told LPN-EE that R62 got weak so lowered R62 down. LPN-EE stated the CNA worksheet had quite a few different transfers for R62 listed. LPN-EE stated the CNA worksheet was the first thing LPN-EE looked at after the fall. LPN-EE stated when a new resident is admitted , the care (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	plan has all transfer options written and the nurse that initiates the care plan should select the appropriate transfer for that resident. Surveyor read to LPN-EE R62's ADL Care Plan transfer interventions that were in place on 1/13/2026 with all transfer options listed. LPN-EE stated yes, that is what the CNA worksheet said. LNP-EE stated the CNA worksheets are printed out from the computer on third shift, but any shift can print them; it pulls information directly from the resident's care plan so what is in the care plan is what is printed. LPN-EE stated R62's care plan and CNA worksheet did not specify what type of transfer R62 was. LPN-EE stated if LPN-EE looked up the care plan in the computer, it would show the same information. LPN-EE stated therapy was not in the building at the time of the fall or LPN-EE would have called them to clarify what type of transfer R62 was. LPN-EE stated therapy has a worksheet that says what kind of transfer each resident should be, but LPN-EE did not see one for R62 on the unit. On 2/9/2026 at 1:43 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and interim DON-GG the concern R62's ADL Care Plan did not have an individualized intervention for transfer status causing staff confusion on 1/17/2026, resulting in R62 having a fall. Surveyor shared R62 had a therapy evaluation completed on 1/14/2026 and a transfer status form was filled out showing R62 should be transferred with a non-motorized sit to stand lift which was not added into R62's ADL Care Plan until 1/19/2026, two days after the fall. NHA-A did not have any further information at that time. 3.) R38 was admitted to the facility on [DATE] with diagnoses of disc degeneration, spondylosis (degeneration of the spine), non-Hodgkin's lymphoma (a cancer of the lymphatic system), and Alzheimer's disease. R38's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R38 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and was receiving hospice services. R38's Falls Care Plan was initiated on 9/4/2025 with the following interventions: -Keep pathways clear and provide adequate lighting. -Keep bed at the appropriate height. -Keep personal items within reach. -Transfer per intake information until seen by therapy, then follow therapy recommendations/plan of treatment. -Orient to room and call light. Surveyor noted there was no clarification as to what the appropriate height for the bed should be. On 12/8/2025 at 3:08 PM in the progress notes, nursing documented R38 was found lying on the floor in R38's room at 10:35 AM. R38 stated R38 was trying to get to R38's son. Hospice and the Nurse Practitioner were notified of the fall. An assessment was completed and R38 complained of pain to the back rating the pain 10 out of 10. Tramadol was administered to help with the pain. No injuries were observed. R38 was able to state name and location. R38 was pleasant, cooperative, and anxious with no change from baseline. R38 could move all extremities with pain, which was baseline for R38. R38 was transferred back to bed using a full body mechanical lift. Safety measures in place at the time of fall included a low bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Fall Scene Investigation Form was completed by nursing staff. The unwitnessed fall occurred on 12/8/2025 at 10:35 AM in R38's room. R38 stated R38 was trying to find R38's son. The form documented hand drawn picture of the fall scene. R38 was next to the bed on the floor. Factors related to the fall were impaired mentation and rolled out of bed. Footwear at the time of the fall was not documented. R38's affect prior to the fall, changes to medications in the past 7 days, and environmental factors observed were not documented. The nurse documented the root cause of the fall to be R38's confusion at times. The interventions implemented was blank. The Certified Nursing Assistant (CNA) statement on the Post Fall Report documented R38 was given food and fluids at 7:30 AM and checked and changed and repositioned at 8:15 AM. The CNA documented R38 was incontinent of bowel and bladder at the time of the fall, the call light was on, the bed was locked, and the bed was low with mats. Surveyor noted the information about the fall mat being present was not indicated on the nursing report of the fall. No IDT Follow Up/Review/Summary page of the packet, including the root cause analysis of the fall, was provided. R38's Falls Care Plan was revised on 12/16/2025, eight days after the fall, with the intervention of a fall mat. On 1/20/2026 at 10:09 AM, Surveyor observed R38 in bed with a tablet in their lap. The bed was at hip height, approximately three feet from the floor. R38 did not have any recollection of having a fall at any time. No fall mat was observed on the floor at that time. In an interview on 1/26/2026 at 10:19 AM, Surveyor asked Licensed Practical Nurse (LPN)-G what the facility protocol was when a resident has a fall. LPN-G stated there is a fall packet at the desk that tells you everything that you need to do. LPN-G stated the nurse gets vital signs, assesses the resident from head to toe for injuries, and if the resident hit their head, they would be sent out right away to the hospital for evaluation, especially if they are on blood thinners. LPN-G stated the unit manager is called and the resident is kept on the floor until the ambulance comes. LPN-G stated if the resident is not hurt, they will use a full body mechanical lift to get the resident off the floor and do neurological checks as written on the flow sheet. LPN-G stated everyone working makes a statement and it does not matter if they saw the fall or not. LPN-G stated the Director of Nursing (DON) and Nursing Home Administrator (NHA) along with management have a meeting every morning to go over the stuff that is on the checklist. Surveyor asked LPN-G if the floor nurse would update the care plan after a fall with an intervention to address the cause of the fall. LPN-G was not sure if an LPN could update a care plan stating LPN-G had never done that. LPN-G thought the unit managers would update any care plans. On 1/26/2026 at 1:54 PM, Surveyor shared with Director of Nursing (DON)-B the concern R38 did not have any root cause analysis with the fall on 12/8/2025 and R38's Falls Care Plan was not revised for eight days after the fall with a fall mat. Surveyor shared with DON-B the conflicting information of R38 having a fall mat at the time of the fall per the CNA but not by the nurse. DON-B did not have any additional information to add at that time. In an interview on 1/27/2026 at 2:39 PM, Surveyor asked Registered Nurse Unit Manager (RNUM)-C what the facility protocol was for following up after a resident has a fall. RNUM-C stated the nurse on the floor does an assessment and tries to figure out why the fall happened and immediately implement an intervention to address the cause. RNUM-C stated all falls are discussed in the morning huddle where the IDT reviews what the floor nurse implemented to see if it is an appropriate intervention, look at past interventions, and review the care plan and see if they can come up with something better to address the fall. RNUM-C stated the IDT consists of the DON, the Nursing Home Administrator (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(NHA), the unit managers, physical therapy, activities sometimes, and the MDS nurse. RNUM-C stated therapy is really good at coming up with interventions. RNUM-C stated about a week ago the IDT discussed they needed to meet to do a root cause analysis because that had not been done; the facility did not have any unit managers for a while. On 1/27/2026 at 3:51 PM, Surveyor shared with NHA-A and RNUM-C the concern R38 had a fall on 12/8/2025 where R38 rolled out of the bed. No root cause analysis was done to determine how the fall occurred and there was no revision to R38's Falls Care Plan for eight days. 4.) R5 was admitted to the facility on [DATE] with a diagnosis of stroke with left sided weakness. R5's admission Minimum Data Set (MDS) assessment completed on 11/24/25, documents that R5 has limited mobility on one side of their upper and lower extremities. The MDS documents that R5 is dependent on staff for dressing and hygiene and that R5 has cognitive impairment and had no prior falls before admission to the facility. On 01/20/2026, at 10:05 AM, Surveyor observed R5 in their wheelchair in their room. On 01/21/2026, at 10:24 AM, Surveyor observed R5 in their wheelchair in Therapy Room. R5 Plan of Care (POC) for Falls initiated on 11/8/25, with a goal date of 2/11/26, documents R5 wants to minimize risk of injury related to falls over the next review period. The Interventions dated 11/8/25 are:-Keep pathways clear and provide adequate lighting.- keep bed at the appropriate height.- keep personal items within reach.- orientate to room and car light.- transfer per intake information until seen by therapy then follow therapy recommendations plan of treatment.On 124/25 R5 had an unwitnessed fall with a intervention to send to the hospital. This was resolved 1/12/26.On 12/26/25 R5 had an unwitnessed fall with an intervention to send to the hospital. This was resolved on 1/12/26. R5's Resident Care Guide, dated 11/8/25, does not document any fall interventions. The Safety Section document area is empty. R5 requires 1 person staff for transfers and activity of daily living. R5 is incontinent of bowel and bladder and uses incontinence briefs. R5's POC (plan of care) does not include any preventative measures related to falls in the facility. R5's medical record documentation included the following falls: On 11/19/25, at 3:53 AM, R5 had an unwitnessed fall from their bed. R5 was discovered face down next to their bed. R5 had a stroke and is unable to communicate clearly. R5 was sent out to the hospital and returned with no injuries. The fall root cause is They wanted something to eat. Surveyor noted that there is no documentation to support this root cause. There is no documentation of an intervention to prevent re-occurrence. There is not a intervention reviewed, or implemented, to prevent re-occurrence based on a possible root cause. On 11/30/

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review, the facility did not ensure staff postings were displayed daily or were accurate to the actual staffing of the facility. Review of staffing schedules and required staff postings from 12/1/2025 -1/20/2026 revealed 7 of 51 daily staff postings were unable to be located. In addition, 2 of 44 days of postings available for review had discrepancies between staffing schedules and staff postings. This resulted in inaccuracies with the total number of licensed staff directly responsible for resident care on night (NOC) shift.This deficient practice has potential to affect 53 out of 53 residents.Findings include:Surveyor reviewed the schedules and staff postings from 12/1/2025 through 1/20/2026. Surveyor noted the daily staff postings were missing for the following dates: 12/19/25, 12/20/25, 12/21/25, 12/26/25, 1/10/26, 1/11/26, 1/14/26. Surveyor compared the actual staffing schedules with the staff postings and noted the following inaccuracies: -1/2/2026: NOC shift staff posting: 4 certified nursing assistants (CNAs); staff schedule: 3 CNAs. -1/18/2026: NOC shift staff posting: 4 CNAs; staff schedule: 3 CNAs. On 1/27/2026, at 10:26 AM, Surveyor interviewed Clinical Coordinator-V who stated Clinical Coordinator-V is responsible for updating the staff postings to reflect actual staff worked on NOC shift the night prior. Clinical Coordinator-V stated the staff postings on 1/2/26 and 1/18/26 should have been updated to reflect only 3 CNAs working on NOC shift. Clinical Coordinator-V was unable to locate the staff postings for 12/19/25, 12/20/25, 12/21/25, 12/26/25, 1/10/26, 1/11/26, 1/14/26 and stated these should have been available. On 1/27/2026, at 1:39 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A of the missing staff postings for the above dates and the discrepancies between the staff postings and staff schedules on 1/2/26 and 1/18/26. No additional information was provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 6) R61 was admitted to the facility on [DATE] with diagnoses which include generalized anxiety disorder. R61 an activated Healthcare Power of Attorney (HCPOA). R61's admission Minimum Data Set (MDS), dated [DATE], indicates R61 has a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment, has anxiety, depression, receives antianxiety and antidepressant medication. Surveyor reviewed R61's Facility provided document, titled Medication Record for 09/2025. Surveyor noted R61 has an order for Hydroxyzine 10 milligrams (mgs) (Atrax, can be used to treat anxiety, tension) by mouth, 3 times per day (8AM, 12PM, 4PM) with a start date of 9/16/2025 and end date 9/25/2025. The following dates and times are noted where R61 received the scheduled medication outside of the scheduled time frames, including the 1 hour before or 1 hour after standard of practice: *9/16/2025- 8 AM dose, given at 10:10 AM & 4 PM dose given at 5:49 PM. *9/17/2025- 8 AM dose given at 10:40 AM. *9/18/2025- 8 AM dose given at 9:52 AM. *9/19/2025- 8 AM dose given at 10:27 AM & 4 PM dose given at 5:26 PM. *9/21/2025- 8 AM dose given at 12:40 PM. *9/22/2025- 8 AM dose given at 10:04 AM & 12 PM dose given at 1:22 PM & 4 PM dose given at 5:23 PM. *9/23/2025- 8 AM dose given at 9:43 AM. *9/24/2025- 8 AM dose given at 10:04 AM. Surveyor noted R61's Hydroxyzine was discontinued on 9/25/2025 and was not restarted until 9/27/2025. Surveyor reviewed R61's Facility provided document, titled SNF (Skilled Nursing Facility) Progress Note, dated 9/25/2025, written by Nurse Practitioner (NP)-U. R61's document indicates, Generalized anxiety disorder: Patient continues to report anxiety. Increased fluoxetine (Prozac) to 20 mg daily per previous plan and daughter's request. Hydroxyzine 10mg three times a day as needed for anxiety. Surveyor noted a progress note, dated 9/26/2025 by Licensed Practical Nurse (LPN)-E indicating LPN-E called NP-U to clarify R61's order for Hydroxyzine. APNP (Advanced Practice Nurse Practitioner)- gave verbal order to continue R61's Hydroxyzine. On 02/04/2026, at 12:52 PM, Surveyor interviewed LPN-E regarding the progress note regarding R61's Hydroxyzine order. LPN-E informed Surveyor, LPN-E clarified R61's medication order after R61's (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	family member informed LPN- of the medication R61 was supposed to be given. LPN-E looked at R61's record and saw R61 did not have order at that time. NP-U gave verbal order to restart R61's Hydroxyzine medication. Surveyor reviewed R61's Facility provided document, titled Medication Record for 09/2025. Surveyor noted R61 has an order for Hydroxyzine HCl 10 mg tablet 3 times per day (8AM, 2PM, 8PM), with a start date of 9/27/2025 and end date 10/7/2025. Surveyor noted the following: *On 9/29/2025- 8 AM dose was given at 9:49 AM & 2 PM dose was left blank, indicating not administered. * On 9/30/2025- 8 AM dose was given at 9:15 AM Surveyor reviewed R61's Facility provided document, titled Medication Record for 10/2025. Surveyor noted R61 has an order for Hydroxyzine HCl 10 mg tablet 3 times per day (8AM, 2PM, 8PM), with a start date of 9/27/2025 and end date 10/7/2025. Surveyor noted the following dates and times were not administered within the scheduled time frame: *10/1/2025- 8 AM dose given at 10 AM. *10/2/2025- 8 AM dose given at 9:45 AM. *10/3/2025- 8 AM dose given at 9:41AM. *10/4/2025- 8 AM dose given at 9:25 AM. *10/5/2025- 8 AM dose given at 9:29 AM. *10/6/2025- 8 AM dose given at 9:07 AM *10/7/2025- 8 AM dose given at 9:16 AM. *10/9/2025- 8 AM dose given at 9:47 AM. *10/10/2025- 8 AM dose given at 10:29 AM. *10/12/2025- 8 AM dose given at 9:10 AM. *10/13/2025- 8 PM dose given at 6:47 PM. *10/14/2025- 8 AM dose given at 9:07 AM. *10/15/2025- 8 AM dose given at 9:09 AM. *10/17/2025- 8 AM dose given at 9:52 AM. *10/18/2025- 8 AM dose given at 10:15 AM. *10/19/2025- 8 AM dose given at 9:45 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525495	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Living - Lakeshore at Siena	5643 Erie Street Racine, WI 53402

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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 - Some	*10/24/2025- 8 AM dose given at 9:53 AM. *10/25/2025- 8 PM dose given at 9:23 PM. *10/27/2025- 2 PM dose given at 12:32 PM. *10/30/2025- 8 AM dose given at 9:12 AM *10/31/2025- 8 PM dose given at 8:12 PM. R61 had a planned discharge from the Facility on 11/3/2025. On 02/04/2026, at 2:56 PM, the Facility was notified of the of the above concerns. On 02/05/2026, at 9:43 AM, Surveyor interviewed Registered Nurse (RN) Unit Manager (UM)-C. Surveyor asked RN UM-C who reviews the provider assessments after visits, RN UM-C indicated she does not know and does not think anyone reviews them. RN UM-C is unaware of who uploads them into the charts or what the process is but indicated it is a good idea to talk about in QAPI to get those reviewed. Surveyor asked RN UM-C what the expectation is for medication administration time scheduling. Surveyor was informed there is a 1 hour before and 1 hour after grace for the scheduled medication especially for medications like R61's Hydroxyzine because it is given 3 times per day and needs to be at the scheduled time to avoid adverse reactions. Based on observation, interview, and record review, the facility did not ensure medications were administered timely for 6 (R21, R3, R56, R49, R2, and R61) of 6 residents reviewed for medication administration. *R21, R3, R56, and R49 were administered morning medications over an hour after they were scheduled to be administered. *R2 did not have intravenous antibiotics signed out as administered timely or at all for 4 out of 17 doses. *R61 was administered R61's scheduled medications, outside the ordered scheduled timeframe. *R61 missed 2 days (9/25/2026 and 9/26/2026) of R61's Hydroxyzine due to a delay in review of orders. Findings include: The facility policy and procedure titled Administering Medications dated 12/2024 documents: . C. Medications shall be administered in accordance with the orders and within the allowable time frame per best practice/regulatory guidelines (60 minutes before the due time and 60 minutes after the due time). 1.) On 1/21/2026 at 10:55 AM, Surveyor observed Registered Nurse (RN)-Y prepare medications for R21. RN-Y administered atorvastatin 20 mg, Vitamin D3 2000u, sertraline 50 mg, Tylenol 1000 mg, propranolol 60 mg, potassium ER 20 mEq, and Eliquis 5 mg at 11:01 AM. The seven medications were scheduled to be administered at 8:00 AM. The medications were two hours past the window for medication (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration. RN-Y stated medications were being administered late because RN-Y had been pulled to other units to administer intravenous medications. RN-Y stated RN-Y still had to give R3 and R56 their 8:00 AM medications. R3 had 12 scheduled medications for 8:00 AM including insulin. R56 had 6 scheduled medications for 8:00 AM. On 1/21/2026 at 8:27 AM, Surveyor observed RN-K prepare medications for R49. RN-K administered tramadol 50 mg and omeprazole 40 mg. Both medications were scheduled to be administered at 7:00 AM. The medications were past the window for medication administration. On 1/21/2026 at 3:03 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Director of Clinical Operations (DCO)-F the concern medications were administered late for R21, R3, R56, and R49. Surveyor shared the observation of RN-Y passing 8:00 AM medications after 11:00 AM. DCO-F nodded their head in understanding. 2.) R2 had an order for cefepime 2 Gm intravenous (IV) every eight hours 1/17/2026-1/23/2026 for a catheter associated urinary tract infection. The administration times were 6:00 AM, 2:00 PM, and 10:00 PM. R2's Medication Administration Record (MAR) documented the three doses of IV cefepime were not administered on 1/17/2026 due to not arriving from the pharmacy. -On 1/19/2026, the 2:00 PM dose of IV cefepime was signed out as being administered at 8:30 AM, five and a half hours early. -On 1/20/2026 and 1/21/2026, the 10:00 PM doses of IV cefepime were not signed out. -On 1/22/2026, the 2:00 PM dose of IV cefepime was not signed out. R2 was transferred to the hospital on 1/22/2026 after 3:30 PM. In an interview on 1/26/2026 at 10:19 AM, Surveyor asked Licensed Practical Nurse (LPN)-G when passing medications, when are the medication signed out on the MAR. LPN-G stated the medications are signed out right after they are taken by the resident. Surveyor clarified that the medications are not administered and then signed out at the end of the shift. LPN-G stated no, they are signed out right away. On 1/26/2026 at 1:55 PM, Surveyor shared with Director of Nursing (DON)-B the concern R2's IV cefepime had been signed out early on 1/19/2026 for the 2:00 PM dose and not at all on 1/20/2026 and 1/21/2026 for the 10:00 PM doses. DON-B stated DON-B would look into the concern. On 1/26/2026 at 4:15 PM, DON-B stated LPNs were working the evening shift, so they had the night shift RN come in early to hang the IV medications. DON-B stated the night shift nurse thought she had signed out the medications but there was no signature. DON-B stated the nurse would be coming in that day to make a late entry and sign out the medications. On 1/27/2026 at 7:58 AM, Surveyor reviewed R2's MAR. The IV cefepime had not been signed out as DON-B had stated. On 1/27/2026 at 3:51 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, Director of (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing (DON)-B, and Director of Clinical Operations (DCO)-F the concern R2's IV cefepime had not been administered as ordered with no signatures for three doses and a dose was given over five hours early on 1/19/2026. DCO-F nodded their head in understanding.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility did not ensure the medication error rate was not 5 percent or greater. 2 (R49 and R21) of 3 residents observed during medication pass were affected. The medication error rate was 30 percent, 9 errors out of 30 opportunities. Findings include: The facility policy and procedure titled Administering Medications dated 12/2025 documents: . C. Medications shall be administered in accordance with the orders ad within the allowable time frame per best practice/regulatory guidelines (60 minutes before the due time and 60 minutes after the due time). On 1/21/2026 at 8:00 AM, Surveyor observed Registered Nurse (RN)-K prepare R49's medications. RN-K administered tramadol 50 mg (milligrams) and omeprazole 40 mg at 8:27 AM. The medications were scheduled to be given at 7:00 AM. The medications were administered after the allowable time frame. On 1/21/2026 at 10:55 AM, Surveyor observed RN-Y prepare R21's medications. RN-Y administered atorvastatin 20 mg, Vitamin D3 200u, sertraline 50 mg, Tylenol 1000 mg, propranolol 60 mg, potassium ER 20 mEq, and Eliquis 5 mg. The medications were scheduled to be given at 8:00 AM. The medications were administered after the allowable time frame. RN-Y broke the potassium ER 20 mEq tablet in half. The ER, extended release, tablet is not to be broken or crushed due to the coating on the tablet. RN-Y stated RN-Y was pulled to another unit to administer intravenous medications and was therefore behind schedule in administering the medications on the unit. On 1/21/2026 at 3:03 PM in the daily exit, Surveyor shared with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Director of Clinical Operations (DCO)-F the concern the medication error rate was 30 percent with 9 errors out of 30 opportunities. Surveyor shared the errors were due to late administration of medication and the breaking of the potassium ER medication. DCO-F nodded in agreement.