STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure all alleged violations were reported immediately to the State Agency, but not later than 2 hours after the allegation is made if the events that caused the allegation involved abuse, for 1 of 2 Facility Reported Incidents (FRI) reviewed involving R6. On 2/9/26 at 11:00 PM, the Nursing Home Administrator (NHA)-A was made aware of an alleged instance of physical abuse involving R6 and Certified Nursing Assistant (CNA)-BB. NHA-A did not report the alleged incident to the State Agency until 2/10/26 at 6:16 AM. Findings include: The facility policy titled Abuse Prevention Program with effective date 1/23/26 and review date 1/23/26 documents: . As part of the resident abuse prevention, the facility's administration will: . protect our residents from abuse by anyone including, but not necessarily limited to facility staff . All covered individuals will receive annual written notification of their obligation to report reasonable suspicion of a crime against a resident, including required timeframes and penalties for failure to report. The facility will provide annual written notice to all covered individuals outlining these obligations and associated penalties. All covered individuals must report any reasonable suspicion of a crime against a resident to law enforcement and the state agency within: . 2 hours if serious bodily injury is involved. investigate and report all allegations of abuse within timeframes as required by federal and state requirements. All reports of resident abuse . shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Reporting . an alleged violation of abuse. will be reported immediately, but not later than: . two (2) hours if the alleged violation involves abuse.R6 was admitted to the facility 6/25/2015 with diagnoses including post-traumatic stress disorder (a mental health condition in people who have experienced or witnessed a traumatic event). R6 had a legal guardian appointed. R6's most recent minimum data set (MDS) assessment dated [DATE] documented R6 had a brief interview for mental status (BIMS) score of 15, indicating intact cognition.On 2/24/26 at 9:11 AM, Surveyor reviewed the Facility Reported Incident (FRI) regarding an allegation of physical abuse involving R6 on 2/9/26, time unknown, who alleged certified nursing assistant (CNA)-BB grabbed R6's arm and R6 felt CNA-BB's nails on R6's skin. Surveyor noted the initial allegation of abuse was submitted to the state agency on 2/10/26 at 2:16 pm. The facility documented in the conclusion of the investigation: The facility was unable to conclusively determine that the scratch was from physical contact between the resident and CNA due to varying statements. Through investigation, it is prudent to deduct the scratch occurring from the CNA making contact with the resident's arm. Due to the facility's ability to substantiate inappropriate use of language, the facility terminated [CNA-BB] on 2/16/26.On 2/24/26 at 11:53 AM, Surveyor spoke with Licensed Practical Nurse (LPN)-AA via phone call, who reported R6's allegation of potential abuse to NHA-A on the evening of 2/9/26. LPN-AA stated R6 told LPN-AA that CNA-BB grabbed R6's arm around 7:30 pm on 2/9/26. LPN-AA stated LPN-AA reported the allegation to NHA-A and (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Director of Nursing (DON)-B shortly after R6 told this information to LPN-AA and asked NHA-A what LPN-AA should do. LPN-AA stated NHA-A told LPN-AA to get a statement from the resident and do a skin check, so LPN-AA did that and gave that information to NHA-A. LPN-AA confirmed CNA-BB was no longer in the facility at the time. LPN-AA stated R6 is alert and oriented and has never made any allegations of abuse since LPN-AA has worked in the facility. On 2/25/26 at 12:22 PM, Surveyor spoke with CNA-BB via phone call. CNA-BB stated CNA-BB worked at the facility from November 2025-2/16/26. CNA-BB stated around dinner time on 2/9/26, CNA-BB went into R6's room to assist another CNA with emptying R6's bedside commode. CNA-BB stated R6 stuck R6's middle finger up at CNA-BB and CNA-BB asked why R6 would do that when CNA-BB is there trying to help R6. CNA-BB stated R6 tried to activate R6's call light while CNA-BB and the other CNA were in R6's room, so CNA-BB reached for the call light to cancel it and knocked over a cup of ice from R6's bedside table. CNA-BB stated CNA-BB cleaned up the ice and then left R6's room and did not return to R6's room the rest of CNA-BB's shift, and CNA-BB clocked out and left the facility at 6:00 pm. CNA-BB was unable to recall the name of the other CNA who was in R6's room at the time. On 2/25/26 at 1:17 PM, Surveyor spoke with CNA-CC who confirmed CNA-CC works for an agency company but was working at the facility and cared for R6 on 2/9/26. CNA-CC stated CNA-CC went to assist R6 on the evening of 2/9/26 with emptying the bedside commode. CNA-CC stated CNA-CC had difficulty getting the top off the commode so requested help from CNA-BB. CNA-CC stated CNA-BB showed CNA-CC how to get the top off the commode when R6 made a noise and CNA-BB told R6 CNA-BB is trying to help, do not give me attitude. CNA-CC stated R6 stuck R6's middle finger up at CNA-BB and CNA-BB yelled at R6 not to do that. CNA-CC stated R6 was trying to grab R6's call light but CNA-BB tried to grab it first and everything fell off the bedside table. CNA-CC stated CNA-CC did not see CNA-BB touch R6. CNA-CC stated after everything was cleaned up, CNA-CC answered R6's call light the rest of the evening without issues and R6 was fine the rest of the shift. CNA-CC stated CNA-CC explained to the nurse on duty what happened but was unable to recall the name of the nurse CNA-CC talked to. In an interview on 2/25/26 at 3:30 PM, NHA-A stated NHA-A initially reported the incident to the state agency on 2/10/26 at 6:16 AM, but the reporting website was not working at the time, so NHA-A sent an email with the initial report. NHA-A provided Surveyor with a copy of the email, and Surveyor noted the email was sent on 2/10/26 at 6:16 AM. Surveyor asked NHA-A why NHA-A did not report the allegation of abuse within 2 hours of initial knowledge of an alleged allegation of abuse. NHA-A replied LPN-AA first texted NHA-A around 11:00 PM on 2/9/26 asking what LPN-AA should do if a resident reports abuse. NHA-A told LPN-AA to get a statement and send it to the NHA-A. NHA-A stated NHA-A did not receive any information that there was potential physical contact until the morning of 2/10/26, and that is why the allegation was not reported to the state agency until the morning of 2/10/26. Surveyor shared concern with NHA-A that an allegation of abuse involving R6 was not reported to the state agency within 2 hours of the allegation, and staff did not report the incident within 2 hours of the alleged abuse occurring. No further information was provided.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure an alleged violation of abuse was thoroughly investigated for 1 of 2 Facility Reported Incidents (FRI) reviewed involving R6. On 2/9/26 at 11:00 PM, the Nursing Home Administrator (NHA)-A was made aware of an alleged instance of physical abuse involving R6 and CNA-BB. The investigation of the allegation of abuse did not include interviews with witnesses and staff the allegations were originally reported to.Findings include: The facility policy titled Abuse Prevention Program with effective date 1/23/26 and review date 1/23/26 documents: . As part of the resident abuse prevention, the facility's administration will: . protect our residents from abuse by anyone including, but not necessarily limited to facility staff . The individual conducting the investigation will, as a minimum: . interview the person(s) reporting the incident; . interview any witnesses to the incident; . interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; . R6 was admitted to the facility 6/25/2015 with diagnoses including post-traumatic stress disorder (PTSD) (a mental health condition in people who have experienced or witnessed a traumatic event). R6 had a legal guardian appointed.R6's most recent minimum data set (MDS) assessment dated [DATE] documented R6 had a brief interview for mental status (BIMS) score of 15, indicating intact cognition.On 2/24/26 at 9:11 AM, Surveyor reviewed the FRI regarding an allegation of physical abuse involving R6 on 2/9/26, time unknown, who alleged certified nursing assistant (CNA)-BB grabbed R6's arm and R6 felt CNA-BB's nails on R6's skin. The facility documented in the conclusion of the investigation: The facility was unable to conclusively determine that the scratch was from physical contact between the resident and CNA due to varying statements. Through investigation, it is prudent to deduct the scratch occurring from the CNA making contact with the resident's arm. Due to the facility's ability to substantiate inappropriate use of language, the facility terminated [CNA-BB] on 2/16/26. On 2/24/26 at 11:53 AM, Surveyor spoke with Licensed Practical Nurse (LPN)-AA via phone call, who reported R6's allegation of potential abuse to NHA-A on the evening of 2/9/26. LPN-AA stated R6 told LPN-AA that CNA-BB grabbed R6's arm around 7:30 pm on 2/9/26. LPN-AA stated LPN-AA reported the allegation to NHA-A and the Director of Nursing (DON)-B shortly after R6 told this information to LPN-AA and asked NHA-A what LPN-AA should do. LPN-AA stated NHA-A told LPN-AA to get a statement from the resident and do a skin check, so LPN-AA did that and gave that information to NHA-A. LPN-AA confirmed CNA-BB was no longer in the facility at the time. Surveyor notes the investigation of the allegation of abuse submitted by the facility did not include a statement or interview from LPN-AA, the individual who reported the incident. On 2/25/26 at 1:17 PM, Surveyor spoke with CNA-CC who confirmed CNA-CC works for an agency company but was working at the facility and cared for R6 on 2/9/26. CNA-CC stated CNA-CC explained to the nurse on duty what happened between CNA-BB and R6 but was unable to recall the name of the nurse CNA-CC talked to. CNA-CC stated the facility did not contact CNA-CC to get a statement about the alleged incident between R6 and CNA-BB. Surveyor notes the investigation of the allegation of abuse submitted by the facility did not include a statement or interview from CNA-CC, the individual who witnessed the incident. In an interview on 2/25/26 at 3:30 PM, Surveyor shared concerns with NHA-A that the allegation of abuse involving R6 and CNA-BB on 2/9/26 was not thoroughly investigated to include statements and interviews from LPN-AA who reported the incident or CNA-CC who witnessed the incident. NHA-A stated NHA-A tried to contact CNA-CC but did not obtain a statement from CNA-CC. No additional information was provided as to why the allegation of abuse involving R6 was not thoroughly investigated to include statements and interviews with the person reporting the incident or the person who witnessed the incident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not provide the necessary Activities of Daily Living (ADL) services for 1 (R55) of 16 residents who were dependent on staff to provide ADL care.R55 is dependent on staff for bathing and toileting. R55 did not receive showers as care planned. R55 was not checked and changed every 2 hours as care planned.Findings include:The facility policy with an effective date of 8/1/25 and titled, ADL support, documents, in part: . Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming and oral care) . elimination (toileting) . R55 was admitted to the facility on [DATE] and has diagnosis that include: Bladder cancer, Cerebral infarction (stroke), Alzheimer's disease, Vascular dementia and Depression.R55's Annual Minimum Data Set (MDS) assessment dated [DATE] documents R55 is severely cognitively impaired. R55 is dependent on staff for all care, mobility and transfers. An interview for daily and activity preferences was not conducted during this assessment.R55 has an activated Power of Attorney (POA).R55's ADL care plan initiated 4/14/22 documents the following pertinent interventions: Bathing/showers: Assist of one with bathing/showers. Ensure fingernails and toenails cleaned and trimmed with bathing/showers. If the bath shower is refused, please offer alternative. Showers twice weekly on Tuesday and Saturdays . Bowel Movements: occasional incontinence, wears briefs, size small. Check for incontinent episodes and change frequently and [as needed]. Voiding: incontinent, wears briefs, size small.R55's Fall care plan 4/26/22 documents the following intervention: Review/revise toileting program, toilet [every 2] hours and as needed (initiated 5/31/24).Surveyor reviewed R55's shower/bathing documentation for the months of December 2025, January 2026 and February 2026. Facility documentation reviewed included shower sheets and Certified Nursing Assistant (CNA) task documentation of bathing. Surveyor reviewed all bathing documentation and found the following dates R55 was supposed to receive a shower and there is no documentation R55 received assistance with showering/bathing: Saturday 1/17/26, Tuesday 2/3/26, Saturday 2/7/26 and Tuesday 2/17/26.On 2/25/26 at 9:58 AM, Surveyor interviewed CNA-P. Surveyor asked about resident showers/baths. CNA-P stated residents get a shower twice a week. CNA-P stated there is a binder at the nurse's station with the days and shifts that each resident receives a shower. There are shower sheets that are completed by the CNA and then the nurse will complete a body skin check. Once completed, the nurse will hand in the paper copy of the shower sheet to Director of Nursing (DON)-B. CNA-P stated CNAs will also document whether it was a bed bath or shower.On 2/25/26 at 10:10 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-C about showers. ADON-C stated residents are supposed to receive showers twice a week. Residents can vocalize what days and times that they prefer. The CNA will document the shower in the POC [CNA task section of the electronic medical record (EMR)] and will complete a shower a sheet. The nurse will complete the skin check which is charted in the EMR and on the shower sheet. The shower sheet is then scanned into the residents EMR.Surveyor reviewed R55's EMR for documentation R55 is being checked and changed every 2 hours as care planned. R55's Every 2 hours check and change log, dated 2/17/26- 2/20/26 documents:2/17 8 AM- Wet2/17 10:00 AM or 11:50 AM (time was not clear and written over)- DrySurveyor noted multiple blank rows with no documentation.2/17 10P M-Wet2/18 Midnight and 2 AM-Dry2/18 4 AM-Wet2/18 6 AM-DryMultiple blank rows with no documentation.2/18 2 PM- Wet2/18 4 PM, 6PM and 8PM- Dry2/18 10 PM2/19 Midnight-Wet2/19 2 AM- Dry2/19 4 AM, 6 AM and 8 AM- (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wet.Surveyor noted according to this check and change log, R55 was not checked/changed on 2/17/26 from sometime before noon until 10 PM, indicating at least 10 hours of not being checked and changed. Surveyor noted on 2/18/26, R55 went from 6 AM until 2 PM without a documented check and change, indicating 8 hours of not being checked and changed.Surveyor reviewed R55's CNA task of bowel and bladder documentation on 2/17 and 2/18/26. Surveyor noted on 2/17/26, CNAs documented urinary incontinence with no bowel movement at 5:59 AM and again at 9:19 PM. Surveyor noted over 15 hours of no other documentation regarding R55's bowel and bladder continence on 2/17/26. On 2/18/26, CNAs documented urinary and bowel incontinence at 1:59 PM and 9:32 PM. Surveyor noted from 2/17/26 at 9:19PM until 2/18/26 at 1:59 PM, almost 17 hours, CNAs did not document any bowel or bladder continence on R55 in the CNA task section of R55's EMR.On 2/25/26 at 9:58 AM, Surveyor interviewed CNA-P. Surveyor asked about R55's every 2-hour check and change log. Surveyor asked when staff started the paper log for check and changing. CNA-P stated CNA-P was not sure. CNA-P stated CNAs are supposed to document whether R55 is wet or dry every 2 hours. At the end of the shift that information is given to the nurse.On 2/25/26 at 10:00 AM, Surveyor interviewed CNA-KK about R55's every 2-hour check and change log. Surveyor asked when staff started the paper log for check and changing. CNA-KK stated that it has been that way since CNA-KK has been employed at the facility for about a year and a half. CNA-KK stated that staff have to document whether R55 is wet or dry every two hours. The completed sheets then go to DON-B.Surveyor noted according to CNA-KK R55 needs to be checked and/or changed every 2 hours. On 2/25/26 at 10:03 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-FF. Surveyor asked if LPN-FF had seen the check and change log for R55. LPN-FF stated yes. Surveyor asked when the log was started. LPN-FF stated it was started on the date listed on the log. 2/16/26. The log is kept in the binder at the nurse's station until it is completed and then the completed log will go to DON-B. Surveyor asked if any other completed log sheets were in the binder. LPN-FF checked the binder and stated there was no other sheets. LPN-FF stated R55 is at the hospital so that is probably why there is none in the binder.On 2/25/26 at 10:10 AM, Surveyor interviewed ADON-C about the check and change log scanned into R55's EMR. ADON-C stated the log is only completed on specific people. ADON-C stated these logs are completed to establish a pattern and are completed for only that specific range of time documented on the log. ADON-C stated there is no policy for these logs.Surveyor noted discrepancy among staff regarding the check and change log. Some staff stated it has been in place long term; some say it is short term. Surveyor concluded that the completed log scanned into R55's EMR provided evidence that R55 was not checked and changed every 2 hours as care planned on 2/17 and 2/18/26. On 2/26/26 at 11:08 AM, Surveyor interviewed Director of Social Services (DSS)-L. Surveyor asked about R55. DSS-L stated DSS-L had noticed a pattern that R55 was in the common area by the tv most of the day. DSS-L stated there was a day that DSS-L walked up to R55 and could smell R55. DSS-L stated DSS-L thought staff were putting R55 in the common area and leaving R55 there most of the day. After DSS-L noticed this and told Nursing Home Administrator (NHA)-A, R55's family called and informed facility staff of the same concern. This was on 1/21/2026. DSS-L stated DSS-L could not argue or dispute the concern because DSS-L saw it firsthand. On 2/26/26 at 1:17 PM, Surveyor informed NHA-A of the concerns R55 did not receive showers as care planned in January and February 2026. R55 was not checked and changed every 2 hours as care planned on 2/17 and 2/18/26.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based in observation, interview, and record review, the facility did not ensure each resident received adequate supervision and assistance to prevent accidents for 3 (R56 R36, and R73) of 5 residents reviewed for falls and 1 (R39) of 1 resident reviewed for smoking. *R56 was observed walking without a 2 wheeled walker in the hallway. R56's care plan was not revised to indicate accurate transfer status for R56. *R36 had falls on 12/4/2025 and 1/27/2026 that were not thoroughly investigated. *R39 did not have a quarterly smoking assessments completed and R39's smoking care plan was not revised to indicate if R39 was to be supervised or unsupervised when smoking or if R39 was safe to hold onto own smoking materials. *R73 had a fall out of bed on 2/15/2026 that was not thoroughly investigated. Findings include: The facility policy titled Care Plan Goals, Objectives, Revisions dated 8/1/2025 documents: Purpose: Care plans shall incorporate goals and objectives that lead to the resident's/ patient's highest obtainable level of independence. General Guidelines: .2. When goals and objectives are not achieved, the individuals clinical record is documented to as why the results were not achieved and what new goals and objectives were established.5. Goals, objectives and interventions are reviewed and/ or revised: .b. When the desired outcome has not been achieved.c. When the resident/ patient has been re-admitted to the facility from a hospital/ rehabilitation stay.d. At least quarterly. The facility policy titled Smoking dated 8/1/2025 documents: Policy statement: This facility has established and maintains safe resident smoking practices.Policy Interpretation and Implementation: .6. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes: .d. Ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation).8. A resident's ability to smoke safely is re- evaluated quarterly, . and as determined by staff.9. Any smoking- related privileges, restrictions and concerns (for example, need for close monitoring) are noted on the care plan . 1.) R56 was admitted to the facility on [DATE] and has diagnoses that include encephalopathy, vertigo, mild neurocognitive disorder, chronic pain syndrome, . and other symptoms and signs involving cognitive functions and awareness. R56's admission minimum data set (MDS) date 1/4/2026 indicated R56 has moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 11 and the facility assessed R56 as being independent with activities of daily living (ADL's) and used a walker for safety. The facility assessed R56 on 12/23/2025 to be a high risk for falls with a score of 8. R56's current functional care plan was initiated on 1/9/2026 with the following intervention:- Resident performance: Toilet use- Limited assist/one-person physical assist, patient will use 2 wheeled walker (2ww) to and from bathroom with assist of 1 staff member. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R56's Impaired physical mobility care plan was initiated on 1/5/2026 with the following intervention:- Determined level of needed assistance based on ADLs evaluation. Surveyor noted R56's care plan was not revised after R56's ADL evaluation to indicate what assistance R56 required. R56's use of a safety device of standard wheelchair with cushion for long distances. 2ww for short distances to and from the bathroom with assistance of 1 staff member care plan was initiated on 1/9/2026 with the following intervention:- Resident will use 2ww to and from the bathroom with assistance of 1 staff member. Wheelchair for longer distances. R56's risk for falls care plan was initiated on 1/14/2026 with the following interventions:- Be sure residents' call light is within reach and encourage the resident to use it for assistance as needed.- Follow facility fall protocol. On 2/24/2026, at 8:54 AM, Surveyor observed R56 walking in the hallway without a walker. Surveyor asked R56 how R56's day was going. R56 stated having bad vertigo and gets dizzy at times. Surveyor asked if R56 is to have a walker when walking. R56 stated R56 is to have a walker but does not like to use it. Surveyor observed a 2ww in the corner of R56's bedroom. Surveyor observed staff walking by and saying Hi to R56 without encouraging to use R56's walker when out in the hallway. On 2/25/2026, at 9:12 AM, Surveyor observed R56 walking in the hallway with R56's right hand on a 2ww and R56's left hand holding a cup of water. On 2/25/2026, at 10:00 AM, Surveyor interviewed registered nurse (RN)-F who stated R56 usually walks around alone. RN-F stated sometimes R56 uses a walker and sometimes R56 does not use a walker. Surveyor asked RN-F if R56 should use a walker at all times when walking. RN-F stated R56 uses a walker if R56's vertigo is bad, otherwise does not use one. On 2/25/2026, at 10:36 AM, Surveyor interviewed certified nursing assistance (CNA)-K who stated it depended on how R56 felt if R56 used a walker or not. CNA-K stated on good days R56 did not use a walker and on bad days R56 did use a walker. CNA-K stated R56 does all ADLs without help unless R56 requested assistance with something. Surveyor asked CNA-K if R56 uses a wheelchair when going long distances. CNA-K stated not recalling R56 ever having a wheelchair, CNA-K stated R56 always walks everywhere. On 2/26/2026, at 8:00 AM, Surveyor observed R56 walking in the hallway without R56's 2ww. Surveyor asked R56 where R56 was going, R56 stated R56 was going to an appointment and would be back to the facility later. Surveyor observed RN-F tell R56 to have a good appointment. On 2/26/2026, at 11:00 AM, Surveyor interviewed director of rehab (DOR)-H who started employment with the facility January 2026. Surveyor asked DOR-H who is responsible for revising care plans after ADL evaluations are completed. DOR-H stated DOR-H is responsible for initiating/revising the residents care plan after the resident gets evaluated for ADLs. DOR-H stated the therapy staff will hand in the evaluations and notify nursing staff of any changes for the residents. DOR-H then revises the care plan based on the therapist's evaluation. DOR-H stated care plans are also discussed in the morning stand up meeting that occur every morning and care plans can also be revised at that time as well. DOR-H stated not knowing what the process was prior to DOR-H hire date in January 2026, however, that is the process currently. Surveyor asked what R56's current ADL status is. DOR-H was not (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	familiar with R56 and requested to review therapy notes and get back to Surveyor. On 2/26/2026, at 11:34 AM, Surveyor shared concern with nursing home administrator R56's care plan was not revised to reflect R56's current ADL status and Surveyor has observations of R56 walking around without a walker. NHA-A stated NHA-A often observed R56 walking all over without a walker at times. On 2/26/2025, at 12:33 PM, DOR-H provided Surveyor with a summary of R56 therapy notes. Surveyor notes DOR-H notes document R56 was on therapy caseload 12/2025, at discharge from therapy it was recommended R56 use a 2ww with supervision for all mobility due to history of vertigo and cognitive impairment. Surveyor asked DOR-H to clarify what supervision assistance means. DOR-H stated supervision is observing the resident but does not require a contact guard assist, so the staff member does not have to hold or steady the resident but should observe for safety and encourage use of safety device in this case the walker for R56. DOR-H stated a staff member does not always have to be by R56's side, however, has to observe safety and encourage use of walker and safety measures. Surveyor asked if R56's care plan should have been revised when discharged from therapy to reflect what R56's current ADL status is. DOR-H stated R56's care plan should have been revised to reflect the proper status of R56's ADL status. 2.) R39 was admitted to that facility on 11/8/2023 and has diagnoses that include Chronic Obstructive Pulmonary Disease (COPD- progressive lung disease), depression, . and cognitive communication deficit. R39's annual minimum data set (MDS) dated [DATE] indicated R39 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 14 and the facility assessed R39 as having no impairments to R39's upper and lower extremities and required minimal assistance with one staff for activities of daily living (ADLs). R39 has a guardian and is documented as being a resident that smokes. R39's smoking care plan has an initiated date of 6/30/2025 with the following interventions:- Assist with transportation to/from smoking area. (Initiated: 11/8/2023, Resolved: 11/29/2024)- Instruct resident about smoking/vaping risks and hazards and about smoking cessation aids that are available. (Initiated: 11/8/2023, Resolved: 11/29/2024)- Instruct residents about the facility policy on smoking/vaping: locations, times, safety concerns. (Initiated 6/30/2025)- Notify charge nurse immediately if it is suspected a resident has violated facility smoking policy.- Observe clothing and skin for signs of cigarette burns. R39's Care Kardex dated 2/25/2026 has the following interventions:Safety:- Notify charge nurse immediately if it is suspected resident has violated facility smoking policy.Monitors:- Observe clothing and skin for signs of cigarette burns.Monitoring:-Instruct residents about the facility policy on smoking/vaping: locations, times, safety concerns. Surveyor notes R39's care plan and Care Kardex do not indicate if R39 is to be supervised or unsupervised when smoking, or if R39 is able to hold onto R39's smoking materials or if the facility should hold onto R39's smoking materials. On 2/24/2026, at 9:00 AM, Surveyor observed R39 lying on R39's bed. Surveyor asked how R39's day was going. R39 stated R39 did not want to talk and waved Surveyor away. Surveyor reviewed R39's medical chart and noted smoking assessments completed on 11/8/2023 (admission assessment) and 6/30/2025 (quarterly assessment). Surveyor noted both assessments on 11/8/2023 and 6/20/2025 do not have documentation noting if R39 is to be supervised or unsupervised when smoking (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility completed a falls risk assessment on 2/6/26, 1/31/26 and 12/4/25. All 3 assessments indicated R36 is at risk for falls. A review of the Individual Plan of Care documents R36 is at High risk for falls evidenced by MORSE FALL RISK Score of 80 r/t Gait/balance problems, Unaware of safety needs, and placing himself on the floor to pick up objection or adjusting items around his room. Actual Fall 7/27/25: Date Initiated: 04/23/2022. Revision on: 07/27/2025. Interventions include: R36 will not sustain serious injury through the review date. Date Initiated: 08/28/2025 Anticipate and meet R36's needs. Date Initiated: 04/23/2022 Educate R36 on the importance of allowing himself to fully wake before transferring to another surface. Date Initiated: 04/18/2025 Educate [name of resident]/family/caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 08/08/2023 Encourage R36 to nap/or rest in bed after lunch. Date Initiated: 11/03/2023*Ensure that R36 is wearing appropriate footwear such as grippy-socks when ambulating or mobilizing in w/c (wheelchair). Date Initiated: 04/23/2022 Follow facility fall protocol. Date Initiated: 04/23/2022 Offer R36 to assist with retrieving things from floor when assistance is needed. Date Initiated: 05/19/2024 PT (Physical Therapy)/OT (Occupational Therapy) to Eval (evaluate) & Treat post fall: Anti-Rollbacks to wheelchair. 7/27/25 Date Initiated: 07/27/2025 R36 needs activities that minimize the potential for falls while providing diversion and distraction. Date Initiated: 08/08/2023 Soft touch call light to alert staff when [name of resident] has active movement in bed. Date Initiated: 03/28/2024 R36's Nursing Note dated 12/5/2025 at 02:28 AM; Post Fall Evaluation Fall Details: Date/Time of Fall: 12/04/2025, 9:50 PM, Fall was not witnessed. Fall occurred in the R36's room. R36 was reaching for item(s) at time of the fall. Reason for the fall was evident. Did an injury occur as a result of the fall: Yes. Injury details: Left eye bruised/Nosebleed. Did fall result in an ER visit/hospitalization: No. Provider: yes Time notified: 12/04/2025. Notified of: Resident fall and nosebleed and bruised left eye. R36's responsible party notified: Yes. Person contacted: son. Details of notification: Inform family of fall with injuries noted. Date of R36's responsible party notification: 12/04/2025 11:28 PM Fall Details Note: R36 in room yelled out for help. Staff LPN and staff CNA went to res room and found resident on floor with bleeding nose and Contributing Factors: Recent change in environment: No. Was fluid spilled on floor: No. Floor mat was on floor: No. Poor lighting in the area: No. Bed was at an improper height: No. Other furniture involved: No. It is unknown whether the wheelchair was involved in fall. Wheelchair was unlocked at time of fall. Wheelchair footrest(s) were not in the way at the time of fall. Wearing glasses at the time of the fall: No. Footwear at time of fall: Socks. R36 was not using cane/walker as instructed. R36 was not wearing oxygen as prescribed at time of fall. Incontinent at time of fall: No. Bedside call light on when R36 was found: No. Bathroom call light on when Resident was found: No. Personal alarm sounding when Resident found: No. Other Residents were not involved in fall. Cool compresses applied. PRN medication provided. See MAR (Medication Administration Record) for details. Skin: Skin note: Bruised 1Skin Issue: #001: Skin issue has not been evaluated. Location: Left eye. Additional location information: Nosebleed Issue type: Bruising. Wound acquired in-house. Exact date: 12/04/2025 Staged by: Health care provider. Undermining: No. Tunneling: No. Nursing note dated 12/5/2025 at 9:09 AM; R36 assessed this AM (morning) post fall, noted significant bruising to left face specifically eye, Pupils 1mm (millimeter) but reactive to light, Moves all extremities purposefully to command, A/O (alert and oriented) x 3-4. Doctor contacted via Zoom chat. NOR (new order) to send out to ER for further evaluation, [ambulance company] called and transported. Surveyor notes R36 returned to the facility the same day with no new diagnosis or new orders. On 2/2/5/26, Surveyor conducted a review of the facility's falls investigation dated 12/4/25. The (continued on next page)

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