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 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents received care consistent with professional standards of practice (N6, Wisconsin Nurse Practice Act) to prevent development of pressure injuries or received care to promote healing and prevent new ulcers from developing for 6 (R6, R46, R66, R35, R1, R49) of 6 residents reviewed with pressure injuries or at risk for developing pressure injuries. *R6 admitted to the facility on [DATE] with a stage 3 pressure injury to the sacrum. A comprehensive assessment of the area was not completed until 9/3/2024. R6's sacral pressure injury resolved on 10/22/2024. R6' sacral wound reopened on 4/24/2025 and 6/9/2025. No root cause was identified to determine why R6's sacral wound reopened or care plan revisions. R6 developed a stage 2 pressure injury to the left ischium on 12/2/2025 with no root cause to determine how it developed. R6 developed a stage 2 pressure injury to the right ischium that declined to stage 3 with no root cause identified or care plan revisions. Nursing did not consistently document R6's treatment to the sacral area being completed per physician orders. Surveyor had observations of R6's heels not being offloaded per care plan and lying directly on the mattress. *R46 admitted to the facility on [DATE] with no skin concerns. On 12/11/2025, R46 developed a fluid filled blister to the right heel. R46 did not have a comprehensive assessment completed or care plan revisions until 12/16/2025. On 12/30/2025 R46's right heel blister declined to an unstageable pressure injury, and on 1/20/2026 declined to a stage 3 pressure injury to the right heel. Facility staff did not consistently document R46's treatments being completed as ordered on R46's treatment administration records. The facility did not identify a root cause as to how R46's right heel blister developed on 12/11/2025 or declined on 12/16/2025 and 1/20/2026. *R66 was admitted on [DATE] with a pressure injury to the left heel and the pressure injury care plan did not have preventative interventions identified. R66 developed a pressure injury to the right heel a week later on 1/14/2026 and the left heel pressure injury declined with an increase in size. It was at that time that heel boots and floating heels interventions were added to R66's care plan. *R35 admitted to the facility on [DATE] with no pressure injuries then developed a deep tissue injury (DTI) to the left heel on 2/14/25. No care plan revisions were implemented after the DTI developed. R35's left heel DTI healed on 9/22/25 but reopened on 10/21/25 and progressed to an avoidable, facility acquired stage 3 pressure injury. Wound physician orders were not followed to change R35's wound treatment on 1/13/26. *R1 developed a facility acquired, avoidable Deep Tissue Injury to the left buttock on 1/13/26. R1's medical record does not contain documentation of a comprehensive wound assessment upon discovery. This would include possible etiology, risk factors and preventative measures, to determine (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 0686 Level of Harm - Actual harm Residents Affected - Some	appropriate interventions for wound healing. On 1/20/26 the Deep Tissue Injury declined to a stage 3 pressure injury which resulted in actual harm to R1's skin integrity. *R49 developed a stage 3 pressure injury on 12/16/25 on their sacrum. The sacrum was noted to have Moisture Associated Skin Damage (MASD) on 12/14/25, along with a treatment for it. R49's medical record does not contain documentation of a comprehensive wound assessment upon discovery. This would include possible etiology, risk factors and preventative measures, to determine appropriate interventions for wound healing. On 12/16/25 R49 developed a stage 3 pressure injury to the sacrum which resulted in actual harm to their skin integrity. Findings include: According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. Per the wound care education institute Best Practices for Wound Assessment and Documentation states, in part: . Foundational elements of wound assessment. A structured approach to wound assessment is key to capturing the clinical picture and determining the best course of action for care. Here are the essential components to document: . 1. Precise anatomical location. 2. Wound classification and etiology. Determine and document the wound's origin. Common types include: Pressure injuries: Classify by stage using the National Pressure Injury Advisory Panel's (NPIAP) guidelines. Arterial or venous ulcers: Note underlying circulatory insufficiencies. Diabetic foot ulcers: These are often neuropathic, so assess the patient's offloading status. The patient should be assigned a [NAME] grade and updated as needed. Surgical incisions or traumatic wounds: Include the mechanism of injury or surgical intent.Documenting wound etiology ensures targeted interventions and appropriate resource use . 3. Accurate wound measurements. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	*Length. *Width. *Depth. 4. Wound bed characteristics Quantify the percentage and type of tissue present: Granulation: Red, moist, and bumpy — This is a sign of healthy tissue growth. Slough: Yellow/white, stringy, or moist. May be adherent or loosely attached. This is non-viable and may require debridement. Eschar: Thick, dry, black, or brown. Document if stable or if debridement is needed. Hyper granulation: Assess for signs of infection and/or necessary treatment changes, such as stopping a collagen application.Descriptive wound bed assessments help monitor healing phases and guide appropriate debridement strategies. 5. Wound edge and margin assessment Evaluate wound edges for signs of healing or chronicity: Defined vs. undefined: Defined edges are more acute, and undefined may suggest chronicity. Epibole (rolled edges): This is common in stalled wounds. Undermining or maceration: This may indicate moisture imbalance or shearing/friction forces.Marginal changes can be early indicators of delayed healing or infection. 6. Exudate characteristics Drainage quality provides vital clues about wound status: Amount: None, scant, light, moderate, or heavy. Type: Serous (clear), serosanguineous, sanguineous, seropurulent, or purulent. Color and consistency: Thick yellow/green with odor may indicate infection. Odor: Describe only after cleansing to eliminate confounding factors.Always correlate exudate changes with wound progression and signs of infection. 7. Peri wound skin statusDocument any abnormal findings in the tissue surrounding the wound: Color: Erythema may signal infection or inflammation. Texture: Watch for induration, bogginess, or dryness. Breakdown: Maceration, excoriation, or denuded skin may indicate excessive moisture or friction.Healthy peri wound skin supports optimal wound healing and should be protected as part of the overall care plan. 8. Pain and symptom reportingPain is a critical, yet often under-documented, aspect of wound assessment. Capture: Intensity: Use a numeric or verbal pain scale. Descriptors: Burning, aching, stabbing, etc. Timing: Before, during, or after dressing changes. Management: Note what interventions alleviate or exacerbate pain. The National Pressure Injury Advisory Panel (NPIAP) document titled, NPIAP Staging for Lightly Pigmented Skin dated 2/14/2020 defines a pressure injury as localized damage to the skin and underlying soft tissue usually over a bony prominence . the injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The document defines the following stages: Stage 2: partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also be present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar (hard, dead scab or crust of tissue) are not present. Stage 3: full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location . if slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.Unstageable Pressure Injury: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. The facility policy titled Pressure Injury Assessment/Treatment last revised 7/2024 with an approval date of 1/2026 documents: Purpose: The purpose of this procedure is to produce guideline for a consistent method of identification of and for the initial care of identified pressure injuries, alterations in skin integrity, and the prevention acquiring additional pressure injuries.General Guideline: A. The pressure injury treatment program should focus on the following strategies:1. Evaluating the residents and the current status of the pressure injury.2. Observe currently used support surfaces and/or pressure relieving devices; initiate as needed.3. Resolution of current pressure injuries and prevention of additional pressure injuries.6. Education and quality improvement.B. Skin risk and general skin assessment is to be completed upon admission and then weekly for 4 weeks. Basic skin assessment is to be completed on residents weekly and as needed.Interventions/ Care Strategies:Pressure injury treatment requires a comprehensive approach .A. Eliminate or reduce the source of pressure using positioning techniques .C. Preventative measures to reduce risk for further tissue loss.E. Interventions that increase the potential for healing.G. Managing systemic issues (Edema, venous insufficiency, etc.) .Documentation:The following information should d be recorded in the resident's medical record, treatment sheet, or designated wound form:A. The date and time the dressing was changed.B. Wound appearance, including wound bed, edges, presence of drainage.C. The name and title of the individual changing the dressing, or initials.D. The type of dressing used, and wound care given.E. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound.F. How the residents tolerated the procedure.G. Any problems or complaints (i.e., pain or discomfort) made by the residents related to the procedure.H. If the resident refused the treatment and the reason(s) why.I. The signature and title of the person recording data, or initials.Reporting:A. Notify the supervisor if the resident refuses the procedure or interventions.B. If the resident refused treatment, the reason for refusal and the resident's response to the explanation of the risks refusing the procedure, the benefits of accepting and available alternatives. Document family and physician notification of refusal.C. Report other information in accordance with community policy and professional standards of practice. 1) R6 was admitted to the facility on [DATE] with diagnoses that include metabolic encephalopathy, sever protein-calorie malnutrition, type 2 diabetes with polyneuropathy, anxiety, . and malignant neoplasms of the right and lower limbs. R6's quarterly minimum data set (MDS) dated [DATE] indicated R6 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 8 and the facility asses R6 as being totally dependent on 1 staff member for toileting, personal hygiene, and repositioning. R6 was admitted to the facility receiving hospice services and had a stage 3 pressure injury to the sacrum. R6 has an indwelling catheter in place and is always incontinent of bowel and wears a protective brief. The facility assessed R6 on 11/13/2025 to be a high risk for pressure injury development with a Braden score of 12. R6's most recent Pressure Ulcer/ Injury Care Area Assessment (CAA) dated 8/28/2025 documents: (R6) has malignant skin cancer with lesions to the back of the right leg and right thigh. (R6) has a stage 3 pressure injury to the sacrum. (R6) is incontinent of bowel and bladder (Surveyor noted resident has an indwelling catheter). (R6) . condition is determined to be terminal . and has limited rang of motion to all extremities, . dependent for bed mobility, . and is mostly bed bound. R6's history of stage 3 pressure injury to the sacrum . and at risk for further pressure injuries and skin concerns related to immobility, malnutrition, incontinence care plan was initiated on 8/13/2024 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	not completed on 4/24/2025 when R6's sacral area opened up. The facility did not do a root cause to determine why R6's sacral wound reopened and there were no care plan revisions made to R6's pressure injury care plan. On 1/27/2026, at 12:36 PM, surveyor interviewed WRN-I who stated R6's sacral wound most likely re-opened because the facility had gotten rid of the air mattresses for residents that were enrolled on Hospice and stated Hospice had to supply the air mattresses. WRN-I was not sure how long R6 was without an air mattress or if the facility waited to switch the mattresses. WRN-I stated the first time WRN-I saw R6's re-opened sacral wound; the sacral wound was already resolved on 4/28/2025. WRN-I could not remember if R6 was on an air mattress at that time. WRN-I stated if R6 was not on an air mattress at that time then WRN-I would have arranged to have one put on since that is always an intervention WRN-I makes sure is implemented right away. WRN-I stated the previous director of nursing (DON) in the facility took away resident's air mattresses unless the resident had a stage 3 or up pressure injury. WRN-I stated it was probably spring 2025 that the air mattress was taken away but could not recall exactly. WRN-I stated care plans were not updated at that time, so it is hard to tell who it had taken away at that time and if there was a decline because of it. On 4/28/2025 wound physician documented R6's sacral pressure injury resolved. On 6/9/2025 the following was documented on R6's skin evaluation form:- Sacrum, full thickness, stage 3 pressure injury (Re-opened)- 1.9 cm X 1.2 cm X 0.1 cm- wound bed moist, 60% slough, 40% granulation, light serosanguinous drainage.- Treatment: Cleanse with wound cleanser, Sureprep to periwound, Therahoney to wound bed, cover with bordered gauze dressing daily and as needed. Surveyor noted the facility did not identify a root cause to determine how R6's sacral pressure injury could have re-opened for a second time, nor revise care plan interventions to prevent R6's sacral pressure injury from worsening, promote healing or other pressure injuries to develop. On 1/27/2026, at 12:36 PM, Surveyor interviewed WRN-I who stated R6's air mattress was not working appropriately sometime in July and has documented in WRN-I's notes R6's air mattress was replaced on 7/29/2025. R6's stage 3 sacral pressure injury continued to be assessed by wound physicians and WRN-I. On 12/2/2025, Wound physician-S documented the following for R6's stage 3 sacral pressure injury:1. Stage 3 pressure wound, Sacrum, full thickness- 2.5 X 3.0 X 0.2, moderate serous drainage- 80% granulation tissue, 20% intact normal skin color. Surveyor noted R6 developed stage 2 pressure injuries to the left and right ischium with the following assessments documented by the wound physician. 2. Stage 2 pressure injury, Left ischium, partial thickness- 1 X 1 X 0.1, light serous drainage, open area with exposed dermis- Treatment: gauze island with border foam dressing, apply once daily and as needed if saturated, soiled, or dislodged. 3. Stage 2 pressure injury, right ischium, partial thickness- 1 X 1 X 0.1, light serous drainage, open area with exposed dermis- Treatment: gauze island with border foam dressing, apply once daily and as needed if saturated, soiled or dislodged. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Surveyor noted the facility did not identify a root cause to determine why R6 developed pressure injuries to the right and left ischium. R6's pressure injury care plan was not revised. On 1/27/2026, at 12:36 PM, Surveyor interviewed WRN-I who stated the facility lost power on 12/2/2025. WRN-I documented in WRN-I's notes going into R6's room and noted R6's air mattress was not functioning and was flat. WRN-I noted R6's air mattress was not plugged in. WRN-I plugged in R6's air mattress in and the air mattress started to function. WRN-I contributed R6's air mattress being deflated to R6 developing stage 2 pressure injuries to the right and left ischium. On 12/16/2025, wound physician-S documented the following for R6's pressure injury assessments:1. Sacrum, full thickness, Stage 4 pressure injury- 1.9 X 1.0 X 0.2, moderate serous drainage, 20% necrotic tissue, 20% slough, 60% Granulation tissue.- Wound is at goal- Treatment: collagen sheet, apply once daily and as needed, apply gauze with bordered dressing.- Wound debrided with no concerns Surveyor noted R6's sacrum pressure injury declined to a stage 4 pressure injury. Surveyor reviewed R6's treatment administration record and noted nursing did not document R6's sacrum wound treatment as completed on: 12/8/2025, 12/9/2025, and 12/19/2025. 2. Right ischium, full thickness, stage 3 pressure injury- 0.7 X 2.0 X 0.2, moderate serous drainage, 50% slough, 50% granulation tissue- Wound debrided with no concerns.- Treatment: apply collagen sheet daily and as needed, cover with bordered gauze dressing. Surveyor noted R6's right ischium pressure injury declined to a stage 3 3. Left ischium stage 2 pressure injury resolved. Surveyor noted the facility did not determine a root cause as to why R6's sacral pressure injury and right ischium pressure injury declined. On 1/27/2026, at 12:36 PM, Surveyor interviewed WRN-I who stated not knowing why wound physician-S staged R6's sacral wound to a stage 4. WRN-I reviewed wound physician-S's assessment and noted assessment documented does not reflect a stage 4, however WRN-I does not do an assessment with wound physician-S, WRN-I documents from wound physician-S's notes, WRN-I was not sure if there was information that WRN-I missed on why the sacral wound was now a stage 4. R6's stage 4 sacral pressure injury and right ischium pressure injury continue to get assessed weekly by wound physician-S and WRN-I without further decline.R6's right ischium stage 3 pressure injury resolved on 12/30/2025R6's Sacral, stage 4 pressure injury resolved on 1/20/2026. On 1/27/2026, at 1:50 PM, Surveyor interviewed wound physician-S who stated wound physician-S was filling in for the prior wound physician for the facility from around 12/6/2025 – 1/20/2026. Surveyor asked wound physician-S opinion on why R6's sacral wound re-opens. Wound physician-S replied he was not sure, R6 is on hospice, lack of circulation, scar tissue, not enough nourishment, not repositioning, . Surveyor asked wound physician-S what determined R6's sacrum pressure injury decline to a stage 4 on 12/16/2025. Wound physician-S reviewed R6's documentation from 12/16/2025. Wound physician-S stated he was not sure why wound physician-S documented stage 4 for R6 on 12/16/2025. Wound physician-S stated it was an error and R6's sacral pressure injury (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	should still have been classified as a stage 3 pressure injury until it resolved on 1/20/2026. On 1/27/2026, at 3:58 PM, Surveyor shared concerns with nursing home administrator (NHA)-A that R6's stage 3 sacral pressure injury re-opened two times in the facility and there was not a root cause determined nor care plan revisions. Surveyor shared concerns R6 developed stage 2 pressure injury to the left ischium and a stage 2 pressure injury to the right ischium that declined to a stage 3 with no root cause or care plan revisions. Surveyor shared observations of R6's heels not being offloaded on 1/21/2026 and 1/22/2026, a comprehensive assessments not always being completed of R6's sacral pressure injury and no root causes into why R6's sacral pressure injury reopened twice, no root cause to why R6 developed a stage 2 to the left ischium and right ischium or why R6's right ischium declined to a stage 3. Nursing did not document R6's sacral pressure injury treatments as being completed per physician orders, and care plan was not revised and was not individualized (Cross reference F657). No further information was provided at the time of this write up. 2) R46 was admitted to the facility on [DATE] with diagnoses that include Parkinsons disease, type 2 diabetes, dementia with anxiety, generalized muscle weakness, and protein-calorie malnutrition. R46' admission Minimum Data Set (MDS) dated [DATE] indicated R46 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 0 and the facility assessed R46 needing minimal assistance of 1 staff member with repositioning, moderate assistance of 1 staff member for lower body dressing, and dependent on 1 staff for putting on and taking off footwear. R46's pressure ulcer/injury care area assessment (CAA) dated 12/3/2025 documents: (R46) is a new admit from a recent hospitalization for worsening weakness and recurrent falls. (R46) has declined in activities of daily living (ADLs) self-performance and needs assistance and staff support with most ADLs including bed mobility, transfers, and toilet use. (R46) is always incontinent of bowel and bladder; (R46's) oral intake is inadequate; and (R46) is mostly wheelchair bound. (R46) shows inattention, disorganized thinking, and is lethargic. R46's . at risk for pressure ulcers and other skin related injuries related to immobility, incontinence, malnutrition, diabetes, and impaired cognition care plan was initiated on 11/25/2025 with the following interventions:- Braden scale to be completed.- Keep bed linens wrinkle free and do not use excess pads.- Observe skin for redness or breakdown during routine cares.- Use pressure injury devices, cushion on wheelchair and off of heels, as indicated.- Follow community skin care policy.- Treatments, as indicated, see physician order sheet.- pressure reducing mattress on bed. On 12/3/25, R46's [NAME] scaled documents a score of 16, indicating R46 is a mild risk for the development of pressure injuries. On 12/11/2025 surveyor noted a skin condition assessment documenting:- Right heel: intact, red/tender/warm, fluid filled blister to right heel- 5.0 X 10.0 X 0 (length X width X depth)- Treatment initiated: Optifoam non adhesive heel dressing- Twice a day apply Optifoam dressing to right heel. Cleanse with Surprep for skin integrity and monitor for drainage. Surveyor noted R46's comprehensive assessment of R46's right heel blister did not include a staging to indicate what kind of pressure injury R46 had. The facility did not complete a root cause analysis to determine how R46 right heel pressure injury developed and R46's pressure injury care plan was not revised with interventions to promote healing of the right heel pressure injury. (Please cross -reference F657) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Surveyor reviewed R46's treatment administration record (TAR) for 12/2025 and noted for R46's 8:00 AM treatment nursing documented on 12/12 – 12/14/2025 the letter (R) indicating R46 refused treatments. On 12/14/2025 R46's right heel treatment was changed to: Sureprep to right heel blister-Offload heel for fluid filled blister (if blister pops, obtain new treatment order. R46's Sureprep treatment was to be done twice a day at 8:00 AM and night shift. On 12/14/2025 R46's night shift sureprep treatment was not documented as being completed. On 12/16/2025, R46 is seen by wound physician (WP)-S. WP-S wound note documents: - Right heel unstageable deep tissue injury (DTI), within and around wound.- 8.0 X 5.0 X 0, blood filled blister-Treatment changed to Alginate Calcium- apply once daily and as needed. Cover with bordered gauze.-General recommendation – Float heels in bed- Specific recommendation to this visit- Pressure 0ff-loading boot. Surveyor noted R46's pressure injury care plan was not revised after developing a blister to the right heel on 12/11/2025 until 12/16/2025 (5 days later). On 12/23/2025, WP-S documented the following wound assessment for R46's right heel pressure injury:-Right heel, full thickness DTI- 8.0 X 8.0 X 0.1, 80% granulation tissues, 20% subcutaneous tissue. Surveyor notes documented tissue percentages; however, R46's right heel pressure injury is staged a DTI On 12/30/2025, WP-S documents the following wound assessment for R46's right heel pressure injury:-Right heel, full thickness unstageable necrosis- 3.0 X 4.3 X unable to determine, light serous drainage- 20% necrotic (eschar) tissue (dead, dry, thick tissue), 70% devitalized necrotic tissue (dead tissue that must be removed for wound healing), 10% granulation tissue- Debrided devitalized tissue at the margins of the wound R46's right heel continued to be assessed by WP-S weekly with no decline of right heel wound. On 1/20/2025, WP-s documents the following wound assessment for R46's right heel pressure injury:-Right heel, full thickness, Stage 3 pressure injury- 2.5 X 3.6 X 0.2, moderate serous drainage-20% necrotic (eschar) tissue, 30% devitalized necrotic tissue, 50% granulation tissue- Debrided necrotic tissue Surveyor reviewed R46's TAR for 12/2025 – 1/2026 and note the following for R46's right heel pressure injury treatment:1. Alginate- Right heel wound: (initiated 12/16/2025)- Cleanse with wound cleanser, Sureprep to periwound, Alginate to wound bed and cover with bordered dressing daily and as needed for pressure wound.- Nursing staff did not document R46's treatment completed on: 12/17/25, 12/18/25, 12/21/25, 1/18/26, 1/19/26, and 1/25/26 2. Off-loading boots: (Initiated 12/16/2025)-Apply to bilateral feet when in bed and when unable to offload pressure in wheelchair. Do not wear for transfers or ambulating. For pressure wound.-nursing staff documented (R) indicating R46 refused to wear the offloading boots.- Surveyor noted there are no care plan revisions or risk verse benefits documented to indicate other interventions were tried or asked what R46's preference was to keep heels heel offloaded. During survey, Surveyor had observations of R46 not wearing bilateral heel boots and had yellow anti (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	slip socks of bilateral feet, bilateral feet were observed lying flat on the floor. On 1/26/2026, at 2:33 PM, Surveyor interviewed wound registered nurse (WRN)-I who stated a complete comprehensive assessment shoul

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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 blood (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 attempts to toilet independently contributed to R58 rolling out of bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. 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 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide appropriate treatment and services for 1 (R41) of 1 resident with a diagnosis of dementia, with behavioral symptoms, to allow them to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.*R41 was admitted to the facility with known behaviors related to dementia. R41 continued to have behaviors that made other residents anxious, scared and showing aggression toward staff and resulted in R41 grabbing R4 by the forearm which caused R4 to have pain. R41's behaviors and interventions were not reassessed and R41 did not receive a consult for psych services.Findings:The facility's policy, titled Dementia Care with a last approved date of 1/2026, documents: The community will provide dementia treatment and services which may include, but are not limited to, the following: . B. Ensuring that the necessary care and services are person-centered and reflect the resident's goals, while maximizing the resident's dignity, autonomy, socialization, independence, choice, and safety; . D. Assessing, developing, and implementing care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible . E. Identifying, addressing, and/or obtaining necessary services for the dementia care needs of residents . R41 was admitted to the facility's 1st floor rehab from the memory care unit located within the same facility on 1/2/2025 with diagnoses including, Dementia (a condition characterized by progressive or persistent loss of intellectual functioning).R41's admission Minimum Data Set, dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 6, indicating that R41 has severe cognitive impairment. The MDS documents that R41 has no impairment in upper or lower extremities, is independent with toileting, rolling left to right, lying to sitting, sitting to stand and chair to bed transfer and that R41 uses an alarm daily for wandering/elopement.R41's Annual MDS, dated [DATE], indicates R41 sometimes can understand and be understood, has a BIMS score of 2, indicating severe cognitive impairment, has physical behavioral symptoms directed towards others, rejection of care, is dependent on staff to roll left to right, and partial/moderate assistance with sit to stand and transfer. R41 received scheduled pain medication and received pain medication as needed or was offered and declined. The MDS also documents that R41 had a fall with major injury without surgical procedure.Surveyor noted that the decline in BIMS score and continued documentation of behaviors directed toward others did not result in documented comprehensive reassessment of behavioral interventions for R41. On 01/20/2026, at 11:38 AM, Surveyor interviewed R4. R4 informed Surveyor that R41 came into R4's room, R4 told R41 to leave, then R41 grabbed R4 by the arm causing R4 to scream LET GO, GET OUT OF HERE!, R41 screamed back at R4 AHHHHHHH, then nurses came running into the room and the counsel (sic, referring to administration) came and put the stop signs up on the doors. R4 indicated R4 has not seen R41 in awhile and asked staff about R41. R4 was told R41 is sick and in a wheelchair now. R4 informed Surveyor that R4 was very scared and it hurt when R41grabbed R4's arm. R4 added that R41 is very scary and should not be on this floor. R4 explained that R4 was trying to figure out what R4 was going to hit R41 with but did not have anything in reach to defend R4's self.Surveyor reviewed R41's Facility provided document, titled Care Plan and noted the following care plan and interventions for R41: Behaviors- start date 1/9/2025, indicating R41 has impaired behaviors related to wandering, shower refusals, yelling and combativeness, interventions include, intervene as necessary to ensure safety, divert attention from stimulus and talk with client in a calm voice when behavior is occurring. On 5/23/2025, R41's care plan was updated to include R41 wanders into another resident's room and may have taken items; a strip of Velcro is placed across this doorway to discourage visits. On 10/16/2025, R41's care plan was updated to include, wander guard left wrist. On 1/2/2026, R41's care plan was updated to include a geri-psych consult and assist R41 to activities. Cognitive Loss/Dementia- start date 4/11/2025, indicating R41 has memory (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	problems, impaired decision making and impaired ability to comprehend related to dementia. With a goal of having basic needs met. Interventions include, orientation to facility routines and activities, provide cues as needed. Surveyor noted R41's dementia care plan was last updated on 10/16/2025 to include refusals of medications, skin checks weight measurements and showers. With interventions to assess R41's individual perception of health problems, develop a therapeutic relationship with client and family, and provide supervision as appropriate.Surveyor reviewed R41's progress notes in R41's electronic health record and noted the following instances:On 1/19/2025, R41 wandered into another resident's room going through her dresser, redirection attempted, R41 tried to swing at staff member. On 1/22/2025, R41 entered other resident's rooms, hit staff, yelling and agitated.On 1/25/2025, R41 attempt to enter another resident's room.On 1/29/2025, R41 entering other resident rooms, laying in other resident's beds, attempt to hit staff times 3.On 1/30/2025, R41 entered another resident's room through a closed door, attempt to hit staff, followed visitor out of unit door, alarm sounded R41 redirected. On 1/31/2025, R41 pulled fire alarm on unit.On 1/31/2025, R41 in other resident rooms. On 2/2/2025, R41went into another resident room while she was sleeping, refused to leave but finally left room. On 2/7/2025, R41 exhibited negative behaviors during worship, making other residents anxious. On 3/20/2025, R41 attempted to exited unit causing door alarm to sound. On 4/26/25, R41 was combative. On 5/3/25, R41 is aggressive during shower, swung shower head at staff and hit staff in the arm. On 6/21/2025, R41 entering other residents rooms, redirected. On 6/25/2025, R41 became aggressive with staff. On 7/30/2025, R41 going into other resident rooms multiple times, aggressive with redirection. On 7/30/2025, SS left message regarding with POA regarding pending transfer to WI Vets On 9/7/2025, R41 combative, nurse assisted with redirection. On 9/22/2025, R41 confused, attempted redirection with limited success. On 11/8/2025, R41 having anxious behavior, noted entering other residents' rooms and attempting to leave unit. On 11/22/2025, R41 anxious and aggressive behavior.On 12/5/2025, R41 refused medications and aggressive.On 12/8/2025, R41 experienced 3 episodes of aggressive behavior, redirection somewhat effective. On 12/19/2025, R41 exit seeking multiple times and aggressive.On 1/1/2026, R41 experienced a witnessed fall is restless, agitated and combative.Surveyor noted there was no evidence documented in R41's electronic health record that indicated the incident between R41 and R4 occurred. Surveyor noted that the facility did not document the resident-to-resident altercation in R41's record which limited the facility's ability to reassess risk and revise any behavioral interventions for R41. Surveyor reviewed R4's electronic health record and noted a progress note dated 10/1/2025, at 11:20 PM, indicating confused resident came into R4's room, grabbed R4 by the forearm, R4 screamed, staff intervened, and residents were separated, no injuries noted. Surveyor noted that the above incident was not documented in R41's electronic medical record and thus the facility did not reassess or have documentation to further assess R41's dementia related behaviors.Surveyor reviewed the Facility provided document, titled COMPLIMENTS,SUGGESTIONS, and CONCERNS, dated 12/9/2025, which indicated R40's family member indicated R41 was seen wearing R40's favorite sweater. The Facility looked into this complaint and found R4"s sweater in R41's room and given back to family.Surveyor reviewed the Facility provided document, titled COMPLIMENTS,SUGGESTIONS, and CONCERNS, dated 5/22/2025, written by R40's family member, indicating R41 was going in R40's room and taking things. Stop signs were implemented on R40's door to discourage R41 from entering R40's room.Surveyor noted that despite the above documentation in R41's medical record, there was no evidence of a formal behavior monitoring or tracking system in place to track frequency, triggers, or effectiveness of R41's dementia behavioral interventions. On 01/21/2026, at 10:42 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-P, and Certified Nursing Assistant (CNA)-Z who informed Surveyor that R41 was a wander risk prior to R41's falls earlier this month, but has not wandered since the falls. Staff would intervene and manage R41's behaviors by taking R41 to activities, walk around, and would show R41 the things in R41's room that R41 enjoyed, play western music, hang out in R41's room or use distraction. LPN-P indicated, R41 was always going in other resident rooms and (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	explained a time when R41 went into a female resident's room while she was sleeping, opened her eyes started screaming, R41 was pulling on bathroom door. LPN-P explained that Velcro straps were put on rooms R41 would go into. R41was never a 1:1 supervision but was on the memory care unit upstairs before coming to this unit. CNA-Z informed Surveyor that R41 has a history of going into other resident rooms but has never been a 1:1 supervision and that the Director of Nursing (DON) would make the decision if someone is a 1:1. CNA-Z informed Surveyor she recalls the incident between R4 and R41 but was not here the day it happened, only heard about the incident.On 01/22/2026, at 10:36 AM, Surveyor interviewed Social Services (SS)-X who started at the Facility in May, 2025. SS-AA informed Surveyor that R41 is being followed by Psych Services as of January 2026 and was seen on 1/6/2026. SS-X indicated SS-X is not involved with the care of R41's behavioral concerns, will implement care plan interventions as a team for behaviors but is not involved in the oversight of those interventions. Care Plan interventions for behaviors is discussed as an IDT team and is a collaborative effort. Behaviors are monitored by nursing staff and SS-AA would expect to be notified of changes in R41's behaviors. SS-AA indicated R41's behavior care plan was initiated around time of admission due to behaviors of R41.SS-AA informed Surveyor that MDS Coordinator-BB created the care plan and Surveyor should ask them regarding behavior monitoring. On 01/22/2026, at 10:48 AM, Surveyor interviewed MDS Coordinator-BB. MDS Coordinator-BB informed Surveyor that R41 came to the Facility from the memory unit upstairs where R41 had wandering behaviors. MDS Coordinator-BB updated R41's care plan recently due to change in condition but was not sure who created the admission care plan. MDS Coordinator-BB explained that the IDT will talk about behaviors to determine interventions and what is working/not working. The IDT will base information on conversations with staff, look at notes and nurse documentation for behaviors. MDS Coordinator-BB indicated Social Services should be monitoring behaviors looks as well as psych medications. Surveyor asked how R41's behaviors being monitored? MDS Coordinator-BB, after looking in R41's electronic health record, indicated no monitoring in Medication/Treatment administration records, only includes functioning of wander guard that she could see. Progress notes are looked at daily by DON, and maybe Nurse Manager who would then bring that information to morning huddles. On 01/22/2026, at 11:03 AM, Surveyor interviewed Registered Nurse (RN) Unit Manager (UM)-C, who started at the Facility on 1/5/2026 and RN UM-T, who started at the Facility 2 weeks prior. RN UM-T informed Surveyor that upon admission, admitting nurse does baseline care plan, MDS Coordinator will look over and update as needed. RN UM-T indicated, monitoring of interventions is discussed in care plan meetings, IDT will discuss interventions, discharge planning, changes, look at those and update care plans as needed. RN UM-T informed Surveyor that if a resident goes into another resident's room, the care plan and interventions should be looked at and discussed. If a staff is hit or a resident has aggression, would need to reevaluate interventions for effectiveness and update accordingly. Behaviors are documented by nurses and we will go through each resident that was documented on the day prior during the morning meeting. If a resident has a risk for hurting themselves or others, they would require a psych consult. If a resident hit a staff member, we should have psych consulted. On 01/22/2026, at 2:07 PM, Surveyor asked SS-X about the progress SS-X wrote regarding R41 possibly going to another Facility. SS-X indicated the former Nursing Home Administrator (NHA) thought another Facility would be a better fit for the services R41 requires. R41's Power of Attorney (POA) filled out paper work and sent in but the Facility had no availability and really wanted R41 to stay here. Former NHA thought R41 needed more resources for memory care then the Facility could provide. After the resident-to-resident incident on 10/1/2025, SS-X informed R41's POA regarding the Facility feeling they are unable to provide R41 with needed 1:1 supervision and R41's POA could not pay for the 1:1 supervision R41 needed.Surveyor reviewed the email correspondents provided by the Facility, which are as follows:On 8/21/2025, at 1:48 PM, SS-X received an email from R41's POA, indicating R41's POA received an application for another facility and asking SW-AA who initiated the request since R41's POA did not request a transfer.On (continued on next page)

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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 0744 Level of Harm - Actual harm Residents Affected - Few	8/26/2025, at 12:03 PM, SS-X responded to R41's POA indicating he believes that due to R41's behaviors and dementia progression, the facility is not an appropriate setting for R41 and requested a meeting with R41's POA. On 10/1/2025, at 7:14 PM, SS-X wrote an email to R41's POA, following up regarding a care plan meeting for alternative placement for R41. Indicating the Facility can no longer manage R41's behaviors and R41 had become physical with another resident after entering their room, believing R41 requires 1:1 supervision which the Facility does not provide and would be issuing a 30-day notice of discharge due to this occurrence.Surveyor noted that a 30-day notice was not issued and R41 still resides at the Facility.On 01/22/2026, at 3:11 PM, Surveyor informed the Facility of the concerns regarding R41's dementia care provided by the Facility. Surveyor noted that the Director of Nursing (DON)-B was not present at the Facility. Director of Clinical Operations-F informed Surveyor that behaviors are usually discussed during daily morning meetings. The Facility is now starting to implement a behavior log which the SW would keep track of. For any new/worsening behaviors, are to be documented/recorded on the log and will be reviewed the following business day. However, if a behavior is dangerous, the expectation is to notify on call physician, nurse, add to log, notify family, on call management, DON, NHA and the team will talk about care plans, as a team, if behaviors remain or increases, as an IDT they should review and revise interventions. NHA-A indicated a paper log is to start in February for behaviors, to track and trend frequency of behaviors, look if interventions are appropriate, talk to social workers, front line staff and help identify interventions and triggers. New guidelines for morning meetings, more comprehensive to identify concerns. NHA-A could not speak to the prior NHA determinations or expectations. Surveyor asked NHA-A if R41 has been seen by psych services, NHA-A indicated that NHA-A has provided all information already to Surveyor. Surveyor noted the Facility provided a paper copy of the order for R41 to see psych services on 1/2/2026, but there is no evidence this was followed through.On 01/26/2026, at 12:21 PM, Surveyor interviewed DON-B and NHA-A regarding dementia care and behavior monitoring for R41. DON-B indicated there might be interventions reassessed/implemented but would need to look for further information that would not be her office. DON-B indicated interventions would need to be reassessed after episodes of continuing behaviors to reassess current interventions. The Facility does provide 1:1 supervision if a resident is unsafe, not able to leave the room for risk of injury, harm to self or others. R41 is kept at the nurses station, needs frequent reminders to not stand up and keeping R41 at the desk provides an opportunity for staff to give reminders, indicating R41's supervision is a team effort, not 1:1. NHA-A informed Surveyor that she would expect IDT discussion based on resident symptoms, review of behaviors, consult with psych provider, look at interventions, talk to family about appropriate setting, if we cannot find a safe way to mitigate behavior or to keep R41 safe, discussion of 1:1 or referral to alternative setting would be initiated. R41's family would have to pay for the 1:1 coverage with individual staff separately, on set schedule, making it individualized and person centered. Chart analysis, medication review, history, time frames, family input, patterns and routine would all be taken into consideration when assessing needs for R41's dementia care.On 01/27/2026, at 11:05 AM, Surveyor interviewed RN UM-C who informed Surveyor that there is no order for a psych consult for R41 that she can see and there is no discontinued order for psych. RN UM-C indicated the nurse would have needed to put in the order, but does not believe that was done and would look further into it.On 01/27/2026, at 4:00 PM, Surveyor informed the Facility of the above concerns, no additional information was provided if R41 received a consultation for psych services, if an appointment was made, or what reassessments were completed for R41's interventions and behaviors, as of time of write up.No additional documentation was provided as to why the facility did not ensure to consistently reassess, revise, monitor, and obtain necessary services for R41's ongoing dementia-related behaviors which resulted in actual harm to R4 and created the potential for further harm to other residents.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on record review and interview, the facility did not ensure it did not employ individuals who were found guilty of abuse, neglect, exploitation or mistreatment by failing to conduct a background information disclosure (BID) every four years for 1 (Director of Facilities Management-W) of 13 facility staff reviewed. This has the potential to affect all 53 residents residing at the facility. Findings include:The facility policy titled Abuse Prevention dated 9/2017 and last revised date 8/2025 documents: . Our residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. screening . it is the policy of this community to screen employees and volunteers prior to working with residents. Screening components include verification of references, certification and verification of license and criminal background check. Will not knowingly employ or otherwise engage any individual who has: . been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law . On 1/26/26, Surveyor reviewed facility employee files to ensure completed background checks including background information disclosure, which are to be completed every four years by State of Wisconsin regulation. Surveyor reviewed the employee file for DFM-W, with hire date documented as 2/6/2019, and located a Background Information Disclosure (BID) form dated 1/16/2019. Surveyor could not locate a BID dated within the last four years in DFM-W's file. In an interview on 1/27/26 at 11:00 AM, Nursing Home Administrator (NHA)-A stated NHA-A will reach out to Human Resources (HR) regarding any additional BID for DFM-W. On 1/27/26 at 12:04 PM, NHA-A provided Surveyor with an updated BID completed by DFM-W dated 1/27/26. Surveyor shared concern with NHA-A that DFM-W's BID was not completed every four years per State of Wisconsin regulation, and NHA-A stated the facility HR department was not aware the BID needed to be completed every four years.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility did not ensure resident medical records were safeguarded against loss, destruction, or authorized use.Resident medical records were observed in cardboard boxes sitting directly on the floor and uncovered, and resident medical records were observed in a storage room which also contained items for the maintenance department. This has the potential to affect all 53 residents residing in the facility.Findings include:The facility policy titled Records Management Policy dated 2/2022 with revised date 5/2024 documents:[Facility Name] retains, stores, manages, and destroys records . in compliance with applicable federal and state laws . records containing confidential and proprietary information should be securely maintained and protected . records should be stored in physically-secure, controlled environments that protect them from damage, tampering, fire, pests, degradation, and other hazards . the confidentiality of the record should be maintained. On 2/4/26 at 10:22 AM, Surveyor toured the medical records storage at the facility with Director of Facilities Management (DFM)-W. Surveyor noted the medical records storage room is in the basement level on the attached convent unit located on the same campus.Surveyor observed a lock on the door which requires a code to enter the medical records storage room. Once inside the room, Surveyor observed several boxes of medical records information sitting directly on the floor, and several boxes were uncovered with no protective lid. Surveyor also observed durable medical equipment (DME) such as wheelchair parts and mattresses in the storage room. Surveyor asked DFM-W who has access to the medical records room, DFM-W confirmed DFM-W has access the room to access the DME and the medical records assistant has access, but DFM-W was not sure who else has access to the room. DFM-W was not sure if any staff from the convent side of the campus has access to the medical records storage room. On 2/4/26 at 11:19 AM Surveyor placed phone call to Medical Records Assistant (MRA)-CC with a request to return Surveyor's phone call. No return call was received. On 2/4/26 at 3:00 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A, who stated previous resident information from the skilled nursing facility and long-term care facility is kept in the basement medical records storage room, and current resident information is kept in MRA-CC's office located on the second floor of the nursing facility. NHA-A stated MRA-CC and DFM-W have access to the basement medical records storage room. Surveyor shared concerns with NHA-A that several boxes of resident medical records were observed being directly on the floor in the basement medical records storage room and several boxes were observed as uncovered, leaving potential for damage, tampering, or other hazards. Surveyor informed NHA-A that current residents who could potentially be discharged could also have medical records stored in the basement medical records room. Surveyor shared the concern with NHA-A that the medical records storage room containing confidential resident information is shared with maintenance for storage of DME. On 2/5/26 at 8:25 AM, Surveyor interviewed MRA-CC. MRA-CC stated current records such as nursing paperwork, controlled medication sheets, pharmacy receipts, incoming resident records are kept in MRA-CC's office on the second floor of the nursing facility. MRA-CC stated older records and previous resident records are stored in the basement medical records storage room. MRA-CC stated MRA-CC previously worked in this role until March 2024 and then returned to this position in July 2025, and MRA-CC is not sure what happened while MRA-CC was gone but stated the medical records storage room became very disorganized and quite a mess. MRA-CC stated MRA-CC has been working with corporate support to reorganize the medical records storage room, but this has been ongoing for the last several months. MRA-CC confirmed DFM-W stores DME in the medical records storage room and stated the long-term plan is to move the medical records to a different location so DFM-W can use the room for maintenance needs instead. Surveyor shared concerns with MRA-CC that several boxes were observed uncovered and resting directly on the floor of the basement storage room, leading to potential for damage or tampering, and that boxes containing confidential resident information were (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	observed to share a room with maintenance department storage.No additional information was provided.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility's Quality Assurance Committee did not make a good faith effort to identify and correct systemic deficiencies prior to the survey. This deficient practice has the potential to affect all 53 residents at the facility. During a recertification, complaint, and extended survey conducted on 1/20/2026-2/9/2026, it was determined 27 deficiencies existed. Three of the 27 deficiencies have been identified as actual harm, including treatment and services to prevent and heal pressure ulcers at F686, freedom from accident hazards at F689, and treatment and services for dementia at F744. The scope and severity at tags F606 and F686 are considered substandard quality of care. Widespread deficient practice was identified at F606 for not employing staff with adverse actions, F842 for medical records, F865 for the QAPI program, F868 for the Quality Assessment and Assurance (QAA) committee, F880 for infection prevention and control, F881 for the antibiotic stewardship program, F882 for designation of a dedicated infection preventionist, and F944 for QAPI training. During the recertification survey, 9 errors were made of 30 opportunities during observation of medication administration, resulting in a medication error rate of 30%, with 8 of the 9 errors related to administering medications after the allowable time frame. The facility's QAPI program failed to identify and prioritize problems and opportunities to address systems of care and management practices to achieve expected clinical outcomes. Findings include:The facility policy titled Quality Assurance and Performance Improvement Plan dated 2026 documents: . the outcome of QAPI is the quality of care and the quality of life of our residents. we use QAPI to make decisions and guide our day-to-day operations. our QAPI program focuses on our organization's systems and processes rather than on the performance of individuals and we strive to identify and improve system gaps. we make QAPI decisions based on data gathered from the input and experience of caregivers, residents and their representatives, health practitioners, and other stakeholders. we set goals for performance and measure progress towards those goals. we support performance improvement by encouraging our associates to support each other, as well as, to be accountable for their own professional performance and practice. we strive to maintain a culture that encourages . associates to identify errors or system breakdowns. The QAPI program aims for safety and high-quality with all clinical interventions and service delivery while emphasizing autonomy of choice and quality of daily life. Action tools and monitoring systems are in place and are consistent for proactive analysis, system failure analysis, and corrective action. the system tracks and monitors adverse reactions that are routinely investigated, with action plans implemented to prevent recurrence. performance improvement projects (PIPs) concentrate efforts on a particular opportunity in one area of the community or on a community-wide basis. They involve gathering information systematically to clarify issues or opportunities and intervening for improvements. The community conducts PIPs to examine and improve care or services in areas that are identified as needing attention. Areas for improvement are identified by routinely and systematically assessing the quality of care and service and include high risk, high volume, and problem prone areas. Consideration is given to the incidence, prevalence, and severity of problems, especially those that impact health outcomes, resident safety, autonomy, choice, quality of life and care coordination. Appendix A of the Quality Assurance and Performance Improvement Plan dated 2026 documents the following Quality Improvement Defined Measures for Fiscal Year (FY) 2026: 1. Community acquired pressure injuriesa. Aim: reduce community acquired pressure injuries to <3.48% each month by June 30, 2026 . b. Approaches: implement process for review new resident admission Braden assessments next clinical day huddle for adequacy of prevention interventions . for person centered care planning; review new pressure injury (PI) occurrences at weekly risk meeting including care plan review and confirmation of implementation of interventions; increase utilization of low air loss mattress for high risk/at risk residents; increase use of floating heels as strategy for preventing PIs, ensure supply adequacy; identify topics and implement in-service training for certified nursing assistants (CNAs) and nurses .; (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	track and trend PI incidence . each month, present during QAPI meetings for identification of additional strategies/modifications to plan; develop and implement audit tool to monitor the following: timely completion of Braden Risk Assessment, completion of weekly skin checks, evaluation by registered dietician (RD) upon PI identification. 2. Rehospitalizations/ED visits . 3. Reduce falls and falls with major injuries . a. Aim: decrease rate of falls with major injury occurrences to < 1 each month through June 2026b. Approaches: increased monitoring including review of falls in daily clinical huddle and during weekly at risk meetings; ensure new interventions in place post fall that address root cause; medical director review of investigations for all serious safety events .; QAPI team track and trend data of fall occurrences and develop community wide interventions based on analysis of data; identify high risk residents through fall risk assessments .; review fall risk assessments for new admissions during next day clinical huddle with interdisciplinary team (IDT) review of care plan interventions based upon identified individual risk factors; identify topics for CNA and nurse education for fall prevention; track and trend fall factors for review during monthly QAPI meetings and identification of strategies for prevention .; implement restorative nursing programs . to improve resident safety during transfers/ambulation. Surveyor notes the QAPI plan for 2026 does not document identification of systemic problems of the infection control and prevention program, including the antibiotic stewardship program and infection preventionist role, dementia care and treatment, or the timeliness of medication administration. In an interview on 1/22/26 at 3:11 PM, Nursing Home Administrator (NHA)-A stated the facility is planning to implement a paper log for behavior monitoring in February. NHA-A states a binder has been established and is ready for use, and the facility identified gaps and ways to improve clinical oversight in this area. No further information was provided regarding why this monitoring was not already implemented. On 1/27/26 at 3:21 PM, Surveyor interviewed NHA-A regarding the facility's QAPI plan. NHA-A stated the facility recently identified concerns regarding falls and wounds at the facility. NHA-A stated the facility is currently working on PIPs in these areas, but they have not yet been fully implemented at the facility. Surveyor asked NHA-A who the current infection preventionist (IP) is, and NHA-A stated the facility is recruiting for an IP, so currently the NHA-A, DON, and quality director or corporate support currently pitch in to cover the role and there is not one person designated as the IP at the QAPI meetings. Surveyor asked NHA-A what the facility's plan is for staffing the facility due to the high amount of agency staff currently working at the facility. NHA-A stated the facility plans to eliminate contracted and agency positions, as it is hard to educate and hold the people in these roles accountable. NHA-A stated the facility recently held a job fair and is implementing efforts to increase retention. NHA-A stated the facility is also looking into hiring a nurse educator to train and develop staff, but this position has not been filled yet. NHA-A stated since starting at this facility in October 2025, there have been multiple problems identified such as falls and wounds but states the facility did not identify all the issues that were identified during this recertification survey. On 1/27/26 at 3:59 PM, Surveyor shared concerns with NHA-A that the QAPI program did not identify systemic problems in the areas of late medications and infection control, and there is no evidence the QAPI program has made a good faith attempt to correct these systematic problems. NHA-A stated PIPs were started for falls and wounds on 1/12/26, and audits have been conducted in these areas, but staff education still needs to occur, so the PIPs are not fully useable at this time. No further information was provided.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interview, the facility did not maintain a quality assessment and assurance committee consisting of the required members to identify issues through the committee. This deficient practice has the potential to affect all 53 residents currently in the facility.The Director of Nursing (DON) did not attend Quality Assurance Performance Improvement (QAPI) meetings on 4 of 10 months reviewed. Findings include:The facility Quality Assurance and Performance Improvement Plan dated 2026 documents:. The QAPI program is structured to incorporate input, participation and responsibility at all levels. Quality Improvement activities are the responsibility of each associate. Leaders are accountable for improved processes and outcomes. QAPI committee members: . director of nursing .On 1/27/26 at 1:41 PM, Surveyor reviewed the facility's QAPI attendance sign in sheets over the last available 12 months as provided by Nursing Home Administrator (NHA)-A. NHA-A provided Surveyor with 10 months of QAPI meeting minutes from February to December 2025.The QAPI meeting minutes dated 2/7/25 documents the name, signature, and position of the attendees. The sign in sheet does not include the DON. The QAPI meeting minutes dated 6/19/25 documents the name, signature, and position of the attendees. The sign in sheet does not include the DON. The QAPI meeting minutes dated 7/1/25 documents the name, signature, and position of the attendees. The sign in sheet does not include the DON. The QAPI meeting minutes dated 11/3/25 documents the name, signature, and position of the attendees. The sign in sheet does not include the DON. On 1/27/26 at 3:21 PM, Surveyor met with NHA-A to discuss the facility's QAPI program. Surveyor inquired who attends the facility's QAPI meetings. NHA-A stated QAPI meetings are held monthly and includes the DON, Medical Director, MDS coordinator, social services, NHA, maintenance, dietary services, activities, admissions, and corporate support. NHA-A stated the pharmacist consultant also attends quarterly. Surveyor shared concern with NHA-A that the DON did not sign in on the monthly QAPI meeting for dates 2/7/25, 6/19/25, 7/1/25, or 11/3/25. No additional information was provided why the DON did not attend these QAPI meetings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not implement an effective infection control program in the facility. This has the potential to affect all 53 residents in the facility.* The facility did not maintain documentation of an on-going infection surveillance in the facility. * The facility did not have documentation of preventative action, and investigation, into 2 covid outbreaks.* The facility did not implement appropriate isolation and enhanced barrier precautions effectively for R11, R66, R67 and R4. Cross Reference F756, F757, F881 and F882. Findings include: The facility policy and procedure Infection Prevention and Control Program dated 6/2025, Statement includes:1. The Infection Prevention and Control P (IPCP) program is a facility wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program.2. The elements of the Infection Prevention and Control Program consist of coordination oversight policies procedures surveillance data analysis antibiotic stewardship outbreak management interventions implemented to promote the prevention of infection education and associate health and safety.3. The IPCP covers all residents, associates, contractors, consultants, volunteers, visitors, others who provide care and services to residents on behalf of the facility and students in the facilities nurse aid training programs or from affiliated academic institutions.4. The IPCP is designed to provide a safe sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.;Policy Interpretation and Implementation:B.1. Prevent detect and investigate and control infections in the community.B.2. Maintain a safe sanitary and comfortable environment for personnel residents visitors and the general public.B.3. Establish guidelines for implementing isolation precautions including standard and transmission-based precautions.B.4. Establish guidelines for the availability and accessibility of supplies and equipment necessary for standard and transmission-based precautions.B.5. Maintain records of incidents and corrective actions related to infections.Coordination and Oversight:1. The IPCP is coordinated and overseen by the infection preventionist.2. The IPCP is based on the Facility Assessment and Infection Risk Assessment that are reviewed annually and as needed for changes to the facility or services that would impact the assessments.3. The Infection Prevention and Control Committee (IPCC) is responsible for reviewing and providing feedback on the overall program4. The Quality Assurance and Performance Improvement (QAPI) committee through the IPOC shall oversee implementation of infection control policies and practices and help department leaders or designee to monitor implementation and maintain compliance. 1.) SURVEILLANCE On 1/20/26, at 11:06 AM, Surveyor met with Nursing Home Administrator (NHA)-A and Director of Nurses (DON) -B. NHA-A stated Quality Director (QD) – L is in training and will gather the IPCP documents requested for Surveyor review. On 1/21/2026, at 3:16 PM, Surveyor asked, the NHA- A and DON-B, who are currently overseeing the facility Infection Control Program. Surveyor requested the facility infection surveillance. The DON-B stated they are still in the process of compiling the data. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/22/2026, at 8:30 AM, the NHA-A spoke with the Survey Team. The NHA-A stated the DON-B is not here today. Any infection control questions the NHA-A and QD-L will address. On 1/26/2026, at 11:51 AM, the NHA-A showed Surveyor a new form for surveillance of infections in the facility the NHA-A started last week. The resident Electronic Health Record (EHR) has an Infection Tracking tab that follows McGeer's. The facility prints off the sheets and puts it in a binder. Surveyor notes the antibiotic compiling sheets provided from DON-B do not document the antibiotics being used in the facility to determine the infection meets criteria for antibiotics. This includes residents on antibiotics upon admission, and acquired, in the facility. The indications for use, organism, duration and appropriate isolation. OUTBREAKS On 1/21/2026, at 8:03 AM, Surveyor interviewed NHA-A and DON-B. The facility Infection Outbreak documents were reviewed. There was a covid outbreak in August 2025 and September 2025. There is only line list documented. There is no documentation of outbreak protocols implemented and investigation into possible sources of the outbreak. NHA-A stated they will look for any additional documents. On 1/21/202, at 6 10:02 AM, NHA-A stated to Surveyor there are no additional documents. 2.) On 1/20/2026 at 11:04 AM, Surveyor observed isolation precaution signs on resident doors with personal protective equipment (PPE), gowns, gloves, and masks, in bins outside of the rooms. R11 had a droplet precaution sign. R66 had a contact precaution sign. Surveyor observed Certified Nursing Assistant (CNA)-M walking in the hallway wearing a pair of gloves and a mask. CNA-M entered R66's room without putting on a gown. CNA-M left the room to get another staff member, still with gloves and a mask on, and went back into the room and closed the door. CNA-M did not put on a gown before entering the room. Surveyor observed Licensed Practical Nurse (LPN)-E enter R66's room. LPN-E did not put on a gown or gloves before entering the room. LPN-E exited R66's room. Surveyor asked LPN-E why R66 was in isolation. LPN-E stated R66 had MRSA (methicillin resistant staphylococcus aureus, a multidrug resistant organism) in R66's wounds. Surveyor asked LPN-E what someone should wear for PPE when entering R66's room. LPN-E stated if you are going to do cares, then you would wear a gown and gloves. Surveyor asked LPN-E if there was a difference between Enhanced Barrier Precautions and Contact Precautions. LPN-E stated if the resident has MRSA, then they would be in contact precautions, but if they have wounds that are not open or have MRSA, then they would be in enhanced barrier precautions. Surveyor asked LPN-E, since R66 was in contact precautions, should a gown be worn when entering the room. LPN-E stated only if you were going to do cares. Surveyor asked LPN-E what LPN-E did in R66's room with CNA-M. LPN-E stated they boosted R66 up in bed. Surveyor asked LPN-E why R11 was in isolation. LPN-E stated R11 had COVID. Surveyor asked LPN-E what someone would wear when entering R11's room. LPN-E stated you would put on a gown, glove, and mask. LPN-E was not sure if you had to wear anything over the eyes anymore. Surveyor asked LPN-E what you wear if you are just dropping off a tray for mealtime. LPN-E stated then you just have to wear gloves. Surveyor reviewed R66's medical record. No documentation of R66 having MRSA was found. On 1/22/2026 at 3:11 PM, Surveyor asked Nursing Home Administrator (NHA)-A and Director of Clinical Operations (DCO)-F how it was determined who was in isolation. NHA-A stated a newly admitted resident's admission packet is reviewed and depending on what organism they have, they would put the resident in the appropriate precautions. DCO-F stated residents with medical devices are put in enhanced barrier precautions and if there is an organism present, then they are put in (continued on next page)

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Ascension Living - Lakeshore at Siena	5643 Erie Street Racine, WI 53402

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	contact precautions. DCO-F stated if the wound is covered, staff would not be required to wear a gown to drop off a meal tray or if they have contact with the resident but not come in contact with the wound. Surveyor asked NHA-A and DCO-F why R66 was on contact precautions. NHA-A stated they would look into it and get back with an answer. Surveyor shared with NHA-A and DCO-F the interview with LPN-E about what PPE is worn in the different types of isolation and if a meal tray is being delivered, no PPE needs to be worn for any type of isolation, and the observation of LPN-E and CNA-M entering R66's room to boost R66 up in bed and no gowns were worn by either staff member. On 1/26/2026 at 10:19 AM, Surveyor asked LPN-G what kind of isolation R66 was in and why. LPN-G stated R66 was in contact precautions because R66 had MRSA. Surveyor asked LPN-G and CNA-H what PPE should be worn when entering R66's room. LPN-G stated a gown and gloves when you are doing cares. CNA-H stated a gown, and gloves should be worn anytime you go in the room. CNA-H stated you might have to wear that just when doing cares, but if you read the sign on the door, the gown and gloves should be put on before you go in the room. CNA-H stated family members just go in the room without putting anything on, so maybe it is just with cares that PPE is put on. On 1/26/2026 at 3:51 PM, Director of Nursing (DON)-B stated they reviewed R66's medical record and R66 did not have MRSA so they took R66 out of contact precautions and put R66 in enhanced barrier precautions because of the urinary catheter and the wounds. The facility policy titled Procedure: Catheter Care, Urinary last revised 12/2017 and approved 1/2026 documents: Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Preparation: A. Review the resident's care plan to assess for any special needs of the resident. Infection Control:A. Use Standard precautions when handling or manipulating the drainage system.B. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag.2. Be sure the catheter tubing and drainage bag are kept off the floor. 3) R67 was admitted to the facility on and has diagnoses that include displaced intertrochanter fracture of the left femur with surgical repair, and urine retention. R67's admission Minimum Data Set (MDS) dated [DATE] assessed R67 has intact cognition with a Brief Interview for Mental Status (BIMS) score 15. R67 was admitted with an indwelling catheter, surgical and vascular wounds, a peripherally inserted central catheter (PICC) line in the right upper extremity and a Methicillin-Resistant Staphylococcus Aureus (MRSA- infection cause by a staph infection) in the right foot wound On 1/20/2026, at 11:07 AM, Surveyor observed R67 being pushed down the hallway in a wheelchair. Surveyor observed R67's catheter bag hanging from under the seat on R67's wheelchair. R67's bottom of the catheter bag and drainage system was dragging on the floor without a protective barrier. Surveyor noted there was not an isolation precautions sign on R67's door indicating R67 is to be on isolation precautions. Surveyor observed a cart with personal protective equipment (PPE) in between R67 and R67's neighbor room however Surveyor noted R67's neighbor was on enhanced barrier precautions noted by the sign on R67's neighbors bedroom door. Surveyor reviewed R67's medical record and noted R67 was admitted with an indwelling catheter, PICC line in the upper right extremity, surgical and vascular wound, and has MRSA in the right foot wound indicating R67 should be on contact precautions. On 1/21/2026, at 7:43 AM, Surveyor noted there was not a contact precautions sign on R67's door indicating to staff and visitors R67 was on contact precautions due to having a MRSA infection in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R67's right foot. On 1/21/2026, at 1:46 PM, Surveyor observed R67's call light was on and R67 was sitting in a wheelchair. R67's catheter bag was lying on the floor without a protective barrier. Surveyor observed there was not a contact precautions sign on R67's door. Surveyor observed certified nursing assistant (CNA)-Q enter R67's room without putting on appropriate PPE and per request of R67, lifted R67's right foot/ lower leg and assist R67 putting it on a foot pedal. Surveyor observed CNA-Q walk out of R67's room and used hand sanitizer to clean hands. On 1/21/2026, at 1:46 PM, Surveyor interviewed CNA-Q who stated CNA-Q was not aware R67 had to be on any precautions. CNA-Q stated usually a resident will have a sign outside the door indicating if and what precautions a resident should be on. Surveyor asked who would be responsible for initiating precautions for a resident. CNA-Q stated CNA-Q works for an agency and does not come to the facility often but thinks the nurses would be the staff to initiate precautions for a resident. Surveyor asked CNA-Q how staff would know a resident is on precautions in addition to signs being on the resident's door. CNA-Q stated CNA-Q will usually be told through shift report of residents that need to be on precautions. Surveyor asked CNA-Q if CNA-Q was aware of what precautions someone with wound, catheter, intravenous (IV) lines or infections should be on. CNA-Q was unable to reply to Surveyor and stated information is passed on in shift report, notified by the staff nurse, or follow the precaution signs that are on the doors. Surveyor asked CNA-Q about maintenance of catheter bags. CNA-Q stated catheter bags should be hung off the floor and below the resident's bladder area. CNA-Q stated CNA-Q did not observe R67's catheter on the floor when CNA-Q was just in the room but will make sure to look at the catheter bag to make sure the catheter bag is located properly for R67. On 1/22/2026, at 7:41 AM, Surveyor noted there was not a contact precautions sign on R67's door indicating staff to were PPE while in R67's room. On 1/22/2026, at 10:44 AM, Surveyor interviewed licensed practical nurse (LPN)-P who stated the admitting nurse is to put up the precautions sign and gather the PPE cart for a resident if the resident is to be on precautions. Surveyor asked what kind of precautions a resident should be on if they have a catheter or wounds. LPN-P stated the resident should be on enhanced barrier precautions if they have a catheter or wounds. Surveyor asked LPN-P why R67 was on an IV antibiotic and if R67 should be on precautions. LPN-P stated would have to look why R67 is receiving IV antibiotics but believes it was because of an infection somewhere. LPN-P stated R67 should at least be on enhanced barrier precautions because R67 has a catheter bag. Surveyor shared with LPN-P R67 is not on any precautions and how are staff aware resident should be on precautions. LPN-P stated there would be a sign on the door. LPN-P and Surveyor walked down to R67's room. LPN-P stated the enhanced barrier precaution (EBP) sign must have been placed on R67's neighbors' door instead of R67's door. Surveyor observed R67's neighbor had an indwelling catheter. Surveyor asked what kind of precautions R67's neighbor should be one. LPN-P looked and stated R67's neighbor should be on EBP and should keep the EBP sign on the door. Surveyor asked LPN-P what indicators someone would be on contact precautions for. LPN-P stated a resident would be placed on contact precautions if the resident had an infection that can spread. Surveyor asked LPN-P if R67 should be on EBP or contact precautions if R67 has MRSA infection in the right foot. LPN-P stated would have to talk with the nurse manager to clarify what precautions R67 should be on. LPN-P stated the infection control nurse and managers walk around the units and are able to assist if someone is supposed to be on precautions if it is missed. 1/22/2026, at 11:12 AM, Surveyor interviewed registered nurse unit manager (RNUM)-C who stated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the facility has a specific staff that would implement precautions. (RNUM-C was not able to recall who that person was at the time of interview.). RNUM-C stated if the staff member was not in the facility, then the nurse admitting the resident would be implementing precautions for the resident. Surveyor asked if the resident does not get placed on precautions with admission or something develops with an existing resident, how are precautions implemented. RNUM-C stated any nurse can implement precautions for a resident and all nursing staff have been educated on the different types of precautions. Surveyor shared concerns with RNUM-C R67 has an indwelling catheter, surgical and vascular wounds, PICC line, and MRSA infection in the right foot and observations of R67 not being on precautions and staff going into R67's bedroom without appropriate PPE. Surveyor also shared observations of R67's catheter bag lying and dragging on the floor without a protective barrier. RNUM-C confirmed R67 should have been on contact precautions when admitted to the facility on [DATE]. On 1/22/2026, at 3:11 PM, Surveyor shared concerns with nursing home administrator (NHA)-A and director of clinical operations (DCO)-F Surveyors observations of R67's catheter bag dragging and lying on the floor without a protective barrier on 1/20/2026, 1/21/2026. Surveyor also shared concerns R67 was not on precautions, specifical contact precautions, for R67's indwelling catheter, PICC line, surgical and vascular wounds, and MRSA infection in the right foot. Surveyor shared observations of CNA-Q going into R67's room without appropriate PPE on and lifting R67's infected foot onto the wheelchair foot pedal. DCO-F asked if R67's foot was covered with a dressing because if it was, staff do not have to put PPE on for that. Surveyor shared R67's right foot was covered with a dressing and asked for a copy of the facility's enhanced barrier precaution sign and contact barrier precaution sign that staff use to indicate a resident is on precautions. On 1/26/2025 Surveyor received the facility's enhanced barrier precaution sign and contact precaution sign that documents:ENHANCED BARRIER PRECAUTIONS: Everyone MUST:-clean their hands, including before entering and when leaving the room.Providers and Staff MUST ALSO:Wear gloves and gown for the following High-contact resident care activities:- Dressing- Bathing/showering- Transferring- Changing linens- Providing Hygiene- Changing Briefs or assisting with toileting- Device care or use (central line, urinary catheter, .)- Wound care- Any skin opening requiring a dressing CONTACT PRECAUTIONS: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(Do not wear same gown and gloves for the care of more than one person)-Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. On 1/26/2026, Surveyor confirmed with NHA-A R67 should have been on contact precautions when admitted to the facility on [DATE] due to having MRSA infection in the right foot and staff should put on appropriate PPE when entering R67's room. (Please cross- reference F690 and F881) 4) R4 was admitted to the facility on [DATE], with diagnoses which include neuromuscular dysfunction of bladder (a dysfunction of the urinary system caused by nerve damage, disrupting communication between the brain, spinal cord, and bladder). R4's Annual Minimum Data Set (MDS), dated [DATE], indicates R4 has a Brief Interview for Mental (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Status (BIMS) score of 12, indicating moderate cognitive impairment and has an indwelling urinary catheter. On 01/20/2026, at 11:45 AM, Surveyor observed R4 in R4's recliner chair with R4's urinary catheter bag hanging from a garbage can without a protective covering. On 01/21/2026, at 10:08 AM, Surveyor observed CNA-Q empty R4's urinary catheter bag, did not change gloves or perform hand hygiene after. CNA-Q then proceeded to provide incontinence care of a bowel movement for R4. Surveyor noted CNA-Q did not change gloves or wash hands after cleaning the fecal matter and continued pulling up R4's pants and assisting R4 with dressing. After CNA-Q was done assisting R4, Surveyor noted CNA-Q disposed of the Personal Protective Equipment (PPE) but did not perform hand hygiene. On 01/22/2026, at 10:20 AM, Surveyor observed R4 sitting in R4's chair with catheter hanging on garbage can. On 01/26/2026, at 9:55 AM, Surveyor notified Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A of the concerns regarding R4's urinary catheter bag hanging on R4's garbage can and the lack of hand hygiene/infection control during R4's cares. NHA-A informed Surveyor that R4's catheter bag should not be hung on the garbage can and should be hanging off the bed, wheelchair or alternative, at the height stated on policy. Surveyor noted there is no evidence to suggest R4 was provided risk versus benefits of having R4's catheter bag hanging on a garbage can or if alternatives were discussed with R4. No further information was provided at time of write up.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on record review and interview, the facility did not establish an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.The facility did not have documentation of antibiotics being administered in the facility including indications for use, duration, isolation, organism, administering for definition of infection criteria.This has the potential to affect all 53 residents in the facility.Findings include:The facility policy and procedure Antibiotic Stewardship dated 6/25, documents under Policy Interpretation and Implementation:1. Antibiotics shall be prescribed and administered to residents under the guidance of the community's antibiotic stewardship program2. The antibiotic stewardship program shall be incorporated in the overall infection prevention and control program and reviewed on an annual basis and as needed3. The antibiotic stewardship program promotes appropriate use of antibiotics for quality-of-care successful resonant outcomes and reduction of potential adverse consequences related to antibiotic use4. A collaborative effort between the resident and resident representative interdisciplinary team prescribing practitioner's medical director pharmacist and leadership team is essential for success of the antibiotic stewardship program5. The facility practices the core elements of antibiotic stewardship outlined by the Centers for Disease control and prevention to optimize the treatment of infections while reducing the 1st events associated with antibiotic use including leadership commitment accountability drug expertise action tracking reporting and education.Procedure:10. The infection preventionist will track antibiotic use monitor adherence to evidence-based criteria and compile reports related to antibiotic usage and resistance data.1.) On 1/20/26, at 11:06 AM, Surveyor met with the Nursing Home Administrator (NHA)-A and Director of Nurses (DON)-B. NHA-A stated the Quality Director (QD)-L is in training and will gather the IPCP documents requested for survey review. On 1/21/2026, at 3:16 PM, at the exit meeting with NHA-A and DON-B, Surveyor requested the infection surveillance that was requested on 1/20/26, at 11:06 AM. DON-B stated they are still in the process of compiling them.On 1/26/2026, at 11:28 AM, Surveyor reviewed the facility's IPCP and Facility Assessment with NHA-A, DON-B and QD-L. NHA-A and DON-B have been overseeing the IPCP in the facility. There is not a designated, and qualified IP, at the facility. QD-L came to the facility on January 14, 2026, and is contracted for 30-days. On 1/26/2026, at 11:51 AM, NHA-A showed Surveyor a new form for surveillance of infections in the facility NHA-A started last week. The resident Electronic Health Record (EHR) has an Infection Tracking tab that follows McGeer's criteria. The facility prints off the sheets and puts it in a binder. The antibiotic compiling sheets provided from DON-B do not document the antibiotics being used in the facility to determine if the infection meets criteria for antibiotics. This includes residents on antibiotics upon admission and acquired in the facility the indications for use, organism, duration and appropriate isolation.No additional information was provided.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not have a designated, and functional, Infection Preventionist (IP) implementing the facility Infection Control policy and procedures.This deficient practice has the potential to affect all 53 residents currently in the facility.* The facility had changes in the IP role and the Nursing Home Administrator (NHA)-A and Director of Nurses (DON)-B are overseeing the program. There is a Quality Director (QA)- L who is still in training for the role.Findings include:The facility policy and procedure Infection Prevention and Control Program dated 6/2025, documents:1. The Infection Prevention and Control P (IPCP) program is a facility wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program.2. The elements of the Infection Prevention and Control Program consist of coordination oversight policies procedures surveillance data analysis antibiotic stewardship outbreak management interventions implemented to promote the prevention of infection education and associate health and safety.3. The IPCP covers all residents, associates, contractors, consultants, volunteers, visitors, others who provide care and services to residents on behalf of the facility and students in the facilities nurse aid training programs or from affiliated academic institutions.4. The IPCP is designed to provide a safe sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.;Coordination and Oversight:1. The IPCP is coordinated and overseen by the infection preventionist.2. The IPCP is based on the Facility Assessment and Infection Risk Assessment that are reviewed annually and as needed for changes to the facility or services that would impact the assessments.3. The Infection Prevention and Control Committee (IPCC) is responsible for reviewing and providing feedback on the overall program4. The Quality Assurance and Performance Improvement (QAPI) committee through the IPOC shall oversee implementation of infection control policies and practices and help department leaders or designee to monitor implementation and maintain compliance.1.) On 1/20/26, at 11:06 AM, Surveyor met with the Nursing Home Administrator (NHA)-A and Director of Nurses (DON) -B. NHA-A stated the Quality Director (QD)- L is in training and will gather the IPCP documents requested for survey review. On 1/26/2026, at 11:28 AM, Surveyor reviewed the facility's IPCP and Facility Assessment with NHA-A, DON-B and QD-L. The Facility assessment dated [DATE] does not document a facility IP. The NHA-A stated the QD-L has not fully started yet. The NHA-A and DON-B have been overseeing the IPCP in the facility. There is not a designated, and qualified IP, at the facility. The QD-L came to the facility on January 14, 2026, and is contracted for 30-days. No additional information was provided as to why the facility did not have a designated infection preventionists who are responsible for the facility's IPCP (Infection Prevention and Control Program).

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interview and record review, the facility did not ensure 2 of 5 direct care staff chosen at random received Quality Assurance and Performance Improvement (QAPI) training with the potential to affect all 32 residents in the facility.* Certified nursing assistant (CNA)-DD and CNA-EE did not receive QAPI training annually.Findings include:The facility policy titled Staff Development and Training dated 1/1/2025 with last approved date 1/1/2026 documents: Purpose: to ensure all staff are competent, qualified, and continuously trained to meet the needs of residents and to comply with the Centers of Medicare & Medicaid Services (CMS) Requirements of Participation. This policy supports safe, high-quality, person-centered care and regulatory compliance. The facility is committed to providing a comprehensive, ongoing staff training and development program. All staff shall receive training appropriate to their roles and responsibilities to ensure compliance with federal regulations, professional standards, and facility policies. The facility maintains a comprehensive training program that: applies to all staff, including employees, agency staff, contractors, and volunteers . is reviewed and updated as necessary based on regulatory changes, QAPI findings, facility assessment identified needs, staff performance evaluations and competency assessments . is designed to promote resident safety, quality of care, and quality of life . Ongoing and annual training . each nurse aide must complete at least 12 hours of in-service training annually, as required by CMS. All staff shall participate in ongoing education based on identified needs through QAPI activities . changes in regulations or facility practices . Oversight and Responsibility . the administrator and director of nursing oversee compliance with training requirements . staff are responsible for attending training and maintaining competency.On 2/4/2026, at 9:17 AM, Surveyor requested annually trainings and education hours for 5 employees.Surveyor reviewed documents and noted CNA-DD and CNA-EE did not have QAPI training documented. On 2/4/2026, at 12:00 PM, Surveyor informed Nursing Home Administrator (NHA)-A QAPI training could not be located for CNA-DD and CNA-EE. NHA-A replied NHA-A would reach out and see what can find. On 2/4/2026, at 12:52 PM, NHA-A shared with Surveyor NHA-A was unable to locate documentation that CNA-DD and CNA-EE received QAPI training. Surveyor asked NHA-A how staff are overseen to make sure education is provided per regulation. NHA-A replied the facility currently does not have a staff educator however, NHA-A has been doing interviews to hire a staff educator. NHA-A stated that one of the current unit managers has an educational background and has been helping with overseeing and making sure staff have the required training completed. On 2/4/2026, at 2:57 PM, Surveyor shared concern with NHA-A that CNA-DD and CNA-EE did not have the required QAPI training. No additional information was provided at the time of this write up.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 6 (R6, R1, R49, R5, R58, and R38) of 14 residents care plans reviewed were revised accordingly. *R6 had a stage 3 pressure injury to the sacrum that healed and re-opened twice. R6's pressure injury care plan was not revised with interventions to prevent R6's sacral injury from reopening or prevent further decline. R6 developed stage 2 to the left ischium and a stage 2 pressure injury that declined to stage 3 to the right ischium. R6's pressure injuries to the left and right ischium were not addressed on the care plan, along with interventions to prevent further decline. R6's refusal to interventions to offload heels and be repositioned were not addressed in R6's care plan. *R1 developed a Deep Tissue Injury (DTI) on their left buttock on 1/13/26. The DTI to the left buttock was not identified on the care plan, along with interventions to prevent further decline. R1 was admitted to the facility on [DATE] with 2 antibiotics, and 1 antiviral medication, to treat health concerns. These medications were not identified on the plan of care for interventions for their targeted health concern, along with side effects of medication use. *R49 developed a stage 3 pressure injury on their sacrum on 12/16/25. The stage 3 sacrum pressure injury was not identified on the plan of care, along with interventions to prevent further decline. *R5 was observed with a left palm guard in use during the survey. This left palm guard was not identified on the plan of care, along with interventions for proper use and care. R5 had developed a wound on the sole of their left foot on 12/24/25. This wound was not identified on their plan of care, along with appropriate interventions to promote healing. R5 had unwitnessed falls in the facility on 11/19/25, 11/30/25, 12/4/25, 12/16/25, 12/26/25 and 12/28/25. The care plan did not identify interventions for prevention of further falls. *R58 had an unwitnessed fall on 12/27/2025 at 4:30 PM and was admitted to the hospital that day with a fractured distal fibula (right) for surgical repair. No revisions to the Falls Care Plan were initiated to address prevention of future falls. *R38 had an unwitnessed fall on 12/8/2025 at 10:35 AM. R38's Falls Care Plan was revised on 12/16/2025, eight days after the fall, with an intervention that did not address the cause of the fall. Findings include: The facility policy titled Care Plans- Comprehensive Person-Centered last revised 10/2021 and approved 1/2026 documents: Policy Statement: A comprehensive, person- centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs, that are identified through evaluation and assessment, is developed and implemented for each resident. Policy Interpretation and Implementation:A. The interdisciplinary (IDT) team, in conjunction with the resident and/or resident representative, develops and implements a comprehensive, person-centered care plan for each resident.B. The care plan interventions are (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	derived from a thorough analysis of the information gathered as part of the comprehensive assessment.I. The comprehensive, person-centered care plan will: .2. Describe the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being.8. Incorporate identified problem areas.9. Incorporate risk factors associated with identified problems.11. Reflect the resident's expressed wishes regarding care and treatment goals.14. Aid in preventing or reducing decline in the resident's functional status and/or functional levels.16. Reflect currently recognized standards of practice for problem areas and conditions.J. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. K. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the residents are the end point of an interdisciplinary process.N. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 1.) R6 was admitted to the facility on [DATE] with diagnoses that include metabolic encephalopathy, sever protein-calorie malnutrition, type 2 diabetes with polyneuropathy, anxiety, . and malignant neoplasms of the right and lower limbs. R6's quarterly minimum data set (MDS) dated [DATE] indicated R6 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 8 and the facility asses R6 being totally dependent on 1 staff member for toileting and personal hygiene, and repositioning. R6 was admitted to the facility receiving hospice services and had stage 3 pressure injury to the sacrum. (Please cross- reference F686) R6's history of stage 3 pressure injury to the sacrum . and at risk for further pressure injuries and skin concerns related to immobility, malnutrition, incontinence care plan was initiated on 8/13/2024 with the following interventions:- Braden scale to be completed.- Keep bed linens wrinkle free and do not use excess pads.- Observe skin for redness and breakdown during routine care.- Use pressure relieving devices, cushion on wheelchair and off of heels.- Follow community skin care policy.- Treatment, as indicated, see physician order sheet.- Pressure reducing mattress on bed. Low air loss mattress, setting #3. Surveyor noted R6's pressure injury care plan was not revised with interventions to prevent further pressure injuries from developing. Surveyor notes R6's sacral pressure injury resolved on 10/22/2024. On 4/24/2025 R6's sacral region, stage 3 pressure injury re-opened. Surveyor notes R6's care plan was not revised to indicate R6's sacral pressure injury re-opened or identified interventions to promote healing. Surveyor notes on 4/28/2025 R6's sacral pressure injury resolved. On 1/27/2026, at 12:36 PM, surveyor interviewed wound registered nurse (WRN)-I who stated R6's sacral wound most likely re-opened because the facility had gotten rid of the air mattresses for residents that were enrolled on Hospice and stated Hospice had to supply the air mattresses. WRN-I was not sure how long R6 was without an air mattress or if the facility waited to switch the mattresses. WRN-I stated the first time WRN-I saw R6's re-opened sacral wound; the sacral wound was already resolved on 4/28/2025. WRN-I could not remember if R6 was on an air mattress at that time. WRN-I stated if R6 was not on an air mattress at that time then WRN-I would have arranged to have one put on since that is always an intervention WRN-I makes sure is implemented right away. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/22/2026, care plan was not revised to indicate R6 refuses repositioning and offloading and interventions were not revised per R6's preference to prevent R6's pressure injury decline or further development of other pressure injuries. No further information was provided at the time of this write up. (Please cross reference F686) *) R46 was admitted to the facility on [DATE] with diagnoses that include Parkinsons disease, type 2 diabetes, dementia with anxiety, generalized muscle weakness, repeated falls. and protein-calorie malnutrition. R46' admission Minimum Data Set (MDS) dated [DATE] indicated R46 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 0. R46's . at risk for pressure ulcers and other skin related injuries related to immobility, incontinence, malnutrition, diabetes, and impaired cognition care plan was initiated on 11/25/2025 with the following interventions:- Braden scale to be completed.- Keep bed linens wrinkle free and do not use excess pads.- Observe skin for redness or breakdown during routine cares.- Use pressure injury devices, cushion on wheelchair and off of heels, as indicated.- Follow community skin care policy.- Treatments, as indicated, see physician order sheet.- pressure reducing mattress on bed. On 12/11/2025, nursing documented a fluid filled blister to R46's right heel. Surveyor noted R46's pressure injury care plan was not revised after developing a blister to the right heel on 12/11/2025 until 12/16/2025 (5 days later), with the following interventions:(R46) has impaired skin integrity related to pressure wound to right heal-- Provide treatment as ordered.- Pressure reducing cushion to chair. Describe: gel matrix.- Maintain head of bed at lowest degree appropriate for resident's clinical condition, ideally 30 degrees or less.- Educate resident and/or family to the importance of frequent turning/shifting and repositioning.- Minimize force and friction applied to skin.- Registered dietician consult.- Assess and evaluate wound size, depth, color, and drainage present every week.- Assist/teach to reposition self to reduce pressure (shifting own weight or turning)- Float heels when in bed.- Specialized mattress on bed. Type: low air loss and setting #2. On 1/20/2026, R46's right heel declined to a stage 3 pressure injury. Surveyor noted R46's care plan was not reviewed/revised to implement interventions to prevent decline of R46's pressure injury or to prevent new areas from developing. On 1/26/2026, at 2:33 PM, Surveyor interviewed wound registered nurse (WRN)-I who stated the pressure injury care plan that is initiated on admission is very basic and all the interventions implemented are basic and not patient specific. WRN-I stated if find an area of concern for a resident, then an individualized care plan is revised to be patient specifically, otherwise WRN-I does not look at resident care plan. Surveyor asked WRN-I how R46 developed a right heel pressure injury. WRN-I feels R46 developed a pressure injury to the right heel due to R46 being weak and would sit in the wheelchair with legs extended and all the weight on R46's heels. WRN-I stated R46 was not aware of R46's surrounds majority of the time and needed to be redirected on what to do, so staff would have to remind R46 not to put pressure on R46's heels, however R46 would often refuse interventions. Surveyor noted refusals for treatments and offloading of heels were documented in the progress notes, however there were no care plan revisions to indicate R46 refuses treatment and cares at time, no revisions were made to R46's care plan per R46 preference for offloading. On 1/27/2026, at 3:58 PM, Surveyor shared concerns with nursing home administrator (NHA)-A R46 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	developed a fluid filled blister to the right heel. There were revisions to the care plan until 12/16/2025 when wound care physician and WRN-I assessed R46 for the first time. R46's right heel declined to a Stage 3 pressure injury to the right heel. Surveyor shared concern the facility did not review or revise R46's care plan interventions to determine if appropriate or per R46's preference. R46's care plan did not reflect decline of R46's right heel pressure injury or refusals to treatment and cares. information was provided at this time. (Please cross- reference F686) R46's potential for falls related to immobility, impaired cognition, Parkinson's disease, incontinence, poor safety awareness, and medications care plan was initiated on 11/25/2025 with the following interventions:- Keep pathways clear and provide adequate lighting.- Keep bed at appropriate height.- Keep personal items within reach.- Orient to room and call light. On 12/25/2025, at 10:48, in the progress notes nursing documented (R46) witnessed by nurse at 10:30 (AM) on 12/25/2025. (R46) was noted sitting in upright position on coccyx with the assistance of 2 staff and gait belt. (R46) reached down to get something off the floor and slid out of R46's wheelchair. On 1/4/2026, at 3:51 (AM), in the progress notes nursing documented (R46) has been calling/ yelling out in R46's sleep [family members name] all shift, at approximately 1:00 AM (R46) was observed sitting on the floor in front of (R46's) bed. (R46) stated was trying to fly when asked what happened. (R46) was asked again how (R46) fell onto the floor, (R46) replied trying to get to the door and pointed to (R46's) bedroom door. Surveyor noted R46's care plan was not revised to prevent future falls from occurring on 12/25/2025 or 1/4/2026. (Please cross- reference F689) On 1/26/2026, at 10:19 AM, A Surveyor interviewed licensed practical nurse (LPN)-G who stated not knowing who or when the residents care plans get revised, LPN-G was not sure if LPNs were allowed to change or add to resident's care plans. On 1/26/2026, at 4:22 PM, Surveyor shared concerns with nursing home administrator (NHA)-A regarding R46's falls on 12/25/2025 and 1/4/2026 care plan interventions were not revised to prevent from happening again. On 1/27/2026, at 2:39 PM, Surveyor interviewed registered nurse unit manager (RNUM)-C who has been employed through contract for a couple weeks with the facility stated in the mornings the IDT gets together for morning huddle and address root causes of the falls. RNUM-C was unsure if the huddles were always occurring but are being completed as of late. RNUM-C stated management is trying to implement all units for nursing staff to implement interventions, then the IDT will review those interventions and make sure residents care plans are updated accordingly and all information from resident falls are included in the fall packet to review the root cause for the fall, if interventions were in place, if any else has to be completed, etc. 3.) R1 was admitted to the facility on [DATE] with acute and chronic respiratory failure, congestive heart failure and mantle cell lymphoma. R1's admission Minimum Data Set (MDS) completed on 12/3/25, assesses that R1 is at risk for pressure injury, and has no current pressure injury, requires partial to moderate assistance for transfers and bed positioning. The Braden Scale Assessment was completed on 11/25/25 and documents a 14 (very high risk). This assesses R1 as a high risk for skin breakdown/injury. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wheelchair. R58 was transferred to the hospital for evaluation and treatment and returned to the facility with no new orders. R58's Falls Care Plan was revised on 8/10/2025 with the intervention to re-educate R58 to call for assistance to ambulate to the bathroom and on 8/12/2025 with the intervention of a Call no Fall sign placed in room. On 12/28/2025 at 12:10 AM in the progress notes, nursing documented R58 had an unwitnessed fall at 4:30 PM when R58 rolled out of bed. A head-to-toe assessment was completed and R58's right leg was broken and actively bleeding. R58 was transferred to the hospital for evaluation and treatment. On 1/5/2026 at 9:49 PM in the progress notes, R58 was readmitted to the facility at 3:40 PM. R58's Falls Care Plan did not have any revisions after the unwitnessed fall on 12/27/2025. In an interview on 1/27/2026 at 2:39 PM, Registered Nurse (RN) Unit Manager (UM)-C stated the nurse on the floor does an assessment of a resident that has fallen and tries to figure out why the fall happened and puts an intervention into the resident's Falls Care Plan. RNUM-C stated the next day the interdisciplinary team, made up of the Nursing Home Administrator (NHA), the Director of Nursing (DON), the UMs, Physical Therapy, and the MDS nurse, review the fall investigation completed by the floor nurse, look at what intervention was implemented after the fall, and determine if that is an appropriate intervention or if a different intervention would be more fitting for the cause of the fall. RNUM-C stated the MDS nurse typically updates the Care Plan if needed. Surveyor shared with RNUM-C the concern R58's unwitnessed fall did not have any Falls Care Plan revisions to address the cause of the fall or to prevent future falls. No additional information was provided. 7.) R38 was admitted to the facility on [DATE]. R38's Falls Care Plan was initiated on 9/4/2025 with the 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. On 12/8/2025 at 3:08 PM in the progress notes, nursing documented R38 was found lying on the floor by staff at 10:35 AM. R38's Falls Care Plan was revised on 12/16/2025, eight days after the fall, with the intervention of a fall mat. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/22/2026 at 3:11 PM, Director of Clinical Operations (DCO)-F stated anyone on the clinical team can update a Care Plan and administration recognized last week the concern with resident Care Plans but have not had time to completely implement updating Care Plans. On 1/26/2026 at 1:54 PM, Surveyor shared with Director of Nursing (DON)-B the concern R38's Falls Care Plan was not revised timely, on 12/16/2025, with an intervention to address R38's fall on 12/8/2025. In an interview on 1/27/2026 at 2:39 PM, Registered Nurse (RN) Unit Manager (UM)-C stated the nurse on the floor does an assessment of a resident that has fallen and tries to figure out why the fall happened and puts an intervention into the resident's Falls Care Plan. RNUM-C stated the next day the interdisciplinary team, made up of the Nursing Home Administrator (NHA), the Director of Nursing (DON), the UMs, Physical Therapy, and the MDS nurse, review the fall investigation completed by the floor nurse, look at what intervention was implemented after the fall, and determine if that is an appropriate intervention or if a different intervention would be more fitting for the cause of the fall. RNUM-C stated the MDS nurse typically updates the Care Plan if needed. No additional information was provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) R66 was admitted to the facility on [DATE] with diagnoses of cellulitis to the right lower 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	housekeeper yelled out that someone was 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 R62 was put into bed. RNUM-C stated the vital signs were obtained when R62 was on the floor. RNUM-C stated R62 had range of motion to arms and legs, was alert, and could talk. Surveyor asked RNUM-C if R62 was able to move (continued on next page)

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Ascension Living - Lakeshore at Siena	5643 Erie Street Racine, WI 53402

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their arms and legs independently or did RNUM-C move their arms for them. RNUM-C stated RNUM-C helped R62 move their arms and there was no pain when they did that. RNUM-C stated R62 was not flaccid. RNUM-C stated Nurse Practitioner (NP)-U was in the facility at the time, so RNUM-C let NP-U know they were going to send R62 out. Surveyor asked RNUM-C if NP-U came and assessed R62. RNUM-C did not think so. Surveyor asked RNUM-C why RNUM-C called a local ambulance company rather than 911. RNUM-C stated R62 did not seem to be in distress. RNUM-C stated R62 was alert and speaking so did not feel 911 should have been called at any time. RNUM-C stated it looked like R62 had rolled directly out of bed, and the bed was not very high with the overbed table about a body width away from the bed. Surveyor asked RNUM-C who made the decision to call an ambulance rather than 911. RNUM-C stated RNUM-C could not remember why RNUM-C made the decision to call an ambulance. RNUM-C recalled R62 was hypotensive and thought R62 had an order for midodrine (to increase blood pressure) but R62 had not gotten their morning medications yet. RNUM-C stated maybe NP-U said to send R62 to the hospital. RNUM-C stated R62 was on Xarelto and being on a blood thinner would trigger them to call an ambulance. RNUM-C stated NP-U was the one who decided to send R62 to the ER. In an interview on 2/5/2026 at 2:04 PM, Surveyor asked NP-U if NP-U assessed R62 on 1/26/026 after the fall out of bed. NP-U stated NP-U was not in the facility when NP-U was notified of the fall. NP-U stated it was reported R62 had an unwitnessed fall and R62 had hit their head on the table. NP-U stated NP-U told the nurse to send R62 to the ER. Surveyor asked NP-U if NP-U specified if the nurse should call an ambulance service or 911. NP-U stated NP-U did not specify but would expect them to call 911. NP-U stated R62 hit their head and was on a blood thinner; NP-U would expect 911 to be called for those reasons. NP-U stated even if the neurological checks were normal and vital signs were normal, you do not know what is going on inside. Surveyor asked NP-U if R62's vital signs were provided. NP-U stated NP-U was not told any vital signs. In a phone interview on 2/9/2026 at 9:47 AM, Surveyor asked Medical Director (MD)-FF what is the expectation of staff when a resident is on a blood thinner and has a fall and hits their head. MD-FF stated first they should check for any injury such as abrasions or bleeding. MD-FF stated they would evaluate by looking for any outward injury and then the resident would need further imaging to determine what the findings are. MD-FF stated any time there is bleeding or a goose egg, a CT of the head would be ordered. Surveyor shared with MD-FF the situation of R62 being on an anticoagulant and falling out of bed hitting their head on the metal base of the overbed table with a blood pressure of 86/57 after the fall. MD-FF stated nursing should do an assessment like neurological checks to determine if there were any internal injuries. Surveyor shared with MD-FF in addition to the low blood pressure, R62 had an altered mental status. MD-FF stated the nurse should call the provider and 911 at the same time and the general guidelines of the facility should be followed. Surveyor shared with MD-FF nursing staff lifted R62 to get the table out from underneath, rolled R62 onto their back and the onto a sling, and lifted R62 into bed before calling the NP and the NP instructed them to send R62 to the hospital. The nursing staff called a local ambulance company and not 911. Surveyor asked MD-FF if 911 should have been called in this situation. MD-FF stated not calling 911 is a problem by itself. MD-FF stated they should have called 911 and sent R62 out; the facility needs a better process. In an interview on 2/9/2026 at 11:06 AM, Surveyor asked interim Director of Nursing (DON)-GG what DON-GG would expect nursing to do when they encounter an unwitnessed fall. DON-GG stated the nurse should put documentation into the computer charting system and notify the family and the physician. DON-GG stated the nurse should do an assessment to make sure the resident is safe and put in an intervention to prevent future falls. DON-GG stated the fall is brought to morning meeting where it is reviewed, what the situation is, what was happening at the time, how many previous falls (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident has had, and update the care plan making sure the process is followed. Surveyor asked DON-GG if someone falls face down, what would you expect staff to do. DON-GG stated the resident has to be assessed some way or another. DON-GG stated the nurse does not have to move the resident, they can assess by feeling or seeing the situation and they can call 911 to have them do the assessment. DON-GG stated if the nurse can assess and communicate with the resident, the resident does not have any extensive pain, and range of motion is within normal limits, it might be appropriate to get them where they can be assessed further by moving them to a better position or getting a pillow to make them comfortable. Surveyor shared with DON-GG the situation with R62 having a fall out of bed and landing on the metal base of the overbed table, being on an anticoagulant, having altered mental status, and a low blood pressure. DON-GG stated DON-GG would not want them to stay on the floor but would have expected the nursing staff to call 911. On 2/9/2026 at 1:43 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, interim DON-GG, and RNUM-C the concern R62's unwitnessed fall was not recognized as a change in condition with a visible abrasion to the forehead, on an anticoagulant, a blood pressure of 86/57 and pulse of 98, and an altered mental status; R62 was normally able to make needs known and after the fall was alert and oriented to person only. R62 was moved off the table base, rolled onto a mechanical lift sling, and moved into bed and then the NP was notified of the fall but was not given any vital signs per NP interview. The NP told the nurse to send R62 to the hospital and the nurse called a private ambulance service and not 911 as the NP would have expected, which delayed care to R62. Surveyor shared the concern RNUM-C did not recognize R62's change in condition. No further information was provided at that time. 4.) 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. 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. An assessment was completed and R38 complained of pain to the back rating the pain 10 out of 10. No injuries were observed and R38 was transferred back to bed using a full body mechanical lift. Surveyor notes this was an unwitnessed fall. R38's neurological assessments were documented on the Neuro Assessment flow sheet. The flow sheet 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. R38 had neurological assessments completed at the following times: 10:35 AM, 10:50 AM, 11:05 AM, 12:20 PM, 12:50 PM and 1:20 PM. No further neurological assessments were documented. Surveyor noted the first four assessments should have been completed in one hour and the 12:20 PM assessment should have been completed and 11:20 AM followed by every half hour assessments. &nbs

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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 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R61's Hydroxyzine order. LPN-E informed Surveyor, LPN-E clarified R61's medication order after R61's 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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*10/19/2025- 8 AM dose given at 9:45 AM. *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, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/27/2026 at 3:51 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, Director of 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility did not store medications in the proper temperature potentially affecting 25 of 53 residents. The medication refrigerators in one of two medication storage rooms were consistently colder than the recommended range for temperature. Findings include: On 1/26/2026 at 1:28 PM, Surveyor accompanied Registered Nurse Unit Manager (RNUM)-C into the medication storage room on the west side of the facility. The medication storage room had two refrigerators, a full-sized refrigerator with a freezer and a small compact refrigerator. Medications were stored in both refrigerators, such as insulin and intravenous medications. The temperature logs were located on the front of each refrigerator. The top of the temperature log documented: Temperatures are logged daily, temperatures out of range 2 degrees-8 degrees C (Celsius) and 36 degrees-46 degrees F (Fahrenheit) are re-checked and action is logged. The January temperature log for the full-sized refrigerator had temperature documentation for 17 out of 26 days. 16 out of 17 of those documented temperatures were below 36 degrees F. Surveyor observed the thermometer inside the full-sized refrigerator to read 30 degrees F. The January temperature log for the compact refrigerator had temperature documentation for 20 out of 26 days. 16 out of 20 of those documented temperatures were below 36 degrees F. Surveyor observed the thermometer inside the compact refrigerator to read 34 degrees F. Surveyor showed RNUM-C the concern with the refrigerator temperatures and the concern they had not been maintained at the proper temperatures. RNUM-C agreed the refrigerators were not at the correct temperatures and stated upper management would be made aware. On 1/26/2026 at 4:26 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern the refrigerators in the med storage room on the west side were not being maintained at the correct temperature with temperatures ranging from 29-35 degrees F. No further information was provided at that time.

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R17) of 14 residents reviewed received the right to self-determination through support of resident choice. The facility failed to accommodate R17's preference for a morning shower. Findings include:The facility policy titled Quality of Life - Self Determination and Participation dated 12/2016 with last revised date 12/2021 documents: . Our community respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. each resident chooses activities, schedules and health care that are consistent with his or her interests, values, assessments and plans of care, including: . daily routine, such as sleeping and waking, eating, exercise and bathing schedules . include information gathered about the resident's preferences in the care planning process . R17 admitted to the facility 10/11/2022 with diagnoses including anxiety, unspecified dementia, depression, and need for assistance with personal care. R17's quarterly Minimum Data Set (MDS) dated [DATE] documents R17 requires maximal assistance for showers, and R17 has a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R17's activities of daily living (ADL) care plan dated 10/25/23 documents the following interventions:-bathing: I need extensive assistance with 1 person staff support. I prefer a shower, start date 10/25/23-[R17]'s assisted showers are scheduled for Saturday AM (morning) and Wednesday AM, start date 4/18/24In an interview on 1/20/26 at 1:55 PM, R17 stated R17 prefers showers in the morning but R17's current shower schedule is Tuesday evening and Saturday morning. R17 stated R17 has requested to have the shower schedule changed to two times per week in the mornings, but the facility has not accommodated that change. On 1/22/26 at 9:22 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-N regarding resident shower schedules. LPN-N stated there is a weekly schedule for all residents on the unit and provided Surveyor with the current shower schedule for the residents on the unit. Surveyor noted the shower schedule documents R17 is scheduled to receive a shower on Saturday AM shift and Tuesday PM shift. In an interview on 1/22/26 at 12:28 PM, R17 stated R17 does not like showers on the PM shift because R17 does not like to go to bed wet, so R17 tells staff R17 does not want a shower when staff come on Tuesday evenings. R17 states R17 is not offered a shower outside of the scheduled Tuesday PM and Saturday AM days. R17's daily charting in the medical record for December 2025 and January 2026 documents no as the response to the question did resident receive a shower and/or bath on the following Tuesdays: 12/16/25, 12/23/25, 1/13/26, and 1/20/26. Surveyor notes no progress note in R17's medical record dated 12/16/25 documenting R17's refusal for a shower or if a shower was offered to R17 on an alternative date or time. A progress note dated 12/23/25 documents R17 refused the shower because R17 does not want R17's hair wet. Surveyor notes no documentation regarding if a shower was offered to R17 on an alternative date or time or alternate options to shower without getting R17's hair wet. A progress note dated 1/13/26 documents R17 refused the shower because R17 has a cold. Surveyor notes no documentation regarding if a shower was offered to R17 on an alternative date or time.A progress note dated 1/20/26 documents R17 refused the shower because the weather is too cold and R17 does not want to go to bed with hair wet or being cold. Surveyor notes no documentation regarding if a shower was offered to R17 on an alternative date or time.Surveyor notes no revisions were made to R17's care plan regarding receiving showers on Tuesday PM shift or alternative interventions if R17 refuses a shower. On 1/26/26 at 1:22 PM, Surveyor interviewed Registered Nurse (RN) Unit Manager (RNUM)-C regarding resident shower schedules. RNUM-C stated the shower schedule is determined by room and the facility should accommodate resident preference for shower schedule. On 1/26/26 at 1:30 PM, Surveyor interviewed RNUM-T, the unit manager for R17's unit. RNUM-T stated the shower schedule should accommodate (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident preference for AM or PM showers. Surveyor shared concern with RNUM-T that R17's preference for morning showers was not being accommodated, and RNUM-T responded RNUM-T would speak to R17 to determine R17's preferred shower schedule. On 1/26/26 at 1:37 PM, Surveyor interviewed Director of Nursing (DON)-B in regard to resident preference for bathing schedules. DON-B stated resident preference should be honored and if the schedule needs to be adjusted, the facility will rework the shower schedule to accommodate resident preference. Surveyor shared concern with DON-B that R17's preference for morning showers was not being accommodated. DON-B stated the facility has changed R17's shower schedule multiple times, but DON-B states anytime R17's shower schedule is changed, R17 has an excuse for refusing the second weekly shower offered. DON-B did not provide any other information regarding why R17's preference for morning showers was not being accommodated. On 1/27/26 at 9:03 AM, NHA-A provided a copy of a progress note dated 1/26/26 at 4:36 PM, to Surveyor which documents RNUM-T spoke with resident regarding shower days . resident was asked what day R17 would like a shower and resident responded Saturday and Wednesday day shift . RNUM-T updated resident that Wednesday AM shower would be fine. NHA-A also provided Surveyor a copy of an updated shower schedule which documents R17's shower schedule was changed to Wednesday AM instead of Tuesday PM.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R7) of 1 resident reviewed for grievances received corrective actions taken by the facility.R7 filed a grievance with the facility on 2/18/25, and there is no evidence that corrective action was taken by the facility to resolve the grievance. Findings include:The facility policy titled Complaints and Grievances dated 11/2017 with last revised date 6/2025 documents: It is the policy of [Facility Name] to provide residents and family members/legal representatives the opportunity to voice complaints and grievances free from restraint, interference, coercion, discrimination or reprisal. acknowledgment of grievance will be provided to complainant when available as soon as possible but no later than 5 working days from date or receipt . issuing of a final decision in writing on all grievances will be provided to the complainant when available within a reasonable time frame but not to exceed 30 days from date of receipt.R7 admitted to the facility on [DATE] with diagnoses including age-related physical debility, anxiety disorder, and depression. R7's quarterly Minimum Data Set (MDS) dated [DATE] documents R7 has a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. In an interview with R7 on 1/20/2026 at 1:35 PM, R7 stated two pairs of pants went missing from R7's room a while ago and were never found. R7 stated R7 talked to everyone R7 could at the facility regarding the missing pants, but nothing was done and R7 stated R7 was upset about the missing pants. Surveyor reviewed the facility's grievance log January 2025-January 2026 and identified a grievance filed by R7 dated 2/18/25 in regard to two pairs of missing pants. The grievance documents Director of Facilities Management (DFM)-W looked through the laundry room and the facility-contracted laundry area, but the pants were not located. The grievance documents the grievance was confirmed, and the corrective action to be taken by the facility is buy new pants for R7. In an interview with R7 on 1/22/2026 at 9:12 AM, R7 stated R7 remembered filing the grievance with the facility about the missing pants, but stated the facility never bought new pants or provided money to purchase new pants. On 1/22/2026 at 9:55 AM, Surveyor interviewed Social Services-X who confirmed Social Services-X oversaw grievances at the facility. Social Services-X was not aware of the grievance filed by R7 on 2/18/25, as Social Services-X was not working at the facility at that time but would look into if any new pants were purchased for R7. No further information was provided to Surveyor from Social Services-X and Social Services-X's last day working at the facility was 1/23/2026.On 1/22/2026 at 2:17 PM, Surveyor interviewed DFM-W who completed the grievance form for R7 on 2/18/25. DFM-W confirmed no pants were located for R7, and the resolution was for the facility to buy new pants for R7. DFM-W was not aware if any pants were purchased or not. On 1/26/2026 at 4:22 PM, Surveyor shared concern with Nursing Home Administrator (NHA)-A that the grievance resolution for R7's missing pants was not followed up on by the facility. NHA-A stated if Social Services-X was unable to provide any further information, there likely is no other information available. On 1/27/26 at 1:26 PM, NHA-A provided Surveyor with an email printout from Business Office Manager (BOM)-O stating no issued checks or check requests were found for R7 between January 2025 and April 2025.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 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 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 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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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 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 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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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 interview and record review, the facility did not ensure 2 (R58 and R7) of 2 residents reviewed for transfer and bed hold notices were notified of the reason for transfer to the hospital and bed hold policy in writing to the resident and/ or their representative and the rate to reserve the resident's bed was not provided to the resident and/ or their representative. A bed hold rate is not provided to residents on Medicaid. *R58 was transferred and admitted to the hospital on [DATE] for further evaluation. A transfer notice and bed hold form were not provided in writing, and a bed hold rate was not provided to R58 and/or R58's representative. *R7 was transferred and admitted to the hospital on [DATE] and 11/11/2025 for further evaluation. A transfer notice and bed hold form were not provided in writing, and a bed hold rate was not provided to R7 and/or R7's representative. Findings include: The facility policy titled Bed-Holds and Returns last revised on 12/2017 with an approval date of 1/2026 documents: At the time of transfer for hospitalization or therapeutic leaves, nursing facility must provide to the residents or residents representatives written notice which specifies the duration fo [sic] the bed hold. Policy Interpretation and Implementation: .2. The current bed-hold and return policy established by the state (if applicable) will apply to residents in the community.3. Prior to transfer, written information will be given to the residents and the resident representatives that explains in detail: a. The duration of the bed-holdb. The reserve bed payment policy as indicated by the state planc. The details of the transfer (per the Notice of Transfer). 1) R58 was admitted to the facility on [DATE]. R58's admission Minimum Data Set (MDS) dated [DATE] indicated R58 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 14 and R58 was their own person. On 12/27/2025 in the progress notes nursing documented R58 had a fall out of bed and was transferred to the hospital for further evaluation. R58 was admitted to the hospital for surgical intervention. (Cross reference F689) On 1/5/2025, R58 was readmitted to the facility. On 1/21/2026, Surveyor reviewed R58's medical record and could not locate a bed hold notice or transfer notice for R58's admission to the hospital on [DATE]. On 1/21/2026, at 3:05 PM, Surveyor requested to review the bed hold/transfer notice for R58's hospitalization on 12/27/2025. On 1/22/2026, at 9:24 AM, A Surveyor interviewed licensed practical nurse (LPN)-N who stated if a resident goes out to the hospital, the nurse calls the physician to get an order to send the resident out and a transfer form gets sent to the hospital with the resident. LPN-N is not aware of what happens to that form after it is put into the resident's transfer packet to the hospital or if a copy is provided to (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident or residents representative. LPN-N stated a copy of the transfer form is not completed, nursing just sends the form and what happens after that LPN-N is not aware. On 1/22/2026, at 12:20 PM, nursing home administrator (NHA)-A provided Surveyor with an email sent by business office manager (BOM)-O documenting R58 did not require a bed hold notice because R58's payer source is Medicaid and Medicaid will pay for a bed hold for 15 days. NHA-A also could not locate a transfer notice for R58's transfer to the hospital on [DATE]. On 1/26/2026, at 9:55 AM, Surveyor interviewed BOM-O who stated nurses send the transfer notice with the resident at the time of being transferred. BOM-O stated a copy of what is sent with the resident is not provided to BOM-O. BOM-O will call the resident or resident representative to discuss the bed hold rate verbally and document the verbal consent on the bed hold agreement. BOM-O stated the bed hold agreement is then scanned into the medical record for the resident. BOM-O stated a copy is not provided for the resident or resident representative unless it is requested. BOM-O stated nursing staff do the transfer notices and is not sure of what that process is. Surveyor asked BOM-O if a bed hold notice is provided for a resident that has Medicaid. BOM-O stated a bed hold agreement is not provided for a resident that receives Medicaid because Medicaid automatically with hold the bed for 15 days. Surveyor asked what if a resident required hospitalization past the 15 days. BOM-O stated would have to contact the regional office for further guidance in the matter. On 1/26/2026, at 4:22 PM, Surveyor asked NHA-A what the process is for bed hold/transfer notices when a resident is sent to the hospital. NHA-a stated bed holds are handled by the business office, and the transfer notices are handled by the nursing staff. Surveyor asked if the bed hold/transfer notice is provided in writing to the resident and/or resident representative. NHA-A stated a copy of the transfer notice/bed hold rate should be getting mailed out and/or given to the resident but will double check to make sure that is being completed. NHA-A stated if a copy is requested the facility can provide copies. Surveyor shared concern that a bed hold rate and transfer notice were not provided for R58 and/or R58's representative when R58 was transported and admitted to the hospital on [DATE] and a bed hold rate should be provided regardless of the resident's payer source. No further information was provided at the time of this write up. 2). R7 was admitted to the facility on [DATE]. R7's quarterly Minimum Data Set (MDS) dated [DATE] documents R7 has a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R7 has an activated healthcare power of attorney (POA). R7 was hospitalized on [DATE] until 9/17/25 for low blood pressure. Surveyor reviewed R7's electronic health record (EHR) and did not locate a notice of transfer or bed hold notice on 9/15/25. R7 was hospitalized on [DATE] until 11/12/25 for chest pain and difficulty breathing. Surveyor reviewed R7's EHR and did not locate a notice of transfer or bed hold notice on 11/11/25. On 1/22/26 at 8:52 AM, Surveyor requested copies of R7's transfer and bed hold notices from the 9/15/25 and 11/11/25 transfers from Nursing Home Administrator (NHA)-A. On 1/22/26 at 9:24 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-N who stated when a resident is transferred to the hospital from the facility, a transfer form and bed hold notice is filled out and gets sent with the resident to the hospital. LPN-N stated if the resident has a POA, the POA would be notified of the transfer, but was not aware if a copy of the transfer and bed hold notice is (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided to the POA. LPN-N stated a copy of the transfer and bed hold notice is not kept at the nurse's station and was not sure where a copy would be kept at the facility. On 1/22/26 at 12:20 PM, NHA-A provided Surveyor with a printed statement from Business Office Manager (BOM)-O which documents R7's hospitalization did not require a bed hold agreement due to being on Medicaid services. On 1/26/26 at 9:55 AM, Surveyor interviewed BOM-O who stated the nurse working the floor is responsible for filling out the transfer notice and for sending the form with the resident to the hospital, which includes information regarding the bed hold policy. BOM-O stated if a resident has a POA, verbal consent to hold the bed would be documented on the bed hold notice form. BOM-O stated BOM-O typically keeps a copy of the bed hold notice and scans the form into the resident's EHR. BOM-O stated if a resident has Medicaid as a payment source, a bed hold is not typically issued to the resident since the bed gets held for 15 days automatically. Surveyor shared concern with BOM-O that Surveyor was unable to locate a transfer notice or bed hold form for R7's hospitalizations on 9/15/25 or 11/11/25. BOM-O stated since R7 has Medicaid, there is no bed hold form for R7. BOM-O was not sure if the transfer notice is provided to a resident's POA in writing. On 1/26/26 at 4:22 PM, Surveyor shared concern with NHA-A that Surveyor was unable to locate evidence that R7's POA was provided a transfer notice or bed hold notice in writing when R7 was hospitalized on [DATE] or 11/11/25. NHA-A stated the POA is made aware of the transfer and bed hold verbally but would have to verify if the notices were provided in writing. No further information was provided.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility did ensure a resident was provided the appropriate care and services with a mobility device. This was observed with 1(R5) of 3 residents reviewed with mobility devices.R5 was observed with a left palm guard device. There was not a documented assessment for use and care of this device.Findings include:The facility policy and procedure Restorative Nursing Splint/Brace Assistance Program dated 1/2026. The Policy Statement documents: residents who have been fitted for a splint or brace are assessed by nursing and or therapy for a Restorative Nursing Splinting Bracing Program to promote independence and quality of life by maintaining or improving a resident's correct alignment through application of splint/brace.The Policy Interpretation and Implementation documents:C. Care plan includes but is not limited to:1. measurable goals:a. Amount of self-performance encouraged;b. Increased resident independence with splint/brace application and care;c. Maintain skin integrity of the skin under/in contact with the splint/brace;d. Prevention of contractures; ande. Encourage use of splint/brace during the day.R5 was admitted to the facility on [DATE] with a diagnosis of stroke with left sided weakness. The admission Minimum Data Set (MDS) assessment completed on 11/24/25 and assesses R5 to have limited mobility on one side of their upper and lower extremities, dependent on staff for dressing and hygiene and have cognitive impairment.On 01/20/2026, at 10:05 AM, Surveyor observed R5 in their wheelchair in their room. R5 had a palm guard on their left hand. On 01/21/2026, at 10:24 AM, Surveyor observed R5 in their wheelchair in therapy room. R5 had a palm guard on their left hand.R5's Plan of Care (POC) does not document the use of a palm guard in the left hand. The Certified Nursing Assistant (CNA) Care List also does not identify the use of a left-hand palm guard.R5's Physician Orders POC does not document the use for a palm guard in the left hand.On 1/22/26, at 3:11 PM, at the facility exit meeting with Nursing Home Administrator (NHA) - A and Director of Clinical Operations (CO)- F. Surveyor requested any addition information for R5's left palm guard.On 1/26/2026, at 9:32 AM, Director of Nurses (DON)-B told Surveyor they are going to ask therapy about the palm guard in the left hand. DON-B did not have any information about the mobility device. On 1/26/2026, at 10:22 AM, Surveyor interviewed Certified Occupational Therapist Assistant (COTA)-JJ. COTA-JJ stated they are trialing the palm guard to decrease tone. COTA-JJ was directed to trial this by Director of Rehab (DOR)- DD. On 1/26/2026, at 10:23 AM, Surveyor interviewed DOR-DD. DOR-DD stated they got a request from a Doctor (this Doctor is not documented anywhere in the medical record) for the palm guard. DOR-DD stated the process is the nurses let therapy know there is an order; therapy staff assesses, and nursing does the care planning. Surveyor requested a copy of the doctor's order and the Therapy Assessment that was completed. On 1/26/26 Surveyor received a Physician Order dated 1/23/26 from R5's Primary Physician. The order documents: Palm Protector (left/beige) twice a day, apply palm protector to left hand at HS (hour of sleep) remove in AM (morning), cleanse hand and report any changes in skin integrity to the nurse. For muscle weakness. Surveyor notes R5's palm guard physician's order was obtained after Surveyor inquired about R5's palm guard. R5'sTherapy recommendations dated 1/23/26 documents: Apply palm protector to left hand twice a day, at HS, remove in AM. Cleanse hand and monitor skin integrity. Decrease risk of contractures.On 1/26/26, at 3:44 PM, at the facility exit meeting with NHA-A, DON-B and Quality Director (QA)- L. Surveyor shared the concerns with R5's palm guard and not having physician orders for use/service and not included in R5's care plan.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure 1 (R67) of 4 residents reviewed received appropriate treatment and services related to catheter care.R67 was admitted to the facility on [DATE] with an indwelling catheter. R67 did not have a baseline catheter care plan initiated and observations were made of R67's catheter not having a privacy cover on it per R67's preference.Findings include:The facility policy titled Care Plans- Baseline last revised 7/2020 with an approval date of 1/2026 documents: A baseline plan of care that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care should be developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation:A. A baseline care plan should be developed within forty eight (48) hours of the resident's admission to meet and maintain the resident's immediate care needs.B. The baseline care plan should include a review of the health care providers orders . and be implemented to meet the resident's immediate care needs .C. The baseline care plan should be used until the associate can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan.R67 was admitted to the facility on [DATE] and has diagnoses that include displaced intertrochanter fracture of the left femur with surgical repair, and urine retention. R67's admission Minimum Data Set (MDS) dated [DATE] indicated R67 has intact cognition with a Brief Interview for Mental Status (BIMS) score 15. R67 was admitted with an indwelling catheter and was their own person.On 1/20 2026, at 11:07 AM, Surveyor observed R67 being pushed in a wheelchair down the hallway. R67's catheter bag was dragging on the floor without a protective barrier (cross reference F880) and did not have a privacy cover on the catheter bag.On 1/20/2026, at 12:50PM, Surveyor observed R67 sitting in a wheelchair in R67's bedroom. R67's catheter bag was hanging on the bottom of the wheelchair seat without a protective barrier on the catheter bag.Surveyor reviewed R67's medical record and could not locate R67's baseline care plan. Surveyor reviewed R67's comprehensive care plan and noted R67 did not have an indwelling catheter care plan initiated. Surveyor requested to review R67's baseline care plan when admitted to the facility on [DATE].Surveyor received the comprehensive care plan for R67. Surveyor noted there was not a catheter care plan initiated for R67's indwelling catheter on admission.Surveyor reviewed R67's physician orders and noted the following orders for R67's catheter:1.Change indwelling catheter and change bag as needed for clinical indications such as infection, obstruction, or when closed system is compromised as needed (Order date: 1/15/2026)2. Cather Care every shift.(order date: 1/15/2026)Surveyor noted there is no documentation to identify the size or type of catheter R67 currently has or what to use in event R67 needs to have catheter replaced.On 1/21/2026, at 7:43 AM, Surveyor noted R67 lying in bed sleeping. R67's catheter bag was hanging on the right side of R67's bed, was visible from the hallway, and the catheter bag did not have a privacy cover on it.On 1/21/2026, at 10:24 AM, Surveyor observed R67 sitting in a wheelchair watching tv. R67's catheter bag was hanging on the right side of the wheelchair, visible from the hallway, and not in a privacy bag. Surveyor asked R67 how long R67 has had a catheter. R67 stated R67 has had a catheter for a very long time. Surveyor asked R67 if R67 minded that other people were able to see R67's catheter bag or if R67 preferred a cover over the catheter bag. R67 stated R67 usually puts a cover over the catheter bag, but since being at the facility R67 has not had one. Surveyor asked if R67 preferred to have a cover over the catheter bag, R67 replied yes.On 1/22/2026, at 7:41 AM, Surveyor observed R67 sitting in a wheelchair in the dining room rating breakfast. R67's catheter bag was hanging on the right side of the wheelchair and did not have a privacy cover over the catheter bag.On 1/22/2026, at 10:44 AM, Surveyor interviewed licensed practical nurse (LPN)-P who stated they not sure why R67 does not have a privacy cover on R67's catheter bag. LPN-P stated some resident's have privacy (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	covers, and other residents do not have privacy covers. LPN-P stated not knowing where to get a privacy cover for the catheter bag. Surveyor asked who and when would a baseline care plan be initiated. LPN-P stated when a resident is admitted to the facility the nurse admitting the resident would be the one to initiate the baseline care plan and then other disciplines would add to it. Surveyor asked if R67 was admitted to the facility with an indwelling catheter, should that be something included on the baseline care plan. LPN-P stated if a resident is admitted with an indwelling catheter, then yes, it should be included on the baseline care plan. LPN-P stated multiple disciplines can revise the care plan and if a nurse noted the indwelling catheter care plan was not initiated on admission, then the nurse could initiate it at any time. On 1/22/2026, at 11:12 AM Surveyor interviewed registered nurse unit manager (RNUM)-C who stated if R67 was admitted with an indwelling catheter a catheter care plan should have been initiated on admission or soon after. RNUM-C was not sure why R67's catheter care plan had not been initiated yet. RNUM-C stated if a resident wants a privacy cover on their catheter bag, then they should have a privacy cover. RNUM-C was not aware R67 did not have privacy cover. Surveyor shared concerns with RNUM-C regarding R67 not having a privacy cover on the catheter bag and a baseline care plan was not initiated for R67 on admission.On 1/22/2026, at 3:11 PM Surveyor share concerns with nursing home administrator (NHA)-A of Surveyor's observations of R67's catheter not having a privacy cover per R67's preference, no documentation regarding what catheter size or type R67 has currently, no evidence R67's indwelling catheter was changed after observations of it lying and dragging on floor and management was notified, and a catheter baseline care plan was not initiated for R67 when admitted to the facility with an indwelling catheter. No further information was provided at the time of this write up,

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility did not ensure a resident received appropriate oxygen services and administration. This was observed with 1 (R1) of 2 residents reviewed with oxygen services.* R1 was observed receiving oxygen per nasal cannula during the survey. R1 did not have a physician order for oxygen administration, nor was it documented as being administered.Findings include:The facility policy and procedure Oxygen Administration dated 12/2025, The Purpose is to provide guidelines for safe oxygen administration. The Preparation documents:A. Verify that there is a physician's order for this procedure. Review the physician's orders or community protocol for oxygen administration.B. Review the residents care plan to assess for any special needs of the resident.C. Assemble the equipment and supplies as needed.:Documentation: .C. The rate of oxygen flow, route, and rationale.1.) R1 was admitted to the facility on [DATE] with acute and chronic respiratory failure, mantle cell lymphoma and congestive heart failure. R1 admission Minimum Data Set (MDS) completed 12/3/25 assesses R1 to have cognitive impairment and using oxygen therapy.On 1/20/2026, at 10:10 AM, Surveyor observed R1 in their room. R1 was receiving oxygen at 2 LPM (liters per minute) per nasal cannula. On 1/21/2026, at 10:26 AM, Surveyor observed R1 in the Therapy Room. R1 was in their wheelchair and was receiving oxygen at 2 LPM per nasal cannula. Surveyor notes R1's medical record did not have a physician order for oxygen administration and there was no documentation of administering oxygen. R1's Medication Administration Record since admission does not include oxygen administration orders or documentation.On 1/22/2026, at 9:40 AM, Surveyor interviewed the Registered Nurse (RN) -K who works on R1's unit. RN-K reviewed R1's Physician Orders with Surveyor. RN-K confirmed R1 did not have oxygen administration orders. RN-K stated there should be orders for the use of oxygen and it should be documented on the administration record. RN-K stated they will call the Nurse Practitioner. RN-K stated they do obtain a pulse oxygen saturation every shift.On 1/22/26, at 3:11 PM, at the facility exit meeting with the Nursing Home Administrator (NHA) -A and Director of Clinical Operations (DCO) -F Surveyor shared the concerns with R1's oxygen services.Surveyor received a Physician Order for R1, dated 1/22/26, which documented to administer oxygen at 1 - 5 liters per minute per nasal cannula to keep oxygen saturations above 90% as needed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not act upon the pharmacy medication review reports when received for 2 (R1 and R6) of 6 residents reviewed. *R1'S Medication Regimen Review Recommendations, dated 1/5/26, indicates they are receiving the antibiotic levofloxacin without a stop date. R1's Primary Care Physician signed the recommendation on 1/22/26 and referred to the prescribing Physician. This recommendation on 1/5/26 was not acted upon promptly. *R6's monthly pharmacy reviews noted a recommendation reported on 8/4/2025, 10/6/2025 and 10/7/2025. There was no documentation the attending physician acted upon the recommendations from the pharmacist. Findings include: The facility policy titled Procedure: Medication Regimen Review for Nursing last approved 12/2025 documents: Policy- The medication regimen of each resident is reviewed by a licensed Pharmacist according to Federal, State, and Local regulations as well as current standards of practice. The pharmacist reports any irregularities to the Attending Physician, the facility's Medical Director and Director of Nursing (DON), and these reports are acted upon in a manner that meets the needs of the residents.Facility/Attending Physician Procedure: .2.Non-Urgent recommendations: Upon receipt of the written consultant pharmacist's report of non-urgent recommendations, the DON or facility designee shall:a. Provide the report to the attending physician(s) or their designee.b. Attending physician or designee should ideally respond to the facility with 7 days of the pharmacist's review date, but no longer than 30 days.H. If the attending physician or their agent fails to address a recommendation or documents a rational for declining a recommendation:1. The DON or designee will be notified.2. The DON or designee will review the incomplete recommendation with the attending physician or their designee.3. A summary of outstanding recommendations shall be provided to the quality assurance and performance improvement (QAPI) committee on a periodic basis. 1) R6 was admitted to the facility 8/13/2024 and has diagnoses that include metabolic encephalopathy, generalized anxiety disorder, malignant neoplasms of the lower extremities, severe protein-calorie malnutrition, and insomnia. R6 is enrolled to receive Hospice services and care. On 1/22/2026, Surveyor requested to review R6's pharmacy medication review recommendations for the last 6 months (July 2025 – current). On 1/26/2025, Surveyor received R6's pharmacy medication review recommendations. Surveyor noted 3 documents containing recommendations that were not signed by a physician. R6's pharmacy medication review dated 8/4/2025 documents pharmacist recommendations that include:- (R6) has received Trazadone 50mg every night (QHS) for insomnia.- Please consider a trial discontinuation of trazodone.- If a gradual dose reduction (GDR) is clinically contraindicated at this time, this contraindication may be documented below in lieu of performing a GDR. Surveyor notes there is no documentation the recommendation was acted upon, or the physician was (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consulted with the recommendations. R6's pharmacy medication review dated 10/6/2025 documents pharmacist recommendation that includes:-(R6) receives an as needed (PRN) antipsychotic, prochlorperazine, with the following issue(s):- Antipsychotic PRN order is older than 14 days/lacks a valid stop date.- Please discontinue this PRN antipsychotic order -or-- Please provide a valid stop date in the directions of the order. Surveyor notes there is no documentation the recommendation was acted upon, or the physician was consulted with the recommendations. R6's pharmacy medication review dated 10/7/2025 documents the same concerns from the pharmacy review for 8/4/2025. Surveyor notes there is no documentation the recommendations were acted upon, or the physician was consulted with the recommendations. On 1/27/2026, at 2:39 PM, Surveyor interviewed registered nurse unit manager (RNUM)-C who stated she was not aware of the facility's process for pharmacy medication reviews, however, usually the DON either completes the recommendations or delegates to staff to complete once reviewed by the physician, but believes the process is driven by the DON. RNUM-C has not received any pharmacy recommendations to review or follow up on while employed with the facility. On 1/27/2026, at 3:58 PM, Surveyor shared concern with nursing home administrator (NHA)-A R6's pharmacy medication review recommendations for 8/4/2025, 10/6/2025, and 10/7/2025 were not reviewed by the physician. NHA-A acknowledged was aware of the concern and was unable to find any physician signed documentation indicating the pharmacy reviews had been addressed. No further information was provided at the time of this write-up. 2.) R1 was admitted to the facility on [DATE] with a diagnosis of acute and chronic respiratory failure, mantle cell lymphoma and pneumonia. The Physician Orders document upon R1's admission on [DATE]: Levofloxacin 500 mg (milligram) every day for pneumonia. (This is an antibiotic medication.) Surveyor notes R's Medication Administration Record correlates with the Physician Medication Orders. R1's Levofloxacin has been signed out as being administered in the months of 11/25, 12/25 and 1/26. Surveyor notes the antibiotic medication has no end date identified. R1's Medication Regimen Review Recommendation, from the Pharmacist, dated 1/5/26 documents the recommendation: antibiotic Levofloxacin has duration for use. The document has R1's Primary Physician signature and is dated 1/22/26 (17 days later) with a note to refer to the medication prescriber. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/26/2026, at 7:52 AM, Nursing Home Administrator (NHA) -A provided Surveyor with R1's Physician Assistant Progress Note dated 11/25/25 which documents the antibiotic Levofloxacin last day of use is 11/26/25 for pneumonia. R1's medication regimen review recommendation for Levofloxacin was not followed up on as recommended. Surveyor notes the Levofloxacin medication was administered upon admission to the facility and was noted it should have been discontinued on 11/26/25 per Physician Assistant progress note however the medication continued to be administered and the physician assistant progress note and pharmacy recommendations were not followed up on. On 1/27/2026, at 2:39 PM, Surveyor interviewed Unit Manager (UM)- C regarding the Pharmacist Recommendation process. The DON-B is not available for interview. The UM-C has only been at the facility for 3 weeks and is on a 30-day contract. The UM-C did not know anything about R1 antibiotic medication recommendations. The UM-C does not know the process in the facility for pharmacy recommendations. The Director of Nurses would follow up on them and should within a week of the review.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 2 (R1 and R67) of 7 residents drug regimen were free of unnecessary drugs. *R1's facility admission physician orders on 11/25/25 prescribe the following: Acyclovir 800 mg BID for pneumonia with no stop date, Levofloxacin 500 mg every day for pneumonia with no stop date and Bactrim-DS 800-160 mg 3 x week for Urinary Tract Infection (UTI) with no stop date. The diagnosis of these medications is listed on the Medication Administration Records for December 2025 and January 2026. The Physician Assistant (PA) Visit Note on 11/25/25 documents the Levofloxacin end of therapy is 11/25/25, and the Acyclovir and Bactrim-DS are prophylaxis for Mantle Cell Lymphoma which did not transfer to R1's MAR. *R67 did not have end dates ordered for an intravenous (IV) antibiotic (Vancomycin) or an oral antibiotic (Flagyl) when admitted to the facility on [DATE] until Surveyor brought to the facility's attention on 1/22/2026. R67 does not have a diagnoses or indication of use for receiving Flagyl antibiotic. Findings include: The facility policy titled Antibiotic Stewardship last revised 6/2025 documents: Policy: The [Facility company name] Antibiotic Stewardship Program's goals are to promote resident safety with the appropriate use of antibiotics, improve resident outcomes, and reduce antibiotic resistance and adverse events. Policy Interpretation and Implementations:1.Antibiotics shall be prescribed and administered to residents under the guidance of the community's Antibiotic Stewardship Program.Procedure: .5. If an Antibiotic is ordered, the physician/practitioner identifies the diagnosis/ indication for use, the appropriate antibiotic, proper dose, duration (stop date provided), and route.a. In the event that the prescribing practitioner orders an antibiotic without identification of infection criteria, the practitioner will identify rational for antibiotic use.6. If the resident was admitted to the facility with an antibiotic ordered, the nurse is to identify:a. Indication for use (diagnosis, lab/radiology results, symptoms, etc.)b. Documentation for dose, frequency, route and duration (ensuring stop date). 1) R67 was admitted to the facility on [DATE] and has diagnoses that include displaced intertrochanter fracture of the left femur with surgical repair, osteomyelitis of the right ankle and foot, . and type 2 diabetes with foot ulcers. R67's admission Minimum Data Set (MDS) dated [DATE] indicated R67 has intact cognition with a Brief Interview for Mental Status (BIMS) score 15. R67 was admitted with a peripherally inserted central catheter (PICC) line to the upper right arm to receive an antibiotic for right foot infection with Methicillin-Resistant Staphylococcus Aureus (MRSA) infection. On 1/21/2026, at 10:34 AM, Surveyor observed R67 sitting in a wheelchair in R67's bedroom. R67 stated having a line in the right arm to receive antibiotics for a foot infection. Surveyor observed a PICC line inserted in R67's right, upper arm. Surveyor reviewed R67's medical record and noted R67 was receiving:1.Flagyl tab 500mg (metronidazole, an antibiotic used to treat bacterial infections of the skin, respiratory tract, and gastrointestinal system)- Take 1 tab by mouth (PO) every 12 hours. 500mg PO twice a day (BID). (continued on next page)

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	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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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted there was not an end date for the antibiotic or a diagnosis or indication of use as to why R67 was receiving the antibiotic. 2. Vancomycin 750mg/ 250mL in 0.9% sodium chloride intravenous solution- 750mg/ 250mL intravenous (IV) every 12 hours for Methicillin Resistant Staphylococcus (MRSA) infection causing disease classified elsewhere. 750mg/ 250mL IV every 12 hours. Surveyor noted there was not an end date for the antibiotic. Surveyor reviewed R67's discharge summary paperwork from the hospital dated 1/15/2026. R67 diagnostic testing on the right foot and revealed septic arthritis and osteomyelitis of the first metatarsal (big toe) and proximal toes that revealed MRSA. R67 was initially started on a broad spectrum IV antibiotic (vancomycin) and transitioned to IV vancomycin and oral metronidazole for a planned 6-week course. Discharge Summary: (Page 10-11) . PICC in place, continue IV vancomycin and oral flagyl 500mg BID as per infectious Disease (ID). Total 6 weeks 1/9/2026 – 2/20/2026. On 1/22/2026, at 10:44 AM, Surveyor interviewed licensed practical nurse (LPN)-P who stated the admitting nurse would enter all the admission orders for the resident and the physician would sign off on the orders. Surveyor asked what staff would be in charge of getting end dates and diagnoses/ indication of use for antibiotics that a resident would be admitted with. LPN-P stated the admitting nurse or staff member that is working with the resident. LPN-P stated if an indication for use or end date is not included, then that is something that should be documented and obtained right away so other staff knows why the resident is receiving it or if there are other precautions that need to be in place. LPN-P stated R67 should have stop dates for both Vancomycin and Flagyl and an indication as to why R67 is taking the flagyl. On 1/22/2026, at 11:12 AM, Surveyor interviewed registered nurse unit manager (RNUM)-C who stated the admitting nurse would initially be in charge of making sure medications (specifically antibiotics, have an indication for use and end date. RNUM-C was not sure why R67 did not have stope dates for vancomycin or flagyl or an indication of use for the flagyl. RNUM-C stated when RNUM-C was auditing charts it was noted that there was not stop date for R67's vancomycin or flagyl and that it was on RNUM-C's list to do. On 1/26/2026, at 4:22 PM, Surveyor shared concerns with nursing home administrator regarding R67's IV vancomycin and Oral Flagyl antibiotics did not have end dates until Surveyor brought to the attention of staff, and R67's Flagyl does not have a diagnosis associated with it or an indication of use. No other information was provided at the time of this write-up. (Please cross-reference F881- Antibiotic Stewardship) 2.) R1 was admitted to the facility on [DATE] with a diagnosis of acute and chronic respiratory failure, mantle cell lymphoma and pneumonia. The Physician Orders document upon admission on [DATE]:-Acyclovir 800 mg(milligram) twice a day for pneumonia. This is an antiviral medication.-Levofloxacin 500 mg every day for pneumonia. This is an antibiotic medication.-Bactrim-DS 800-160 mg 3 x week for a urinary tract infection. This is an antibiotic medication. R1's Medication Administration Record correlates with the Physician Medication Orders. These medications are signed out as being administered daily on 11/25, 12/25 and 1/26. These medications (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	do not include a duration date or appropriate indications for use. On 1/20/2026, at 11:06 AM, Surveyor met with the Nursing Home Administrator (NHA)-A and Director of Nurses (DON)- B. Surveyor requested the last 3 months of facility infection surveillance records. NHA-A stated the Quality Director (QD)-L will be the designated Infection Preventionist for the facility and is still in training. On 1/21/2026, at 3:16 PM, Surveyor asked, NHA- A and DON-B, who are currently overseeing the facility Infection Control Program. Surveyor requested the facility infection surveillance. DON-B stated they are still in the process of compiling the data. On 1/22/2026, at 8:30 AM, NHA-A spoke with the Survey Team. NHA-A stated the DON-B is not here today. Any infection control questions NHA-A and QD-L will address. On 1/22/26, at 3:11 PM, at the facility exit meeting with NHA-A and Director of Clinical Operations (DCO)- F Surveyor requested information related to R1's antiviral and antibiotic medications. On 1/26/2026, at 7:52 AM, NHA-A provided Surveyor with R1's Physician Assistant Progress Note dated 11/25/25. This documents the antibiotic Levofloxacin last day of use is 11/26/25 for pneumonia. The Acyclovir and Bactrim-DS are prophylaxis for immune deficiency for the diagnosis of Mantle Cell Lymphoma. This is managed with Oncology. Surveyor notes R1's medication Levofloxacin was not ended as ordered. The Acyclovir and Bactrim-DS did not have the correct indications for use and monitoring.

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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.

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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.