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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that residents at risk for pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 1 of 2 residents (R3) reviewed for pressure injuries.R3 is at risk for developing pressure injuries. On 1/17/26, facility staff found a left breast abscess that was not comprehensively assessed when identified. On 1/22/26, facility staff documented a new skin issue on R3's upper right gluteus. A treatment order was not placed for this new skin issue until 2/25/26. On 2/2/26, Wound MD-Q assessed R3's wounds for the first time. In an interview, Wound MD-Q stated that after this initial assessment, R3's left breast wound etiology was changed from abscess to pressure. In addition, on 2/2/26, Wound MD-Q found a new left trochanter hip wound and recommended treatment that was not put in place by facility staff until 2/25/26. Wound MD-Q could not assess R3's wounds weekly because R3 is out at an off-site dialysis center when wound rounds take place. Facility staff did not complete comprehensive weekly assessments when wound appointments were missed. Facility staff did not always update R3's care plan when R3's pressure injuries deteriorated. On 2/20/26, Wound MD-Q ordered an antibiotic to be given 2 times a day for 14 days for R3's left breast pressure injury. Facility staff entered this order incorrectly and R3 missed 7 doses of the ordered antibiotic. R3 has a diagnosis of Diabetes. R3's daily diabetic foot checks were not documented as completed in the days prior to developing a facility acquired right heel Deep Tissue Pressure Injury on 2/24/26.Findings include:The facility's policy with an effective date of 9/2025 and titled Pressure injury and skin impairment prevention and management documents in part: . [Facility] is committed to providing a comprehensive pressure injury and skin impairment prevention and management program that is consistent with professional standards of practice to promote the resident's highest level of functioning and well-being and to prevent the development of in-house acquired pressure injury, unless the individual's clinical condition demonstrates they are unavoidable. The goal is that all residents receive prompt assessment and treatment for all skin conditions. Any resident with a pressure injury receives treatment and services consistent with promoting healing and preventing infection and new pressure injuries from developing. Weekly comprehensive wound assessment will be completed and documented in [electronic medical record (EMR)] skin and wound application. the assessment should include at least the following parameters: Location of wound which may provide information related to the etiology of the wound. Length, width, and depth measurements recorded in centimeters. Direction and length of tunneling and undermining. Appearance of the wound base. Type and percentage of tissue in wound (eschar, slough, granulation, epithelial). Drainage amount and characteristics including color, consistency.The facility's policy titled Medication Orders dated 8/2/22, last reviewed 10/21/25, documents in part: The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. Treatment Orders - When recording treatment orders, specify the treatment, frequency and duration of the treatment.R3 was admitted to the facility on [DATE] with diagnoses that include Type 2 Diabetes (chronic condition characterized by insulin resistance and high blood sugar levels,) Paraplegia (a form of paralysis, the (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 - Few	inability to voluntarily move or control the lower parts of the body,) morbid obesity (severe obesity,) congestive heart failure (chronic condition where the heart is unable to pump blood effectively,) muscle weakness, and end stage renal disease with dependence on renal dialysis (final stage of kidney disease, where the kidneys can no longer function adequately to sustain life without treatment.)R3's Annual Minimum Data Set (MDS) assessment dated [DATE] documents R3 is cognitively intact. R3 is dependent on staff for all other cares, mobility, and transfers.R3 is always incontinent of bowel and bladder. R3 is at risk for pressure injuries but does not have any current pressure injury or skin problems.R3's Pressure injury Care Area Assessment (CAA) dated 12/29/25 documents in part: The resident has potential for pressure ulcer development [related to] [history] of ulcers, [diabetes mellitus], immobility and obesity. Follow facility policies/protocols for the prevention/treatment of skin breakdown.R3's comprehensive care plan documents the following pertinent interventions: Pressure relieving mattress and cushion in wheelchair. Encourage [R3] to wear Prevalon boots. [R3] often declines Prevalon boots and prefers pillow under bilateral legs and feet. Remind [R3] to float heels (initiated on 4/13/22). Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness (initiated on 4/9/23). Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning (initiated 4/26/23). Follow facility policies/protocols for the prevention/treatment of skin breakdown (initiated 4/26/23). If the resident refuses treatment, confer with the resident, [Interdisciplinary team (IDT)] and family to determine why and try alternative methods to gain compliance. Document alternative methods (initiated 4/26/23).R3 receives Hemodialysis outside of the facility every Monday, Wednesday, and Friday.R3's Braden scale assessments (an assessment completed to determine how at risk a resident is for developing pressure injuries) completed on 12/3/25 and 1/5/26 document a score of 15, indicating R3 is at risk for developing pressure injuries.R3's potential for pressure ulcer development care plan documents the following intervention initiated on 1/5/26: Resident agreeable to not wear bra until rash area resolves.Surveyor reviewed R3's progress notes, skin assessments, and EMR and did not locate any other documentation regarding R3's rash.R3's skin check assessment dated [DATE] documents: No skin issues.R3's skin check assessment dated [DATE] documents: No skin issues. No new skin issues found on this evaluation.R3's skin check assessment dated [DATE] documents: No skin issues.R3's progress note dated 1/17/26 at 9:43 PM documents in part: Writer found left breast abscess with purulent drainage leaking from wound and right upper buttock abrasion. Nurse notified Wound Care MD and [Director of Nursing] and received order to Clean Left breast with Dakins, apply calcium alginate and cover with border gauze.to start Resident on Doxycycline [two times a day for] 14 days. Staff educated on making sure resident has the correct brief size on at all times .R3's Skin issue assessment dated [DATE] documents in part: New skin issue: Left breast; Issue type: Abscess; Wound acquired in-house; Signs and symptoms of infection: Smell increased; Increased exudate; New skin issue: Buttocks, Right; Issue type: Abrasion; Wound acquired in-house.Surveyor noted R3's initial wound assessments on the left breast was not comprehensive and complete. The assessment did not include measurements or tissue type in wound per facility policy.R3's MD order with a start date of 1/18/26 documents:-Left Breast Abscess, Clean with 1/2 strength Dakins, apply calcium alginate cut to size, [followed by (f/b)] Border Gauze. One time a day.-Doxycycline Hyclate Oral tablet 100 [milligrams (mg)] two times a day for abrasion to left breast for 14 days.R3's MD orders with a start date of 1/19/26 document:-Obtain [ultrasound (US)] of left breast [related to] possible abscesses.-Refer to plastic surgeon clinic for flap [related to] abscesses left breast.Surveyor reviewed R3's medical record and noted that an ultrasound and plastic surgery referral was not completed by facility staff.R3's Skin issue assessment completed by Director of Nursing (DON)-B dated 1/19/26 documents in part: Writer in to measure [and] complete skin assessment on reported new concern to Left Breast, Noted superficial site of interrupted tissue, Measures 4.5 [centimeters (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	(cm)] x 1.3 cm x 0.1 cm has small site of slough measuring 1.3 x 0.5 cm located inside of area, small serous drainage, no odor, peri wound of normal character. [Wound MD-Q] updated on assessment, no nodules or firmness noted to breast. [New order] to place hold on US (ultrasound) and Referral to Plastics, continue [antibiotics] until completion and change dressing to Xeroform Gauze [followed by] Border, change [every day].Surveyor noted R3's comprehensive left breast wound evaluation was completed 2 days after the wound developed. Surveyor noted R3's left breast wound was not comprehensively assessed when found and was not evaluated until 2 days later.On 2/26/26 at 11:23 AM, Surveyor interviewed Wound MD-Q. Surveyor asked about the MD orders of ultrasound and plastics referral. Wound MD-Q stated that originally the left breast wound was thought to be an abscess. Wound MD-Q stated Wound MD-Q was unable to assess the wound and had to rely on the description given by facility staff. Wound MD-Q stated Wound MD-Q believed the ultrasound was ordered to confirm abscess and that would be appropriate. Wound MD-Q stated Wound MD-Q did not remember ordering a plastics referral and did not know why a plastics referral was ordered. Surveyor asked if Wound MD-Q wanted the ultrasound or plastics referral completed even after antibiotics were completed. Wound MD-Q stated it was held because the description changed and was no longer needed.On 2/26/2026 at 12:03 PM, Surveyor interviewed DON-B. DON-B stated that R3's breast wound presented as an abscess. When DON-B assessed the wound at first, DON-B saw 3 little spots and the middle one had slough. DON-B updated Wound MD-Q about that assessment. DON-B stated that DON-B thought it could be from the fit of R3's wheelchair and the fact that R3 leans and lays on the left side all the time. Surveyor asked who ordered the ultrasound and plastics referral. DON-B stated that Wound MD-Q ordered them. Surveyor informed DON-B that Wound MD-Q did not remember ordering a plastics referral. DON-B stated again that DON-B thought it was Wound MD-Q but could have been the facility Nurse Practitioner too. Either way, after the assessment of the wound, the ultrasound and plastics referral were put on hold.R3's MD order with a start date of 1/21/26 documents: Left Breast-abrasion, Clean with 1/2 strength Dakins, apply Xeroform Gauze, [followed by] Border Gauze. Every day shift for Abscess to Left breast.R3's Skin issues assessment dated [DATE] documents in part: Left breast; Issue type: abrasion; Overall wound characteristics improved; 4 x 1 x 0.1; No undermining Cleansing solution: Soap [and] water. Xeroform.Surveyor noted on 1/26/26, R3's left breast was cleansed with soap and water. R3's MD order documents that R3's left breast wound should be cleansed with half strength Dakins.R3's Wound MD-Q Wound evaluation note dated 2/2/26 documents, in part: Wound of the left breast full thickness. Etiology-Infection/bacterial; 4 x 6 x 0.1. Cluster wound-open ulceration area of 19.20 cm. 80% granulation tissue. 20% skin; Treatment Plan: Xeroform gauze apply once daily and as needed. Gauze island [with border].Non-pressure wound of the left hip full thickness. Etiology-Trauma/Injury. Duration: >1 day; 2 x 4 x 0.1. 80% granulation. 20% skin. Treatment plan: Xeroform gauze apply once daily and as needed; Gauze Island [with border dressing].Surveyor noted that R3's left breast wound developed on 1/17/26 and the first time Wound MD-Q evaluated it in person was on 2/2/26.Surveyor noted Wound MD-Q's treatment plan for the Left breast was Xeroform and Gauze Island dressing. Surveyor reviewed R3's MD orders, MAR, and TAR, and noted facility staff continued to treat R3's left breast with half strength Dakins.Surveyor noted R3 has a new Left hip wound.Surveyor reviewed R3's MD orders, MAR and TAR, and noted that facility staff did not enter treatment MD orders for R3's new left hip wound or right buttock wound. R3's skin issues assessment completed by WC RN-G, dated 2/2/26 at 11:38 AM, documents in part: Rear left trochanter; Issue type: pressure ulcer; Pressure ulcer staging: Unstageable pressure injuries presenting as deep tissue injury. Wound acquired in-house. It is unknown how long the wound has been present.Surveyor noted that R3's new left hip wound was first assessed by Wound MD-Q on 2/2/26 and is documented as a pressure injury per facility staff. On 2/26/26 at 11:23 AM, Surveyor interviewed Wound MD-Q. Wound MD-Q stated that initially staff described the wound as an abrasion/abscess so Wound MD-Q went with that. Wound MD-Q stated, that was the story I was given. After Wound MD-Q saw R3's breast wound for the first time, Wound (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	MD-Q changed the diagnosis/etiology to pressure.Surveyor noted that Wound MD-Q stated in interview that when Wound MD-Q assessed R3's breast wound for the first time on 2/2/26, Wound MD-Q changed the etiology from abscess/abrasion to pressure. Surveyor noted that despite this fact, Wound MD-Q's wound evaluation documented the left breast wound as bacterial/infection in R3's Wound note evaluation documentation.On 2/25/26 at 11:55 AM, Surveyor interviewed and observed WC RN-G. Surveyor asked about R3's Left trochanter hip wound. WC RN-G stated that it started because of pressure on R3's left hip from leaning to the left in bed and in R3's wheelchair. WC RN-G stated that at the first assessment of the wound it was determined to be an unstageable pressure wound.Surveyor noted the discrepancy between WC RN-G's documentation and Wound MD-Q's documentation about R3's left hip wound. Surveyor noted that despite Wound MD-Q documenting R3's left hip wound as non-pressure related, Wound MD-Q had not seen R3's left hip wound regularly and noted that WC RN-G had been treating R3's left hip wound regularly. Interview with WC RN-G revealed that the facility believed R3's left hip wound was caused by pressure as R3's leans to the left in bed and in R3's wheelchair and that R3's left hip wound was located over a bony prominence and was caused by pressure. R3's progress note dated 2/9/26 at 2:41 PM, documents: Resident not seen by wound MD today due to resident unavailable at a Dialysis appointment. MD rescheduled for next week.Surveyor reviewed R3's medical record and noted R3 did not have comprehensive wound assessments for R3's breast or left hip pressure injuries for the weeks of 2/9 through 2/15.On 2/26/26 at 12:03 PM, Surveyor interviewed DON-B. Surveyor asked how often residents with pressure injuries need to have thorough assessments of the wounds. DON-B stated that it is weekly. DON-B indicated that with R3, it has been difficult to assess R3's wounds because R3 goes to dialysis at the same time that Wound MD-Q comes to do wound rounds at the facility. DON-B stated that Wound MD-Q will go off of what we send him in regard to assessments and measurements.On 2/26/26 at 10:33 AM, Surveyor interviewed WC RN-G. Surveyor asked who assesses the resident if Wound MD-Q is unable to see the resident. WC RN-G stated that WC RN-G is the one who would have to do the weekly assessment.On 2/26/26 at 11:23 AM, Surveyor interviewed Wound MD-Q. Wound MD-Q stated that seeing and assessing R3's wounds was challenging because of R3's dialysis appointments. R3 is typically out to dialysis on Monday mornings when Wound MD-Q comes weekly for wound rounds at the facility. Wound MD-Q stated that Wound MD-Q is chasing R3 for weekly wound rounds.R3's MD order with a start date of 2/13/26 documents: Left breast abrasion, Clean with [normal saline], apply Xeroform gauze, [followed by] border gauze. Surveyor noted facility staff updated R3's wound care order for R3's left breast to match what Wound MD-Q recommended on 2/2/26, 11 days later. Surveyor also noted the discrepancy in Wound MD-Q's documentation which documents R3's left breast pressure injury as an abrasion despite Wound MD-Q confirming that R3's left breast wound was pressure related.Surveyor reviewed R3's MD orders, MAR, and TAR, and noted that facility staff have not entered treatment MD orders for R3's left hip wound Surveyor noted daily treatments for R3's left hip were not being documented as completed daily.R3's progress note dated 2/16/26 at 1:59 PM, documents in part: Resident seen by wound MD today. Resident has no new orders but encouraged to shift [R3's] weight and reposition every 2 hours to promote healing.R3's Wound MD-Q Wound evaluation note dated 2/16/26, documents in part: Wound of the left breast full thickness. Etiology: Infection/Bacterial; 7 x 20 x 0.1; Cluster wound: open ulceration area of 98 cm. 70% granulation. 30% skin; Treatment plan: Alginate calcium apply once daily and as needed. ABD pad. Surveyor noted the discrepancy in Wound MD-Q's documentation which documents R3's left breast wound as having an etiology of infection/bacterial, despite Wound MD-Q confirming that R3's left breast wound was pressure related.Non-pressure wound of the left hip full thickness; Etiology: trauma/injury; 2 x 4 x 0.1. 80% granulation. 20% skin; Treatment plan: Xeroform gauze apply once daily and as needed; Gauze Island [with border]. Surveyor noted the discrepancy in Wound MD-Q's documentation which documents R3's left hip wound as having an etiology of non-pressure, despite WC RN-G confirming that R3's left breast wound was pressure related.Surveyor reviewed R3's MD (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	orders, MAR, and TAR, and noted that facility staff did not enter the new treatment order of Calcium Alginate to R3's Left breast wound that was recommended on 2/16/26. Surveyor noted that facility staff did not enter treatment MD orders for R3's left hip wound. Surveyor noted treatments for R3's left hip wound are not being documented as completed daily.On 2/26/26 at 10:33 AM, Surveyor interviewed WC RN-G. Surveyor confirmed that R3's breast wound was due to pressure. Surveyor asked if R3 has any intervention for offloading of R3's breast. WC RN-G stated that WC RN-G knows that R3 has an order to turn and reposition every 2 hours. WC RN-G thought WC RN-G put offloading of the breast in as well. WC RN-G checked R3's medical record and stated that it was not there but that WC RN-G will put that in right away.R3's MD order with a start date of 2/21/26 documents: Left breast abrasion, clean with half strength Dakins, apply Calcium Alginate gauze, [followed by] ABD pad two times a day.Surveyor noted the discrepancy in Wound MD-Q's documentation which documents R3's left breast wound as having an etiology of an abrasion, despite Wound MD-Q confirming that R3's left breast wound was pressure related.Surveyor noted facility staff updated R3's left breast wound treatment 5 days after Wound MD-Q recommended Calcium Alginate.R3's MD order with a start date of 2/20/26 documents: Doxycycline Hyclate oral tablet 100 mg. Give 1 tablet by mouth two times a day every 14 days for wound infection.On 2/25/26 at 11:55 AM, Surveyor interviewed WC RN-G. Surveyor asked why R3 was placed on antibiotics on 2/20/25. WC RN-G stated that the left breast wound had worsened so WC RN-G called Wound MD-Q, and the antibiotic was ordered two times a day for 14 days. WC RN-G stated that R3 is currently taking this for the left breast wound.Surveyor noted that R3's antibiotic Doxycycline order was supposed to be given 2 times a day for 14 days but instead was entered incorrectly in the medical record as 2 times a day EVERY 14 days. Facility staff recognized the error and corrected R3's antibiotic order on 2/24/26. Surveyor reviewed R3's MAR and noted that because of this transcription error, R3 missed 7 doses of R3's antibiotics.On 2/26/26 at 11:23 AM, Surveyor interviewed Wound MD-Q about R3's antibiotics. Wound MD-Q stated that Wound MD-Q was told that R3's breast wound was odorous. Wound MD-Q then ordered the antibiotics. Surveyor asked if Wound MD-Q was aware that R3 missed 7 doses of R3's antibiotics. Wound MD-Q stated that Wound MD-Q did not know about any missed medications.R3's progress note dated 2/23/26 at 12:39 PM documents: Resident was not seen by wound MD today due to the fact [R3] was at Dialysis. MD wants to send resident to wound care for more consistent follow up.Surveyor reviewed R3's medical record and noted facility staff did not comprehensively assess R3's wounds when R3's Wound MD was unable to assess R3's left breast and left hip pressure injuries.R3's progress note dated 2/24/26 at 3:51 PM, documents in part: Writer spoke with resident today about not being able to see the wound MD on a consistent basis due to her dialysis appointment every week. MD suggests that resident go out to wound clinic so that [R3] can have a consistent follow up on [R3's] wound treatment. Writer asked resident and [R3] declined to go to an outside wound clinic. Resident states [R3] wants to continue to be seen here at the facility and does not want to go to another wound clinic. Writer also educated resident on the importance of offloading [R3's] breast area where [R3's] wound is in order for the area to heal. Resident states [R3] will try but the difficulty [R3] has on laying on [R3's] right side prevents [R3] but [R3] will call the Dialysis Center. to try to get [R3's] chair time changed on Mondays in order to be seen by the wound MD.R3's Skin check assessment dated [DATE] at 6:04 and 6:11 PM, documents in part: Left breast. Issue type: Abrasion. Signs and symptoms of infection: Smell increased. 5 x 4 x 0.1.Surveyor noted the discrepancy in Wound MD-Q's documentation which documents R3's left breast wound as having an etiology of an abrasion, despite Wound MD-Q confirming that R3's left breast wound was pressure related.Right heel. Issue type: Pressure ulcer / injury. Stage 1 Pressure ulcer / injury - non-blanchable erythema of intact skin. Wound acquired in-house. Wound is new; Staged by: In-house nursing; 1.5 x 1; Cleansing solution: Normal saline. Other primary dressing: skin prep Secondary dressing: Foam.Surveyor noted a new Right heel pressure injury developed and was first assessed on 2/24/26.Surveyor noted R3 has a diagnosis of diabetes. Surveyor reviewed R3's diabetic foot checks (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	for the month of February. R3's CNA task documents that foot checks are to be completed daily before bed. Surveyor reviewed CNA documentation and noted missing foot checks for the following days in February: 2/2, 2/6, 2/7, 2/9, 2/10, 2/11, 2/12, 2/17, 2/18, 2/20, 2/22, 2/23, and 2/24. Surveyor noted in the days prior to developing a right heel pressure injury, facility staff did not complete the ordered daily foot checks.On 2/26/26 at 12:03 PM, Surveyor interviewed DON-B. Surveyor asked if R3 should have foot checks. DON-B stated that R3 should have daily foot checks because R3 is diabetic. DON-B stated that the foot checks are completed by CNAs and should be documented daily in the EMR.R3's MD orders with a start date of 2/25/26 include:-Left Hip: Cleanse with [normal saline] apply Xeroform dressing [followed by] border gauze.-Right heel: skin prep to heel with foam dressing covering daily.Surveyor noted that R3's left trochanter hip pressure injury was found by Wound MD-Q on 2/2/26. The first treatment MD order was placed to start on 2/25/26. R3's left trochanter hip wound was not documented as treated daily per Wound MD-Q's treatment plan recommendations for 23 days. On 2/23/26 at 12:50 PM, Surveyor observed and interviewed R3 while she was seated in her wheelchair. R3 was in her room and stated that she recently got back from dialysis. R3 was wearing socks and tennis shoes and was well groomed. Cushion noted in R3's wheelchair. R3 has an air mattress that is on and functioning. Surveyor asked if R3 has any wounds. R3 stated she has a wound on her left hip, left breast, and a butt wound and they have been there for about a month. Surveyor asked how often facility staff change the dressings. R3 stated that it is supposed to be every day, but it depends on what staff is working. R3 stated that the wound doctor has come to see her but not as often as the facility wants. R3 stated she went to dialysis later last week so she could see the Wound MD.On 2/24/26 at 8:54 AM, Surveyor observed R3 on her back in bed. Head of bed was slightly elevated. Air mattress was on. R3's heels elevated with pillows. No heel boots noted. R3 is leaning to her left side and sleeping.On 2/25/26 at 11:55 AM, Surveyor interviewed and observed WC RN-G complete wound treatments on R3's wounds. WC RN-G stated that R3 has a left hip, right buttock, left breast, and right heel wound. WC RN-G started with R3's left breast wound. WC RN-G stated that the wound is due to pressure. WC RN-G stated that the wound started as one area of infection that Wound MD-Q called an abrasion. Then, with time, the wound had added pressure because of how R3 is positioned, and Wound MD-Q changed the etiology to pressure. WC RN-G stated that R3 tends to lean to the left. When in R3's wheelchair, the left arm rest and the way the chair is made puts pressure on R3's left side. WC RN-G took Surveyor to R3's wheelchair. Surveyor noted the chair has curved sides to the back that are meant to keep R3 sitting straight. In addition, the left arm has a curved side that cradles R3's elbow and forearm. WC RN-G stated that the way R3 leans in the chair puts pressure in the exact places that would cause pressure and is what caused R3's breast wound.WC RN-G then went to R3's side and removed R3's left breast dressing. Surveyor noted a wound the size of a small paper plate with cluster areas of slough noted. No eschar noted in the wound area. WC RN-G used half strength Dakins to cleanse the wound, then used calcium alginate and an ABD pad to cover the area. Next, WC RN-G moved to R3's left hip. Surveyor noted R3 did not have a bandage on the wound. Surveyor asked if R3 should have a dressing in place. WC RN-G stated that the dressing must have come off when staff washed R3 up this morning.WC RN-G then used normal saline to wash the wound. Surveyor asked what caused this wound. WC RN-G stated it was due to pressure. WC RN-G stated that it was initially an unstageable pressure injury but now it is healing well. Surveyor observed a dime sized area that was pink in color. No slough or eschar noted. WC RN-G then placed Xeroform and bordered gauze over the wound.WC RN-G then gathered supplies to complete the treatment to R3's right heel. WC RN-G stated that the area was found yesterday and assessed by WC RN-G. WC RN-G stated that R3 refuses to wear heel boots but does agree to float heels on pillows. R3 confirmed to Surveyor that she did not want to wear heel boots. WC RN-G educated R3 about risks and benefits of the boots. R3 then agreed to wear a heel boot on the right foot and will float her left heel on a pillow. WC RN-G stated that R3's heel wound developed because of pressure.WC RN-G held up R3's lower leg. Surveyor noted R3 did not have a dressing on her heel wound. Surveyor asked if (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	there should be a dressing. WC RN-G stated that the dressing probably came off when CNAs put R3 back to bed after dialysis. WC RN-G then sprayed skin prep on R3's heel. Surveyor noted a circular blackened area the size of 2 half dollars on R3's heel. Surveyor asked what stage this wound was. WC RN-G stated that it is an unstageable deep tissue injury (DTI). WC RN-G then placed a foam dressing over the wound and put the boot on R3's right foot.Surveyor noted that during the wound treatment observation, R3 did not have dressings in place to R3's right heel and left hip wound as MD ordered.Surveyor noted that according to WC RN-G, R3's left breast wound, left hip wound, and right heel wound developed because of pressure.On 2/26/26 at 8:29 AM, Surveyor observed R3 in bed. R3 had a heel boot on her right foot. R3's left heel was elevated with pillow. Air mattress was on. R3 was leaning to her left side and sleeping.On 2/26/2026 at 8:28 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-Y. LPN-Y stated that if a wound is found, the nurse needs to do an assessment, call the doctor, and get a treatment order. LPN-Y stated that they would also let WC RN-G know of any new wound. LPN-Y stated whoever gets the treatment order should enter it as an MD order in the resident's medical record. Surveyor asked when R3's left breast wound started. LPN-Y stated LPN-Y was not sure when it started but stated that R3 lays on that area all the time. LPN-Y stated that R3 has a wedge sometimes when R3 is in the wheelchair and LPN-Y stated that LPN-Y believes the chair and wedge are causing friction and pressure. LPN-Y stated that the wedge is gone now, and staff are using a pillow instead.On 2/26/26 at 10:33 AM, Surveyor interviewed WC RN-G. WC RN-G stated that wound rounds are completed with Wound MD-Q every Monday morning. Wound MD-Q will see all residents with wounds at that time and will offer recommendations. The recommendations are reviewed and entered as MD orders after wound rounds are completed. WC RN-G stated that Wound MD-Q has been unable to assess R3 every week because of R3's dialysis appointments. That's why they wanted R3 to go to an outside wound care clinic. R3 did not agree to that so WC RN-G had R3 change her dialysis time on Monday mornings. Now, R3 will be able to be assessed by Wound MD-Q weekly. Surveyor asked how positioning at dialysis is for R3. WC RN-G stated that WC RN-G will get R3 sitting in the wheelchair before R3's dialysis appointments. R3 remains in the wheelchair at the appointment. WC RN-G stated that when R3 returns, she is back to leaning on her left side.On 2/26/26 at 12:23 PM, Surveyor interviewed Nursing staff-Z at R3's Dialysis center. Nursing staff-Z stated that Nursing staff-Z had been with the dialysis center since October of 2025. Surveyor asked if R3's facility staff had communicated any positioning concerns regarding R3's pressure injuries. Nursing staff-Z stated that Nursing staff-Z has not received any communication and there is no documentation stating that facility staff had communicated to the dialysis center about R3's pressure injuries.Nursing staff-Z stated that R3 has told Nursing staff-Z about her pressure injuries. Nursing staff-Z stated they do use a Hoyer lift to put R3 into the reclined dialysis chair so R3 can recline during dialysis.Surveyor noted that facility staff did not communicate any pressure injury interventions to the dialysis center.On 2/26/26 at 1:32 PM, Surveyor informed Nursing Home Administrator (NHA)-A of the concerns that facility staff did not always complete a comprehensive wound assessment when new wounds were found on R3 and Wound MD-Q's treatment orders are not always followed. On 2/2/26, Wound MD-Q assessed R3's wounds for the first time. In an interview, Wound MD-Q stated that after this initial assessment, R3's left breast wound etiology was changed from abrasion/abscess to pressure. In addition, on 2/2/26, Wound MD-Q found a new left trochanter hip wound and recommended treatment that was not put in place by facility staff until 2/25/26. Facility staff did not complete comprehensive weekly assessments when wound appointments were missed. Facility staff did not always update R3's care plan when R3's wound deteriorated. On 2/20/26, Wound MD-Q ordered an antibiotic to be given 2 times a day for 14 days for R3's left breast pressure injury. Facility staff entered this order incorrectly and R3 missed 7 doses of her antibiotic. R3's daily diabetic foot checks were not documented as complete in the days prior to developing a facility acquired right heel Deep Tissue Pressure Injury on 2/24/26.No additional information was provided.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interviews, the facility did not ensure the garbage and refuse were properly disposed in the outside garbage storage receptacles.This deficient practice has the potential to affect all 63 residing at the facility.Findings include:On 2/23/2026, at 9:15 AM, Surveyor went on a tour of the facility garbage area with dietary manager-M. Surveyor observed the following:- Two large dumpsters with lids open. Both dumpsters were full and both dumpsters had full garbage bags falling out and hanging out of both dumpsters. - Behind both dumpsters were piles of garbage that included large cans, open bags of garbage, Styrofoam cups, plastic lids, and straws. Surveyor was not able to see the ground behind the dumpsters due to the amount of garbage behind both dumpsters.- Gloves, and soiled briefs/depends were lying on the ground around the dumpster area not in an enclosed garbage bag.- [NAME] body towels and hand towels were lying on the ground between both dumpsters and several broken cardboard boxes were lying around both dumpsters.Surveyor asked Dietary Manager- M who manages/ monitors the dumpster area. Dietary Manager-M was not sure what staff managed the dumpster area and stated it may be maintenance.On 2/24/2026, at 12:56 PM, Surveyor toured the outside dumpster area with Maintenance Director-N. Surveyor shared observations of the ground surrounding the two dumpsters. Surveyor noted both dumpsters had been emptied and 1 dumpster had the lids closed while the other dumpsters' lids were open. Garbage was still noted to be around the dumpster area. Surveyor asked who was in charge of monitoring and maintaining the dumpster area.Maintenance Director-N stated the dumpster area is shared with the apartment complex next door. There is a dumpster for the facility that is labeled with (facility address numbers) and the second dumpster is labeled to indicate the apartment complex dumpster. Currently there is no one managing the dumpster area because no one knows if it should be the facility maintenance department or the apartment complex maintenance department managing the area or if it should be shared. Maintenance Director-N confirmed concerns of the area surrounding the dumpsters and the amount of garbage that is surrounding the dumpster area. Maintenance Director-N was unsure how often garbage came to empty the dumpster garbage's.On 2/24/2026, at 3:00 PM, Surveyor shared observations with Nursing Home Administrator (NHA)-A of the facility dumpster area outside the facility. Surveyor shared concern there was no monitoring or maintaining of the area and requested to review the facility policy for the maintenance of the outside garbage storage receptacles. On 2/25/2026, at 9:49 AM, NHA-A stated the facility did not have a policy for the maintenance of the outside garbage storage receptacles and understood Surveyors observations and concerns of the facility dumpster area. No further information was provided at the time of this write up.

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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 staff interview, the facility's Quality Assessment and Assurance Committee did not meet at least quarterly to identify and evaluate quality issues through assessment and assurance activities. The deficient practice had the potential to affect all 63 residents in the facility.The Quality Assessment and Assurance (QAA) Committee did not meet on a quarterly basis to determine quality deficiencies within the facility and develop and implement plans of action to correct any deficiencies. The QAA Committee meeting was held on 9/30/25 and 2/13/26 and did not meet for Quarter 4 of 2025.Findings:On 2/26/26, at 12:46 PM, Surveyor asked Nursing Home Administrator (NHA)-A how often the QAA Committee meets. NHA-A stated the facility meets quarterly but they missed their last quarter (Quarter 4) 2025 QAA Committee meeting due to staff being out of the office. NHA-A stated the facility identified the facility was not compliant with the quarterly QAA Committee meetings on 1/26/26. NHA-A stated the facility has since met on 2/13/26 and 2/23/26 with plans to start meeting quarterly with the next meeting scheduled for 3/23/26. Surveyor shared concerns with QAA Committee missing quarterly meetings as required.NHA-A provided a Past Non-Compliance Plan to Surveyor which documents the following:*The facility identified the facility was out of compliance with QAA meetings on 1/26/26.*QAA Committee meeting was scheduled with the Medical Director for 1/26/26. The Director of Nursing was unable to attend the meeting and was rescheduled for 2/23/26.*The root cause was identified as sporadic changes in Nursing Home Administrator and Director of Nursing throughout the month of October and November.Immediate Correction Action documents the following:*The facility reviewed the Medical Director's schedule and concluded QAA Committee meetings will be held the 3rd Monday of the next month.*The facility has created a QAA Committee calendar and will audit QAA meetings quarterly.No additional information was provided.

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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 observation, interview and record review, the facility did not establish and maintain an infection prevention and control program based upon current standards of practice, designed to provide a safe environment and to help prevent the development and transmission of communicable diseases and infections. This deficient practice has the potential to affect all 63 residents. * Staff were observed not wearing appropriate personal protective equipment (PPE) while providing gastrostomy tube (g-tube) cares for R25 and R26. Staff were also observed not performing appropriate hand hygiene during medication pass with R25 and R26. * The facility's Water Management Plan (WMP) was not based on current standards of practice and did not: -Identify where control measures should be applied based on where Legionella could grow and spread -Include a process to confirm the WMP is being implemented and is effective. * Staff were observed not wearing appropriate personal protective equipment (PPE) while providing colostomy and indwelling catheter cares for R72. * Staff were observed not following appropriate personal protective equipment (PPE) precautions while providing wound care to R3. * Staff were observed not wearing appropriate personal protective equipment (PPE) while providing respiratory care to R6. Findings include: The facility's policy titled Standard Precautions, dated 8/1/25, documents the following: *Standard precautions are used in the care of all residents regardless of their diagnoses or suspected or confirmed infection status. Standard precautions to presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. *Standard precautions apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. *Hand hygiene refers to handwashing with soap (antimicrobial or non-antimicrobial) or use of alcohol-based hand rub (ABHR), which does not require access to water. *Hand hygiene is performed with ABHR or soap and water: -Before after contact with the resident. -Before performing an aseptic task. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Before moving from work on a soiled body site to a clean body site on the same resident. -After contact with items in the resident's room. -After removing gloves. Hands are washed with soap and water: -When visibly soiled with dirt, blood, or body fluids. -After contact with blood, body fluids, or contaminated surfaces. The facility's policy titled enhanced barrier precautions, dated 3/25/24, documents the following: *Enhanced barrier precautions refer to an infection control intervention designed to reduce transmission of Multidrug-resistant organisms (MDRO) that employs targeted gown and gloves use during high contact resident care activities. *An order for enhanced barrier precautions will be initiated for residents with any of the following: -Wounds (chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and indwelling medical devices (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. -Infection or colonization with a Center for Disease Control (CDC)-targeted MDRO when Contact Precautions do not otherwise apply. *Personal Protective Equipment (PPE) for enhanced barrier precautions is only necessary when performing high contact care activities (listed below) and may not need to be donned prior to entering the resident's room. High contact resident care activities include: -Dressing -Bathing -Transferring -Providing hygiene -Changing linens -Changing briefs or assisting with toileting -Device care or use: center lines, urinary catheters, feeding tubes, tracheostomy ventilator tubes -Wound care: any chronic skin opening requiring a dressing (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's policy titled Legionella Water Management Program, not dated, documents the following: *The purposes of the water management program are to identify areas in the water system where legionella bacteria can grow and spread and will reduce the risk of legionnaire's disease. *The water management program includes the following elements: The identification of areas in the water system that would encourage the growth and spread of legionella or other waterborne bacteria, including the following: -Storage tanks -Water heaters -Filters -Aerators -Shower heads and hoses -Misters, atomizers, air washers and humidifiers -Hot tubs -Fountains *The control limits or parameters that are acceptable and that are monitored. *A diagram of where control measures are applied. *A system to monitor control limits and the effectiveness of control measures. *Documentation of the program. 1.) On 2/24/26, at 8:23 AM, Surveyor observed LPN-R perform medication administration for R26. Surveyor observed LPN-R enter R26's room that had a sign on the entryway indicating R26 was in Enhanced Barrier Precautions (EBP). Surveyor observed LPN-R enter R26's room with no gown and applied gloves. LPN-R then administered medications through R26's gastrostomy tube (g-tube) while only donning gloves. After completing medication administration through R26's g-tube, Surveyor observed LPN-R remove her gloves, throw the gloves in the garbage and walk over to the medication cart without performing proper hand hygiene. Surveyor notes, LPN-R did not don a gown using EBP while administering medications through R26's g-tube and did not use appropriate hand hygiene throughout medication administration for R26. On 2/24/26, at 8:34 AM, Surveyor observed Licensed Practical Nurse (LPN)-R perform medication administration for R25. Surveyor observed LPN-R enter R25's room that had a sign on the entryway indicating R25 was in EBP. Surveyor observed LPN-R enter R25's room with no gown and applied gloves. LPN-R then administered medications through R25's g-tube while only donning gloves. After (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	completing medication administration through R25's g-tube, Surveyor observed LPN-R remove her gloves, throw the gloves in the garbage and walk over to the medication cart without performing proper hand hygiene. Surveyor notes, LPN-R did not don a gown using EBP while administering medications through R25's g-tube and did not use appropriate hand hygiene throughout medication administration for R25. On 2/26/26, at 10:01 AM, Surveyor notified Nursing Home Administrator (NHA)-A of concerns with LPN-R not performing appropriate hand hygiene or donning appropriate EBP equipment while administering medications through R25 and R26's g-tube during observation of medication pass. NHA-A acknowledged these concerns. 2.) On 2/25/26, at 11:16 AM, Surveyor reviewed the facility's Water Management Program and was unable to locate documentation of where control measures should be applied based on where Legionella could grow and spread, and unable to locate documentation of implementation of monitoring to confirm if the water management program is effective. Surveyor notes the facility is unable to identify possible dead leg units identified and unable to confirm if flushing and monitoring has been completed routinely. On 2/26/26, at 10:35 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who provided additional flushing logs for the facility. Surveyor reviewed the flushing logs provided and noted detailed flushing logs completed in 2023 and noted to NHA-A there are no current flushing logs documented to indicate the facility has been implementing and monitoring the water management program. NHA-A stated the previous maintenance employee left the facility in September 2025 and NHA-A stated she has been implementing the water management program since September 2025. NHA-A stated the East unit was previously closed and is now open. NHA-A also stated housekeeping will go in and complete water flushing. Surveyor asked NHA-A for documentation and NHA-A stated the facility does not have documentation of flushing and monitoring of the water management program being completed. Surveyor notified NHA-A of concerns with the facility not implementing, monitoring and documenting the water management program as required. NHA-A acknowledged these concerns. 3.) R3 was admitted to the facility on [DATE] with diagnosis that include Paraplegia (a form of paralysis. The inability to voluntarily move or control the lower parts of the body), Muscle weakness and End stage renal disease with dependence on renal dialysis (final stage of kidney disease, where the kidneys can no longer function adequately to sustain life without treatment). R3's Annual Minimum Data Set (MDS) assessment dated [DATE] documents R3 is cognitively intact. R3 requires set up and clean up assistance for eating and oral hygiene. R3 is dependent on staff for all other cares, mobility and transfers. On 2/23/26 at 12:50 PM, Surveyor interviewed R3 in R3's wheelchair. Surveyor asked if R3 has any wounds. R3 stated that R3 has a wound on R3's left hip, left breast and a butt wound, and they have been there for about a month. On 2/23/2026, at 12:55 PM, Surveyor observed R3's door and noted there was an Enhanced Barrier Precaution (EBP) sign hanging. R3's active MD order documents: Enhanced Barrier Precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/25/26 at 11:55 AM, Surveyor observed Wound Care Registered Nurse (WC RN)-G provide wound care treatments to R3. WC RN-G completed hand hygiene and put on gown and gloves before starting wound care. WC RN-G stated that R3 has a left hip, right buttock, left breast and right heel wound. WC RN-G started with R3's left breast wound. WC RN-G removed the dressing, removed gloves and completed hand hygiene before putting on clean gloves. WC RN-G then completed the cleansing and treatment of R3's left breast wound. WC RN-G removed gloves and completed hand hygiene. WC RN-G then left R3's room with used gown on to get supplies from WC RN-G's wound cart in the hallway. WC RN-G returned to R3's room with the same gown on. WC RN-G completed hand hygiene before putting on clean gloves. WC RN-G then completed cleansing and treatment of R3's left hip wound. Next, WC RN-G then moved R3 to R3's left side to do the treatment on R3's buttock. WC RN-G removed R3's dressing to R3's right buttock wound. WC RN-G removed gloves and completed hand hygiene. WC RN-G realized WC RN-G did not have any more clean gloves and left R3's room to retrieve gloves. WC RN-G left WC RN-Gs used gown on when going to get gloves. WC RN-G returned to R3's room with the same used gown on. WC RN-G completed hand hygiene and put on clean gloves. WC RN-G completed cleansing and treatment to R3's right buttock wound. WC RN-G then moved to R3's right heel. WC RN-G removed used gloves and completed hand hygiene. WC RN-G then left R3's room to gather more supplies for R3's right heel wound. WC RN-G left R3's room with the same used gown on. WC RN-G returned to R3's room with supplies. WC RN-G completed hand hygiene, put on new gloves and completed the wound treatment to R3's right heel. After all treatments were completed. WC RN-G removed gown and gloves, completed hand hygiene and left R3's room. Surveyor noted R3's trash can inside of R3's room did not have any used gowns disposed of in the trash can before WC RN-G put one gown in the can. Surveyor noted that during wound care observation, WC RN-G left R3's room [ROOM NUMBER] times with the same gown on. On 2/26/2026 at 12:03 PM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked if an EBP sign is posted outside of a resident's door, if staff are expected to follow Enhanced Barrier Precautions. DON-B stated yes. DON-B stated that the only time that a staff member does not have to put on gown and gloves is if the staff member is not touching the resident. Surveyor asked if during wound treatments, if staff can leave an EBP room with the same gown on. DON-B stated staff cannot walk out of the room with their gown on. DON-B stated staff are expected to take off gown when leaving the room and put on a new one when reentering the room. On 2/26/2026 at 1:32 PM Surveyor informed Nursing Home Administrator (NHA)-A of the concern that during wound treatment observation, WC RN-G left R3's room and returned to R3's room [ROOM NUMBER] times with the same used gown on. 4.) R72 was admitted to the facility on [DATE] and has diagnoses that include osteomyelitis of vertebra of the sacral and sacrococcygeal region, Stage 4 pressure injury. R72's admission minimum data set (MDS) dated [DATE] indicated R72 was admitted with an indwelling foley catheter, a colostomy to the right lower abdomen, a stage 4 pressure injury to the sacrum with chronic osteomyelitis, and unstageable pressure injuries to the right and left heels. On 2/23/2026, at 10:45 AM, Surveyor observed R72 lying in bed sleeping. Surveyor noted on R72's door there was an Enhanced Barrier Precaution (EBP) sign and behind it was a Contact Precaution sign. On 2/24/2026, Surveyor reviewed R72's medical record. Surveyor noted the following physician (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	order:- Enhanced Barrier Precautions and Contact Precautions. Order date: 2/24/2026 On 2/25/2026, at 9:30AM, Surveyor observed certified nursing assistant (CNA)-O and CNA-P perform catheter and colostomy cares for R72. Surveyor noted CNA-O and CNA-P did not put on gowns when emptying R72's colostomy or foley catheter. CNA-O and CNA- did not put gowns on when repositioning R72. Surveyor asked if a resident has both EBP and contact precautions signs outside the door, how do staff know what the resident is supposed to be on or what personal protective equipment (PPE) is needed and when. CNA-O stated a gown only has to be worn if someone is on contact precautions for a certain issue. R72 stated R72 forgot to put on a mask and R72 should not be on contact precautions, that is why the EBP sign is in front of it. Surveyor asked if staff were supposed to wear a gown for EBP's CNA-O stated no, only gloves and a mask. Surveyor reviewed the EBP sign outside R72's door with the following recommendations:Enhanced Barrier Precautions: EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities.- Dressing- Bathing/ Showering- Transferring- Changing linens- Providing Hygiene- Changing briefs or assisting with toiletingDevice care or use: .- Urinary catheter .- Wound Care: any skin opening requiring a dressing. Surveyor reviewed the contact precautions sign outside R72's door that is underneath the EBP with the following recommendations: 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 . Surveyor confirmed neither EBP nor contact precautions require staff to wear a face mask, however both precautions require staff to wear a disposable gown during contact with the resident. On 2/25/2025, at 10:30 AM, Surveyor interviewed registered nurse (RN)-F who stated R72 is on contact precautions due to R72's pressure wound to R72 sacral areal and right and left heels. RN-F stated a gown should only be worn if provided wound care for R72. Surveyor asked what PPE should be wearing if providing other cares or repositioning R72. RN-F stated staff would have to look at the sign so see what PPE was needed. Surveyor asked how staff would know if R72 was supposed to be on EBP or contact precautions. R72 was not sure. On 2/26/2026, at 11:51, Surveyor interviewed director of nursing (DON)-B via phone. DON-B stated if a resident is on EBP and another sign is posted (such as contact precautions) the EBP always trumps the other precaution, so staff would follow the EBP PPE recommendations. Surveyor asked how staff would know why a resident is on contact or when to wear a gown since contact requires staff to wear a gown when entering room. DON-B stated staff would have to read the recommendations on the sign and determine if a gown is needed. Surveyors clarified with DON-B, DON-B's statement indicating if someone was on more than one precautions staff should always follow EBP recommendations first. DON-B stated correctly, staff need to look at the recommendations and ask questions if needed. On 2/26/2026, at 1:21 PM, Surveyor shared concerns with nursing home administrator (NHA)-A and regional nurse-D Surveyors observations of staff not wearing appropriate PPE when performing colostomy, catheter, and repositioning cares for R72. Surveyor shared concerns staff do not know when to wear appropriate PPE for residents that are on precautions other than EBP. NHA-A understood the concern; no further information was provided at the time of this writeup. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5.) R6 was admitted to the facility 6/25/2015 with diagnoses including chronic respiratory failure (long-term lung damage), chronic obstructive pulmonary disease (long-term lung disease leading to difficulty breathing), dependence on respirator (ventilator) status (reliance on a machine to breathe), and tracheostomy (surgically created opening in the windpipe) status. R6 had a guardian. R6's most recent minimum data set (MDS) assessment dated [DATE] documents R6 receives oxygen therapy via invasive mechanical ventilator with suctioning and tracheostomy care. R6's ventilator and respiratory care plan documents the following interventions with initiated dated 6/7/23 and revised date 3/20/24:-the resident requires enhanced barrier precautions related to presence of artificial opening and potential exposure to multidrug resistant organisms (MDRO)-apply personal protective equipment (PPE) per facility policy -implement enhanced barrier precaution R6's risk for MDRO transmission care plan documents the following interventions with initiated date 10/29/25:-follow enhanced barrier precautions when outside the resident's room when indicated-PPE for enhanced barrier precautions is only necessary when performing high contact care activities . high contact includes: . device care or use: . tracheostomy/ventilator . On 2/24/26 at 1:09 PM, Surveyor observed Respiratory Therapist (RT)-U perform suctioning care for R6's tracheostomy. Before entering the room, Surveyor observed a sign outside of R6's door documenting enhanced barrier precautions were in place. The sign documents: .Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and a gown for the following high-contact resident care activities. device care or use: . tracheostomy . Surveyor observed RT-U perform hand hygiene then don gloves, but RT-U did not don a gown prior to providing suctioning and tracheostomy cares to R6. On 2/24/26 at 1:20 PM, Surveyor interviewed RT-U regarding when a gown would be worn when providing resident care. RT-U replied not all residents require a gown, but RT-U would wear one if a resident were on droplet or contact precautions. Surveyor asked if RT-U would wear a gown if a resident were on enhanced barrier precautions, and RT-U said yes, RT-U would wear a gown if there were an enhanced barrier precautions sign outside of a resident's door. Surveyor asked why RT-U did not wear a gown when performing suctioning and tracheostomy cares for R6, and RT-U replied RT-U is the only RT working on the unit and has to constantly go in and out of resident rooms to answer the ventilator alarms and did not have time to put on a gown. In an interview on 2/26/26 at 12:16 PM with Director of Nursing (DON)-B via phone call, DON-B stated enhanced barrier precautions should be followed any time staff are performing tracheostomy cares, and proper PPE should be worn to include a gown and gloves. On 2/26/26 at 1:32 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Regional Nurse-D that Surveyor observed RT-U perform tracheostomy care and suctioning without wearing a gown. 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. Based on interview and record review, the facility did not ensure a designated Infection Preventionist works at least part time at the facility for the responsibility of the facility's Infection Prevention Control Program. Director of Nursing (DON)-B was designated as the facility's Infection Preventionist (IP) in addition to performing DON responsibilities and working on the Ventilator Unit as a floor nurse, which resulted in the inability to implement an effective Infection Prevention Control Program. Findings include: Surveyor reviewed the Facility assessment dated 10/2023, last reviewed 02/2026, which documents the facility as having one (1) full-time Director of Nursing and one (1) full-time Infection Preventionist. On 2/26/26, at 12:19 PM, Surveyor interviewed Director of Nursing (DON)-B who stated she dedicates Mondays to the Infection Prevention Program. DON-B stated she works two (2) days a week on the Ventilator Unit as a floor nurse and three (3) days a week as the DON. Surveyor expressed concerns with DON-B not having enough dedicated time to perform the IP responsibilities. DON-B stated there is a new interim DON who has started at the facility which will allow DON-B to dedicate 2-3 days out of 10 days for IP responsibilities. DON-B stated she works 10 days in two (2) weeks and will dedicate 2-3 days out of that time to the Infection Prevention Program. On 2/26/26, at 10:01 AM, Surveyor notified Nursing Home Administrator (NHA)-A of concerns with the facility not having a dedicated full-time Infection Preventionist. NHA-A acknowledged these concerns. No additional information was provided.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 that 7 (R6, R3, R55, R7, R36, R8, and R78) of 7 residents reviewed for transfers or discharges received the proper written notice of transfer, written bed hold policy with reserve bed payment identified and that proper notification was sent to the State Long-Term Care Ombudsman. *R6 was transferred to the hospital 10/25/25, 11/9/25, and 1/5/26. The facility was unable to locate a written notice of transfer or bed hold notice from 10/25/25 or 11/9/25 transfers to the hospital. The bed hold notice dated 1/5/26 did not list the bed payment rate. The facility did not notify the State Ombudsman of R6's hospitalizations. *R3 was transferred to the hospital on [DATE]. The bed hold notice dated 12/16/25 did not list the bed hold payment rate. The facility did not notify the State Ombudsman of R3's hospitalization. *R55 was transferred to the hospital on [DATE], 12/3/25, and 1/12/26. The bed hold notices dated 10/9/25, 12/3/25, and 1/12/26 did not list the bed hold payment rate. The facility did not notify the State Ombudsman of R55's hospitalizations. *R7 was transferred to the hospital on [DATE]. The facility did not notify the State Ombudsman of R7's hospitalization. *R36 was transferred to the hospital on 1/28/26. The facility did not notify the State Ombudsman of R36's hospitalization. *R8 was transferred to the hospital on [DATE] and 1/12/26. The facility did not notify the State Ombudsman of R8's hospitalizations. *R78 was discharged from the facility on 1/13/26. The facility did not notify the State Ombudsman of R78's discharge. Findings include: The facility policy titled Bed Holds and Written Notice with effective date 8/1/25 documents: . Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies.All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these polices . at the time of transfer (or, if the transfer was an emergency, within 24 hours). Multiple attempts to provide the resident representative with notice . should be documented in cases where staff were unable to reach and notify the representative timely. The written bed-hold notices provided to the residents/representatives explain in detail: . the per-diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the state bed-hold period (for Medicaid residents). Medicaid residents who exceed the state's bed-hold limit and/or non-Medicaid residents who request a bed-hold are responsible for the facility's basic per-diem rate while their bed is held. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1). R6 was admitted to the facility 6/25/2015. 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. Surveyor conducted a review of R6's electronic health record (EHR) and noted R6 was sent to the hospital on [DATE], 11/9/25, and 1/5/26 for further evaluation. Surveyor was unable to locate a written notice of transfer or bed hold notice in R6's EHR for dates 10/25/25 or 11/9/25. Surveyor located a written notice of transfer and bed hold notice in R6's EHR dated 1/5/26, but Surveyor notes the documents were signed by R6 instead of R6's guardian and the per diem rate to hold the bed is not documented on the bed hold notice. There is no evidence in R6's EHR that the written notice of transfer and bed hold notice on 1/5/26 were provided to R6's guardian. On 2/24/26 at 3:29 PM, Surveyor requested R6's written notice of transfer and bed hold notices from 10/25/25 and 11/9/25 and evidence the State Ombudsman was notified of R6's hospitalizations from Nursing Home Administrator (NHA)-A. During an interview on 2/25/26 at 10:32 AM, NHA-A stated NHA-A was unable to locate the written notice of transfer and bed hold notice for R6 for R6's transfers on 10/25/25 or 11/9/25. On 2/25/26 at 3:13 PM, NHA-A informed Surveyor the Ombudsman has not been notified of any resident hospitalizations since August 2025. Surveyor shared concern with NHA-A there is no evidence of written notice of transfer or bed hold for R6's hospitalizations on 10/25/25 or 11/9/25, R6's bed hold notice dated 1/5/26 did not document the per diem bed hold rate, there is no evidence R6's guardian was provided the notice of transfer or bed hold notice in writing, and that the Ombudsman was not notified of R6's hospitalizations on 10/25/25, 11/9/25, and 1/5/26. NHA-A understood the concerns and no additional information was provided. On 02/26/2026 at 11:08 AM, a Surveyor interviewed Director of Social Services (DSS)-L regarding the process for notifying the Ombudsman of discharged residents from the facility. DSS-L stated DSS-L has not sent the Ombudsman information as this task has gotten away from DSS-L. DSS-L stated DSS-L was always sending the Ombudsman notification at the beginning of the month for the previous month. DSS-L stated DSS-L will get back into it going forward. On 2/26/26 at 11:52 AM, Surveyor interviewed Business Office Manager (BOM)-T regarding bed hold notices. BOM-T stated BOM-T is alerted when a bed hold notice is required but the floor nurse responsible for sending a resident out to the hospital usually completes the form and gives it to the Director of Nursing (DON). BOM-T stated the floor nurse would be responsible for calling the resident's POA/guardian to notify them of the transfer and to obtain consent to hold the bed. BOM-T stated the floor nursing staff would not know the specific per diem rate because it is specific to each resident, so that is probably why it was not filled out on R6's bed hold notice on 1/5/26. BOM-T stated BOM-T will follow up with a resident's POA/guardian to provide the bed hold rate if the floor nurse was unable to provide that information, but BOM-T stated this information is not provided in writing to the POA/guardian and is only provided verbally. BOM-T stated the rate is discussed with residents and their POA/guardian on admission, but BOM-T will educate the nurses on the different rates to make sure that information gets added to the written bed hold notice. 2.) R3 was admitted to the facility on [DATE]. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's Annual Minimum Data Set (MDS) assessment dated [DATE] documents R3 is cognitively intact. On 12/16/25, R3 experienced a change of condition and was transferred to the hospital. R3's written notice of transfer and bed hold notice in R3's Electronic Health Record dated 12/29/25 is signed but Surveyor notes the per diem rate to hold the bed is not documented on the bed hold notice. On 2/24/26 at 3:29 PM, Surveyor requested evidence the State Ombudsman was notified of R3's hospitalization from Nursing Home Administrator (NHA)-A. On 2/25/26 at 3:13 PM, NHA-A informed Surveyor the Ombudsman has not been notified of any resident hospitalizations since August 2025. Surveyor shared concern with NHA-A that R3's bed hold notice dated 12/16/26 did not document the per diem bed hold rate, and that the Ombudsman was not notified of R3's hospitalizations on 12/16/25. On 02/26/2026 at 11:08 AM, Surveyor interviewed Director of Social Services (DSS)-L regarding the process for notifying the Ombudsman of discharged residents from the facility. DSS-L stated that DSS-L has not sent the Ombudsman information as this task has gotten away from DSS-L. DSS-L stated that DSS-L was always sending the Ombudsman notification at the beginning of the month for the previous month. DSS-L stated DSS-L will get back into it going forward. On 2/26/26 at 11:52 AM, Surveyor interviewed Business Office Manager (BOM)-T regarding bed hold notices. BOM-T stated BOM-T is alerted when a bed hold notice is required but the floor nurse responsible for sending a resident out to the hospital usually completes the form and gives it to the Director of Nursing (DON). BOM-T stated the floor nurse would be responsible for calling the resident's POA/guardian to notify them of the transfer and to obtain consent to hold the bed. BOM-T stated the floor nursing staff would not know the specific per diem rate. BOM-T stated the rate is discussed with residents and their POA/guardian on admission, but BOM-T will educate the nurses on the different rates to make sure that information gets added to the written bed hold notice. 3.) R55 was admitted to the facility on [DATE]. R55's Annual Minimum Data Set (MDS) assessment dated [DATE] documents R55 is severely cognitively impaired. On 10/9/25, 12/3/25 and 1/12/26 R55 had a change of condition and was transferred to the hospital. R55's written notice of transfer and bed hold notice in R55's Electronic Health Record dated 10/9/25 is signed but Surveyor notes the per diem rate to hold the bed is not documented on the bed hold notice. R55's written notice of transfer and bed hold notice in R55's Electronic Health Record dated 12/3/25 is signed but Surveyor notes the per diem rate to hold the bed is not documented on the bed hold notice. R55's written notice of transfer and bed hold notice in R55's Electronic Health Record dated 1/12/26 is signed but Surveyor notes the per diem rate to hold the bed is not documented on the bed hold notice. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/24/26 at 3:29 PM, Surveyor requested evidence that the State Ombudsman was notified of R55's hospitalizations from Nursing Home Administrator (NHA)-A. On 2/25/26 at 3:13 PM, NHA-A informed Surveyor that the Ombudsman has not been notified of any resident hospitalizations since August 2025. Surveyor shared concern with NHA-A that R55's bed hold notices dated 10/9/25, 12/3/25 and 1/12/26 did not document the per diem bed hold rate, and that the Ombudsman was not notified of R3's hospitalizations. On 02/26/2026 at 11:08 AM, Surveyor interviewed Director of Social Services (DSS)-L regarding the process for notifying the Ombudsman of discharged residents from the facility. DSS-L stated that DSS-L has not sent the Ombudsman information as this task has gotten away from DSS-L. DSS-L stated that DSS-L was always sending the Ombudsman notification at the beginning of the month for the previous month. DSS-L stated DSS-L will get back into it going forward. On 2/26/26 at 11:52 AM, Surveyor interviewed Business Office Manager (BOM)-T regarding bed hold notices. BOM-T stated BOM-T is alerted when a bed hold notice is required but the floor nurse responsible for sending a resident out to the hospital usually completes the form and gives it to the Director of Nursing (DON). BOM-T stated the floor nurse would be responsible for calling the resident's POA/guardian to notify them of the transfer and to obtain consent to hold the bed. BOM-T stated the floor nursing staff would not know the specific per diem rate. BOM-T stated the rate is discussed with residents and their POA/guardian on admission, but BOM-T will educate the nurses on the different rates to make sure that information gets added to the written bed hold notice. 4.) R7 was originally admitted to the facility on [DATE]. Surveyor conducted a review of R7's medical record and noted R7 was transferred to the hospital for further evaluation on 12/22/25-12/30/25. There was no evidence provided by the facility that the State Ombudsman had been notified of R7's transfer to the hospital on [DATE]. On 02/26/2026 at 11:08 AM, Surveyor interviewed DSS (Director of Social Services)-L regarding the process for notifying the Ombudsman of discharged residents from the facility. DSS-L stated she has not sent the Ombudsman information as this task has it has gotten away from her/him. DSS-L stated that she/he was always doing them (notifications) at the beginning of month for the previous month. DSS-L stated she/he will get back into it going forward. 5.) R36 was admitted to the facility on [DATE]. Surveyor conducted a review of R36's medical record and noted R36 was transferred to hospital 1/28/26- 1/31/26 for further evaluation. There was no evidence the State Ombudsman had been notified of R36's transfer to the hospital on 1/28/26. On 02/26/2026 at 11:08 AM, Surveyor interviewed DSS (Director of Social Services)-L regarding the process for notifying the Ombudsman of discharged residents from the facility. DSS-L stated she has not sent the Ombudsman information as this task has gotten away from her/him. DSS-L stated she/he was always doing them (notifications) at beginning of month for the previous month. DSS-L (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she/he will get back into it going forward. 6.) R8 was admitted to facility on 10/26/25. Surveyor conducted a review of R8's medical record and noted R8 was transferred to the hospital 12/16/25-12/26/25 and 1/12/26-1/17/26. There was no evidence the State Ombudsman had been notified of R8's transfer to the hospital on [DATE] or 1/17/26. On 02/26/2026 at 11:08 AM, Surveyor interviewed DSS (Director of Social Services)-L regarding the process for notifying the Ombudsman of discharged residents from the facility. DSS-L stated that she has not sent the Ombudsman information as this task has gotten away from her/him. DSS-L stated that she/he was always doing them (notifications) at beginning of month for the previous month. DSS-L stated she/he will get back into it going forward. 7.) R78 was admitted to the facility on [DATE]. R78 discharged to an assisted living facility on 1/13/26. R78's medical record documented the physician signed discharge orders/medication list on 1/12/26. Facility progress notes dated 1/13/26 at 6:13 PM, documented: Pt (Patient) daughter came and told writer pt is being discharged today to go to assisted living and took pt belongings. Surveyor found no evidence the Ombudsman was notified of R78's discharge. On 2/25/26 at 12:00 PM, Surveyor asked Nursing Home Administrator (NHA)-A about R78's discharge. NHA-A stated, We were planning for his discharge but ultimately it did not go as planned. His daughter just showed up and said he was discharging to assisted living. Surveyor informed NHA-A of concern there is no evidence the ombudsman was notified of R78's discharge. NHA-A reported the facility does not have evidence the ombudsman was notified of discharge, stating We only have a list from August, and she wasn't doing them after. No additional information was provided.

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Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not complete and transmit entry tracking, Medicare 5 day, quarterly, or discharge assessments as required for 6 (R25, R28, R40, R44, R64, and R73) of 8 residents reviewed for Minimum Data Set (MDS) assessments and transmission.1.). R25's entry MDS dated [DATE] and quarterly MDS dated [DATE] were not transmitted.2.). R28's quarterly MDS dated [DATE] was not transmitted timely.3.). R40's quarterly MDS dated [DATE] was not transmitted timely. 4.). R44's modification to quarterly MDS dated [DATE] was not transmitted. 5.). R64's entry MDS dated [DATE] was not transmitted timely. 6.). R73's discharge MDS dated [DATE] was not transmitted timely. Findings include:The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.19.1 dated October 2024, documents long-term care facilities participating in Medicare and Medicaid programs must meet the following conditions: Completion timing: -For all non-admission OBRA (Omnibus Budget Reconciliation Act) and PPS (Prospective Payment System) assessments, the MDS completion date (item Z0500B) must be no later than 14 days after the Assessment Reference Date (ARD) (item A2300). Transmitting data:-Comprehensive assessments must be transmitted electronically within 14 days of the care plan completion date (V0200C2 + 14 days). -All other MDS assessments must be submitted within 14 days of the MDS completion date (item Z0500B + 14 days). -For entry tracking records, information must be transmitted within 14 days of the event date (item A1600 + 14 days for entry records). The MDS must be transmitted (submitted and accepted) into iQIES (Internet Quality Improvement Evaluation System). 1). On 2/25/26, Surveyor reviewed R25's MDS assessments in R25's EHR. R25's entry tracking MDS assessment documented the entry date (item A1600) as 4/16/25; there was no accepted date documented on the assessment. R25's quarterly MDS assessment documented the completed date (item Z0500B) as 4/21/25; there was no accepted date documented on the assessment for tranmission. 2). On 2/25/26, Surveyor reviewed R28's MDS assessments in R28's EHR. R28's quarterly MDS assessment documented the completion date (item Z0500B) as 3/7/25 and the accepted date as 4/10/25, which is outside of the 14-day transmission window. 3). On 2/25/26, Surveyor reviewed R40's MDS assessments in R40's EHR. R40's quarterly MDS assessment documented the completion date (item Z0500B) as 3/7/25 and the accepted date as 4/10/25, which is outside of the 14-day transmission window. 4). On 2/25/26, Surveyor reviewed R44's MDS assessments in R44's EHR. R44's modification to quarterly MDS assessment documented the completion date (item Z0500B) as 4/8/25; there was no accepted date documented on the assessment for transmission. 5). On 2/25/26, Surveyor reviewed R64's MDS assessments in R64's EHR. R64's entry tracking MDS assessment documented the entry date (item A1600) as 3/22/25 and accepted date as 4/10/25, which is outside of the 14-day transmission window. 6). On 2/25/26, Surveyor reviewed R73's MDS assessments in R73's EHR. R73's discharge return anticipated MDS assessment documented the completion date (item Z0500B) as 2/8/26; there was no accepted date, and the MDS assessment documented submit by 2/22/26. On 2/25/26 at 1:50 PM, Surveyor shared the above concerns with Regional Nurse-D who confirmed all 6 of the above MDS assessments were completed or transmitted incorrectly. Regional Nurse-D stated Regional Nurse-D has been transmitting the facility MDS assessments for the last few months. Regional Nurse-D was not sure why the assessments were missed because Regional Nurse-D usually runs a report from the EHR which shows any MDS assessments that need to be submitted. On 2/25/26 at 2:59 PM, Surveyor shared the above concerns with Nursing Home Administrator (NHA)-A. No additional information was provided.

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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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not 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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/8/2023 and 6/20/2025 do not have documentation noting 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 has to hold onto R39's smoking materials. On 2/25/2026, Surveyor requested all smoking assessments for R39 for 2025. On 2/25/2026, at 10:00 AM, Surveyor interviewed registered nurse (RN)-F who stated R39 usually goes outside to smoke without supervision. Surveyor asked if R39 held onto R39's smoking materials or if facility held onto R39's smoking materials. RN-F stated R39 must hold onto R39's smoking materials because R39 never asked for smoking materials when going outside to smoke. Surveyor asked how often smoking assessments are completed. RN-F stated smoking assessments are completed yearly but was not sure. Surveyor asked RN-F who completes smoking assessments for residents. RN-F was not sure who completes smoking assessments for residents. On 2/25/2026, at 10:36 AM, Surveyor interviewed certified nursing assistant (CNA)-K who stated R39 will go outside to smoke by self. CNA-K stated R39 holds onto R39's smoking materials. Surveyor asked CNA-K where the information is located to see if a resident is safe to smoke unsupervised or needs supervision and if the resident can hold onto their own smoking materials. CNA-K stated usually it is documented on the resident's care Kardex, or through report with the previous shift. On 2/25/2026, at 2:55 PM, Surveyor asked nursing home administrator (NHA)-A and regional nurse-D if anymore of R39's smoking assessments could be located. Regional nurse-D stated the only assessments that could be located were R39' s admission smoking assessment on 11/8/2023 and a quarterly smoking assessment completed on 6/30/2025. Surveyor asked how often smoking assessments are to be completed. NHA-A stated smoking assessments should be completed on admission, then quarterly, or as needed if a change has occurred. Surveyor asked if it should be documented if a resident is safe to smoke supervised or unsupervised and if the resident can or cannot hold onto their own smoking materials. NHA-A stated the assessment should determine and document if a resident is safe to smoke supervised or unsupervised and if the resident could hold onto their own smoking materials. Surveyor shared concerns R39 did not have quarterly smoking assessments completed, and R39 smoking assessments completed on 11/8/2023 and 6/30/2025 and R39's care plan do not indicate if R39 is safe to smoke supervised or unsupervised and if R39 can hold onto R39's smoking materials or if the facility holds onto R39's smoking materials, NHA-A and regional nurse-D understood the concerns and no further information was provided. 3.) Review of Fall Prevention and Management Policy- effective date: 8/1/2025Purpose: It is the goal of [name of facility] to identify residents' risk of falls and to promptly implement interventions to decrease risk.Procedure: (includes)3.) When a resident falls:a. Staff who witness the fall or is the first to find the resident who has fallen, stays with the resident to ensure they are safe.b. RN must assess the resident for injury when they are in the building, if a RN is not in the building the on-call RN will be updated.f. The Nurse of designee assigned to the neighborhood leads the fall investigation/root cause analysis via falls huddle. The Nurse documents the information on the Fall Scene Investigation Report. g. New interventions are implemented based on root cause analysis of the fall.h. The Nurse ensures all documentation occurs, including the care plan update and the CNA pocket note update. The fall is noted on the 24-hour report and the IDT progress notes. R36 was admitted to the facility on [DATE] with diagnosis that included paraplegia, morbid obesity. The most recent quarterly MDS (Minimum Data Set), dated 11/13/25, documents R36 has a BIMS (brief interview for mental status) score of 4, indicating R36 is severely cognitively impaired. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	report documents the nurse was called to unit per staff. Staff escorted R36 back to wheelchair after hearing him call out for help. R36 unable to give description. Immediate action taken: Staff attended to nosebleed and left eye black. Ice pack applied. Taken to hospital- noThe report asked if there are any injuries- documented yes bruise to face. The report asks to document any predisposing environmental factors physiological factors or situation factors. None is noted for all 3 categories. Statements: (no name documented) date 12/4/25. I was told by other night LPN (Licensed Practical Nurse) that they escorted resident off floor in room, resident had nosebleed and bruised eye. Surveyor notes no notifications found or additional notes regarding the fall had been documented. Surveyor notes the fall investigation does not provide the same documented information as the post fall evaluation on 12/5/25. It was noted in the fall's investigation R36 was unable to provide any description of what happened and there were no witnesses to the fall. The falls evaluation documents R36 was reaching for item(s) at the time of the fall. The falls investigation nor the falls evaluation do not document the last time R36 was seen by staff or when he was last provided assistance from the staff. The investigation does not include whether R36 had fallen from the bed, wheelchair or lounge chair in his room. The falls investigation does not include staff statements who may have had knowledge of R36's condition prior to the fall and what fall prevention interventions were in place at the time of the fall. There is no root cause identified, no new fall prevention interventions put into place to keep R36 safe from further falls. On 2/25/26 at 3:00 PM, Surveyor interviewed Nursing Home Administrator- A regarding R36's fall with injury on 12/4/25. Surveyor asked if the facility had conducted a comprehensive assessment of R36's fall, determined a possible root cause and then evaluated the need for additional interventions to be put in place to get R36 safe from further falls. Nursing Home Administrator- A stated she would need to review and get back to the Surveyor. As of the time of exit on 2/26/26, no additional information had been provided. 4) R73 was admitted to the facility on [DATE] with diagnosis that included Cerebrovascular Disease, dysphagia, chronic respiratory failure, significant spasticity, type 2 diabetes. The most recent quarterly MDS (Minimum Data Set), dated 12/24/25 documents R73 is in a comatose state. R73 has impaired range of motion on both sides, both upper and lower extremities. R73 is dependent on staff for all activities of daily living, R73 has not had any falls since admission. On 2/4/26, the facility conducted a fall risk evaluation and determine R73 was at risk for falls. Nursing note dated 2/15/2026 at 7:30AM; Called to room, R73 was found face down next to her bed. Res has an abraised area on the R (right) side of her forehead. R73 is non-verbal. Hips are intact bilaterally, no clicks heard or felt. No other visible signs of further injuries. [Name of ambulance company] ambulance called as per requested by Power of Attorney and will transport to [name of hospital] ER. Nursing note dated 2/15/2026 at 10:38 AM; Writer informed of unwitnessed fall occurring prior to writer arrival to unit. On arrival noted R73 laying on left side of bed on floor in supine position with head towards head of bed. all equipment intact, Assessed for injuries, EMS (Emergency Medical Services) here currently for transport. On 2/15/2026 at 11:10 AM, the facility documented on the Post Fall Evaluation Fall Details: Fall was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not witnessed. Fall occurred in R73's room. Activity at the time of fall: Possibly coughed. The reason for the fall was not evident. Did an injury occur as a result of the fall: No. Did fall result in an ER visit/hospitalization: Yes.ER Visit/Hospitalization Details: Will review on R73's return. Provider: HUCU Time notified: 02/15/2026 Notified of: Fall Resident's responsible party notified: Yes. Person contacted: POA (power of attorney) Details of notification: Fall Date of Resident's responsible party notification: 02/15/2026 8:10 AM Contributing Factors: Recent change in environment: No. Was fluid spilled on floor: No. Clutter present on the floor: No. Floor mat was on floor: No. Poor lighting in the area: No. Medication Changes: Recent change to Resident's medications: No. Vitals: BP 136/88 - 2/15/2026 10:45 Position: Lying l (left)/arm P: 76 - 2/15/2026 10:45 Pulse, Type: Regular R 20.0 - 2/15/2026 10:45, O2 (Oxygen) 98.0 % - 2/15/2026 10:45, Method: Oxygen via Mask, Pain: Indicators of pain: None. Skin: Skin warm & dry, skin color WNL (Within Normal Limits and turgor is normal. Skin warm and dry, skin color WNL, and turgor is normal. Physical Findings: Change in diagnosis status: No. Recent diagnosis of stroke, TIA or arrhythmia: No. Decrease in fluid intake: No. Change in blood glucose levels: No. Change in blood pressure: No. Change in mental status: No. Change in behaviors: No. Change in mobility status: No. Recent weight loss: No. R73 did not have a recent fever. R73 had a recent cough. R73 did not have a recent cold. Sensory impairment: No. R73 does not have orthostatic BP (Blood Pressure) changes. Physical findings note: R73 is notable unresponsive to any outside stimuli although eyes open spontaneously, no purposeful response. Surveyor conducted further review of R73's medical record and noted the plan of care was revised on 2/16/25 to include: R73 is at risk for falls: 2/15/26 Actual Fall (Unwitnessed) Date Initiated: 09/16/2025, Revision on: 02/16/2026. The resident will be free of injury through the review date. 2/15/26: For repositioning, Staff will utilize soft pillows. Date Initiated: 02/16/2026. Revision on: 02/16/2026 Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Date Initiated: 09/16/2025 Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 09/16/2025 Ensure that the resident is wearing appropriate footwear. Date Initiated: 09/16/2025 Follow facility fall protocol. Date Initiated: 09/16/2025 Resident readmitted to facility 02/24/2026: bed in lowest position, fall mats on side of bed. Bolsters placed.Date Initiated: 02/24/2026.Revision on: 02/24/2026. Surveyor conducted a review of the facility's falls investigation dated 2/15/26 at 8:00 AM. The following was documented:Writer informed of unwitnessed fall occurring prior to writer arrival on unit. On arrival noted R73 laying on left side of bed on floor in supine position with head towards head of bed. All equipment intact. Assessed for injuries. EMS (Emergency Medical Services) here currently for transport. Not witnessed. Assessed to apparent notable injuries, transported to ER for further eval. No injuries observed at time of incident. Level of consciousness- alert, mobility wheelchair bound. Unable to note change in orientation as R73 is nonverbal. No injuries observed post incident. Predisposing Environmental Factors- none. Predisposing Physiological factors- none. Predisposing situation factors- none. Other Info- Resident has a very strong cough. POA notified 2/15/26, 8:05AM. Surveyor noted the falls investigation contained statements from staff that reported CNA1 (name unknown agency) and CNA 2 (name unknown agency) along with RT Therapist repositioned R73 at 7:15 AM on 2/15/26. By 7:21 Am on 2/15/26, CNA1 and CNA 2 walked past R73 and saw R73 on floor and notified RT (Respiratory Therapist) promptly. The adaptive devices are being used if incident was a fall: low bed, wedges, boots. Surveyor notes the fall investigation did not identify a root cause for the fall. On 2/26/26 at 11:50 AM, Surveyor interviewed Director of Nursing (DON)- B regarding R73's fall from bed on 2/15/26. DON- B stated she came to work because of a call in on the vent unit and arrived (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	about 8:00 AM. At this time [name of ambulance company] ambulance had also arrived and reported was here for a fall for R73. DON- B stated she was surprised by this and went to R73's room. Staff were with R73 and DON-B conducted an assessment of R73. R73 was laying on the floor with her pillow. R73's bed was in the lowest position and DON-B did not observe any injuries or abrasions. DON- B immediately interviewed the Respiratory Therapist and the 2 Certified Nursing Assistants (agency staff) about what happened. It was reported that the 2 CNAs were repositioning R73 and providing cares. R73 does have an air mattress and regular staff know not to put R73 completely on her thigh when repositioning. Sometimes the bed sheets can come off the air mattress and R73 has been coughing. Surveyor notes it was DON- B's root cause analysis that R73 coughed and the way she was positioned on the air mattress and possible with the sheet un-done, R73 rolled from the bed. DON- B stated she called R73's POA and spoke with them. DON- B stated they did have questions because R73 is not able to move about the bed on her own and is nonverbal. DON-B stated she explained she thought R73 must have coughed really hard and the fitted sheet may have not been attached to the air mattress and R73 could not have been positioned in a way to prevent her from rolling out of bed. DON- B stated R73 is now in bed with bolsters to each side, mats on each side of the bed and bed in lowest position. As of the time of exit, the facility was not able to provide additional information as to how R73, who does not have any bed mobility on her own, was able to fall from the bed to the floor on 2/15/26.

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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 and interview, the facility did not ensure the storage of drugs and biologicals were stored in locked compartments and permit only authorized personnel to have access to the keys. 1 of 5 medication carts were observed to be unlocked and unattended in access to a public area of the facility. The deficient practice had the potential to affect 10 (vent unit) residents whose medications are stored in the medication cart. Findings include: The facility's policy titled Medication Labeling and Storage, dated 8/1/25, documents the following:The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner.Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. On 2/24/26, at 8:21 AM, Surveyor observed Licensed Practical Nurse (LPN)-R passing medications to residents on the vent unit. Surveyor observed LPN-R walk away from the vent unit medication cart, leaving the cart unlocked and unattended throughout LPN-R's morning medication pass. On 2/24/26, at 11:33 AM, Surveyor observed the vent unit medication cart unlocked and unattended. On 2/24/26, at 1:02 PM, Surveyor observed LPN-R walk away from the vent unit medication cart, leaving the vent unit medication cart unlocked and unattended. On 2/26/26, at 10:01 AM, Surveyor notified Nursing Home Administrator (NHA)-A of concerns with observation of the vent unit medication cart being unlocked and unattended throughout the day on 2/24/26. NHA-A acknowledged these concerns. No additional information was provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility did not ensure that food was stored, prepared and served under sanitary conditions in 3 of 3 unit refrigerators. On 2/24/26, at 12:35 PM, a refrigerator was observed to have multiple food and drink items opened and not dated. This deficient practice has the potential to affect 10 residents on the Vent Unit of the facility. On 2/26/26, at 8:39 AM, a refrigerator was observed to have multiple food and drink items opened and not dated. This deficient practice has the potential to affect 14 residents on the Rehabilitation (Rehab) Unit of the facility. The Rehab Unit refrigerator temperature log was noted to have the following missing dates 2/16/26, 2/18/26, 2/21/26, and 2/24/26. On 2/25/26, at 8:44 AM, a refrigerator was observed to have multiple food and drink items opened and not dated. This deficient practice has the potential to affect 34 residents on the North and [NAME] Unit of the facility. Findings include: The facility's policy titled Food Storage, dated 8/1/25, documents:Foods shall be received and stored in a manner that complies with safe food handling practices.All foods belonging to residents are labeled with the resident's name, the item and the use by date.Refrigerators must have working thermometers and are monitored for temperature according to state specific guidelines.Beverages are dated when opened and discarded after seventy-two (72) hours.Other opened containers are dated and sealed or covered during storage. On 2/24/26, at 12:35 PM, Surveyor observed the Vent Unit refrigerator to have open drinks, a take-out Styrofoam container, multiple Styrofoam cups with lids, and an opened bottle of thickened lemon water that was not dated or labeled with a resident name. Surveyor observed the Vent Unit freezer to have a Culvers bag and a cardboard box full of food in grocery bags that were not labeled and not dated. On 2/26/26, at 8:39 AM, Surveyor observed the Rehab Unit refrigerator temperature log located on the front of the refrigerator that was noted to have the following missing dates 2/16/26, 2/18/26, 2/21/26, and 2/24/26. Surveyor observed the refrigerator to contain multiple grocery bags with food, a used Dominos pizza box, and a Qdoba take out bag that contained food that was not labeled with a resident name or dated. Surveyor observed the freezer to contain two opened water bottles, on opened and not sealed waffle bag with one waffle in it, and a grocery bag with contents that were not labeled with a resident name or dated. On 2/25/26, at 8:44 AM, Surveyor observed the refrigerator on the North and [NAME] Unit of the facility and noted 2 Styrofoam cups with caps on, 2 grocery bags with content, and a pitcher of pink juice about 2/3 full that was not dated or labeled with a resident name. On 2/26/26, at 10:01 AM, Surveyor notified Nursing Home Administrator (NHA)-A of concerns of the above findings. NHA-A acknowledged the concerns. No additional information was provided.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure 1 (R6) of 1 resident was assessed to self-administer medications. On 2/24/26, Surveyor observed Licensed Practical Nurse (LPN)-R set R6's medications down on R6's bedside table and exit the room. R6 did not have a self-administration assessment completed to identify if R6 was able to safely self-administer medications. Findings include:The facility policy titled Self Administer Medications with an effective date of 8/1/25 documents the following: . Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. The IDT considers the following factors when determining whether self-administration of medications is safe and appropriate for the resident: . The medication is appropriate for self-administration; . The resident can follow directions and tell time to know when to take the medication; . The resident comprehends the medication's purpose, proper dosage, timing, signs of side effects and when to report these to staff; . The resident has the physical capacity to . remove medications from a container and to ingest and swallow . the medication; .If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status. Standing order obtained by Medical Director of residents to be able to self administer after assessment completed deeming them safe. R6 was admitted to the facility 6/25/2015 with diagnoses including chronic respiratory failure (long-term lung damage), chronic obstructive pulmonary disease (long-term lung disease leading to difficulty breathing), paroxysmal atrial fibrillation (abnormal heart rhythm), chronic diastolic (congestive) heart failure (the heart muscle cannot pump blood normally), chronic kidney disease (long-term kidney damage), hypertension (high blood pressure), anemia (low levels of healthy red blood cells), post-traumatic stress disorder (a mental health condition in people who have experienced or witnessed a traumatic event), and unspecified convulsions (seizures). R6 had a guardian. R6's most recent minimum data set (MDS) assessment dated [DATE] documents R6 has a brief interview for mental status (BIMS) score of 15, indicating intact cognition. During an interview with R6 on 2/24/26 at 8:19 AM, Surveyor observed LPN-R enter R6's room with R6's cup of medications and a cup of applesauce. Surveyor observed LPN-R set the medication cup containing approximately nine medications and applesauce on R6's bedside table then leave the room without watching R6 take the medications. Surveyor asked R6 if R6 always takes medications independently, and R6 nodded yes. During review of R6's electronic health record (EHR), Surveyor was unable to locate a self-administration medication assessment. Surveyor was unable to locate any documentation that R6 was assessed to be capable of self-administering medications in R6's care plan, orders, Medication Administration Record (MAR), or Treatment Administration Record (TAR).On 2/25/26 at 8:46 AM, Surveyor interviewed Registered Nurse (RN)-S regarding how a resident would be determined appropriate to self-administer medications. RN-S replied there would be a formal assessment in the resident's EHR and it would be in the resident's care plan. RN-S stated there would be documentation in the resident's chart stating medications can be left at bedside. RN-S was not sure if R6 was able to take medications independently but would be administering R6's medications shortly and would check R6's chart. On 2/25/26 at 9:13 AM, RN-S informed Surveyor there is nothing in R6's chart noting R6 can self-administer medications. RN-S would expect to see a task in the MAR (Medication Administration Record) or TAR (Treatment Administration Record) for self-administering medications and confirmed there is no such task in R6's MAR or TAR. On 2/25/26 at 10:32 AM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that Surveyor observed (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN-R leave R6's medications on R6's bedside table and Surveyor was unable to locate a self-administration assessment for R6. NHA-A responded LPN-R was educated. No further information was provided.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility did not ensure the medical record reflected the resident's accurate advanced directive wishes for 1 (R55) of 16 residents reviewed.*R55's Do Not Resuscitate form was signed on [DATE] and scanned into R55's medical record. On [DATE], at the start of Survey, R55's active MD order and Electronic Medical Record (EMR) dashboard documented R55 to have elected a full code status. Findings include: The facility policy with an effective date of [DATE], and titled, Cardiopulmonary Resuscitation and Automated external defibrillation, documents, in part: The purpose of this policy and procedure is to provide guidelines for the initiation of Cardiopulmonary Resuscitation (CPR) in victims of sudden cardiac arrest. Determine and record a code status for each resident in his or her [electronic medical record (EMR)], along with obtaining an order. The newest form will be kept in a binder at the nurse's station. When checking a resident for their code status, this binder will be the only place to find that information.R55 was admitted to the facility on [DATE] with diagnosis that included bladder cancer, Cerebral infarction (stroke), Cardiomyopathy (enlarged heart), Alzheimer's disease, Vascular dementia and Depression.R55's Discharge Minimum Data Set (MDS) assessment dated [DATE] documents R55 is moderately cognitively impaired. R55 is dependent on staff for all care, mobility and transfers.R55 has an activated Power of Attorney (POA).R55's Advance Directives Care Plan initiated on [DATE] documents, in part: CODE STATUS: Refer to orders/documentation.On [DATE] at 11:27 AM, Surveyor reviewed R55's EMR for R55's advanced directive wishes. When opening R55's EMR, the dashboard of R55's chart documents, Full code, Next to the words full code, is a hyperlink that reads, Advance Directives. Surveyor clicked and the hyperlink and was taken to a signed document titled, Emergency care DO NOT RESUSCITATE ORDER (DNR). Surveyor reviewed the DNR state form and noted it was signed by R55's POA and Nurse Practitioner (NP) on [DATE].Surveyor noted a discrepancy in R55's EMR documentation of whether R55 was a full code or DNR.Surveyor reviewed R55's EMR and noted another Emergency care DO NOT RESUSCITATE ORDER (DNR) state form that was signed by R55's POA and Doctor on [DATE]. On [DATE], R55 had an active order dated [DATE] which documented: Full code.R55's NP note dated [DATE] at 10:30 AM, documents, in part: Patient is DNR.Surveyor noted 2 days after a full code order was placed in R55's EMR, R55's NP documented that R55 is DNR. On [DATE], Surveyor asked Nursing Home Administrator (NHA)-A for all copies of R55's advanced directives. NHA-A provided two of R55's, Emergency care DO NOT RESUSCITATE ORDER (DNR) forms that were signed on [DATE] and [DATE]. Surveyor noted NHA-A did not provide any documentation that R55 had elected a full code status.On [DATE] at 3:49 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-HH and CNA-JJ. Surveyor asked how staff know the residents' advanced directive status. CNA-JJ stated that the nurse will address the code status with the resident and/or the POA. After that, the form designating full code or DNR is placed in the code binder at each nurse's station. The binder is in alphabetical order, so it is easy to find code status fast. Surveyor asked what R55's code status is. CNA-HH stated that R55 is a DNR. CNA-HH stated that CNA-HH remembers that R55 wears a DNR bracelet. CNA-JJ stated that CNA-JJ thinks that R55 is a full code. CNA-JJ stated R55 still goes out to the hospital for treatment so thinks R55 is a full code. CNA-JJ grabbed the code binder at the nurse's station. CNA-JJ found a full code order under R55's name. Surveyor observed the full code order sheet that had R55's name on it and designated R55 as a full code and the order sheet was undated. Surveyor noted full code was highlighted in pink at the top of the form.On [DATE] at 3:51 PM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked about how the facility documents advanced directives for residents. DON-B stated the process just recently changed earlier this month. Now, each unit has a code binder at the nurse's station. It is in alphabetical order, and the code status is highlighted in pink. DON-B stated all staff were educated on the new process. Surveyor (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked what R55's code status is. DON-B stated R55 was a full code for a long time but now it is a DNR. DON-B stated let me look. DON-B looked in the EMR and stated R55 was listed as a full code but when clicked on the hyperlink, it leads DON-B to the signed DNR form. DON-B stated that DON-B would look into it and get back to Surveyor. On [DATE] at 7:47 AM, DON-B returned to Surveyor. DON-B stated DON-B had to call R55's POA to confirm R55's code status. DON-B stated R55's POA confirmed R55 is a DNR. DON-B stated that R55's POA can sometimes change their mind regarding DNR and FULL code, but they decided R55 is a DNR. DON-B stated DON-B did a verbal order and put the DNR order in R55's EMR and in the code binder. On [DATE] at 7:47 AM, Surveyor reviewed the code binder at R55's nurse's station. R55 had a physician order designating R55 as a DNR. This order was documented as signed on [DATE] by R55's NP.R55's MD order with a start date of [DATE] documents DNR (Do Not Resuscitate). On [DATE] at 8:15 AM, Surveyor reviewed R55's EMR. Surveyor noted R55 had both an active Full code MD order and an active DNR (DO Not Resuscitate) order. Surveyor also noted that in the dashboard of R55's EMR is listed both full code and DNR. On [DATE] at 2:00 PM, Surveyor reviewed R55's EMR. Surveyor noted R55's has one active MD order for DNR and one advanced directive, DNR, listed in the dashboard of R55 EMR.On [DATE] at 3:16 PM, Surveyor informed Nursing Home Administrator (NHA)-A of the concern R55's advanced directives/code status was not easily identified for the first 2 days of the Survey. NHA-A stated that audits are being completed on code status, and one was completed today. The audit fixed the issue of both advanced directives listed in R55's EMR.On [DATE], NHA-A provided additional information. NHA-A documented, in part: The center had two code statuses listed in EMR on [DATE] on the patient dashboard. The center conducted a complete code status audit on [DATE]. The center implemented a new policy/procedure for code status on [DATE]. The new procedure reflects: Each unit (East, North, West, Vent and Rehab) has a code status binder. The binder on the unit contains documentation of each individual resident's code status.Should a resident code, the staff are to reference the code status binder to know the respective residents code status.Important Note: The facility had the correct documentation (DNR) and ensured this was filed in the code status binder on [DATE]. Although the center had both DNR and CPR listed in the resident dashboard, both the order and the code binder reflected accuracy and remained compliant with the updated Policy and Procedure.Surveyor noted NHA-A documented the correct code status for R55 as of [DATE] was DNR. Surveyor noted that at the beginning of Survey on [DATE], R55's medical record had an active Full code order, Full code listed in the resident's dashboard and a full code order in R55's binder, which was confirmed by interview with CNA-JJ and DON-B.

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	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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents whose Medicare part A benefits ended, was provided with written beneficiary protection notifications for 1 (R83) of 3 residents sampled for beneficiary notifications. The facility did not provide R83 with a written Advanced Beneficiary Notice (ABN), which includes financial liability information and appeal rights, at the time Medicare Part A coverage ended. Findings include: Notice of Medicare Non-Coverage (NOMNC) (Form CMS 10123-NOMNC) is utilized to provide written notification to resident or resident representative that Medicare Part A coverage is ending in two or more days. The notification includes appeal rights and provides the third-party reviewer name and phone number to begin an immediate appeal. Advance Beneficiary Notice (ABN) (Form CMS-10055) is utilized to provide written notification to resident or resident representative of services Medicare A will no longer cover, an estimated cost of those services, and three options which include each choice's effect on appeal rights. On 2/24/26, at 10:08 AM, Nursing Home Administrator (NHA)-A provided Surveyor with the beneficiary notification paperwork for sampled residents. NHA-A verified no ABN or NOMNC was provided to R83 who was discharged to home on [DATE] and stated she had additional information as to why an ABN and NOMNC were not provided. Surveyor requested the additional information. On 2/24/26, at 10:15 AM, NHA-A provided Surveyor documentation indicating the facility recognized on 1/9/26, a NOMNC and ABN form was not provided to R83. The facility conducted audits and education during an Interdisciplinary Team (IDT) meeting with Director of Social Services-L and Business Office Manager (BOM)-T. On 2/25/26, at 1:00 PM, Surveyor interviewed BOM-T who stated Director of Social Services-L is responsible for providing NOMNC and ABN documentation to residents within the facility and BOM-T stated she will help cover the responsibility. BOM-T stated the facility will be notified Medicare is being discontinued, BOM-T or Director of Social Services-L will provide NOMNC and ABN forms to the residents and talk to the residents about appeal options. BOM-T stated the forms get scanned into the resident's Electronic Medical Record (EMR) and Director of Social Services-L will keep the hard copies in a file folder. BOM-T stated she has not had any recent or additional training regarding NOMNC or ABN forms and states she has been with the facility for a while and just knows how to do it. On 2/26/26, at 10:01 AM, Surveyor notified Nursing Home Administrator (NHA)-A of concerns that R83 was not provided appropriate forms to review and sign when R83's was being informed Medicare Part A coverage was ending.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record and residents who use psychotropic drugs receive behavioral interventions in an effort to discontinue these drugs for 1 of 1 (R9) residents reviewed for psychotropic medications.R9 was hospitalized and re-admitted to the facility with an order for Zyprexa. The facility did not follow up as to why the medication was prescribed and there were no indications for use. R9 admitted to the facility on [DATE] and has diagnoses that include unspecified dementia, unspecified severity with psychotic disturbance, and depression.The facility policy titled Psychotropic Medication Use dated 8/1/25 documents (in part) .Residents will not receive medications that are not clinically indicated to treat a specific condition.1. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior.2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring and review requirements specific to psychotropic medications: a. Anti-psychotics.3. Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes:a. Indications for use; b. dose (including duplicate therapy); c. duration; d. adequate monitoring for efficacy and adverse consequences, and e. preventing, identifying and responding to adverse consequences.4. Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record.8. Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes.Resident Evaluations1. Situations which may prompt an evaluation or re-evaluation of the resident include:a. admission or re-admission.f. A new medication order or renewal or orders.3. When determining whether to initiate, modify or discontinue medication therapy, the IDT (Interdisciplinary Team) conducts an evaluation of the resident. The evaluation will attempt to clarify whether:a. Other causes for symptoms (including symptoms that mimic a psychiatric disorder) have been ruled out; b. Signs and symptoms are clinically significant enough to warrant medication therapy; c. A particular medication is clinically indicated to manage the symptoms or condition; and d. The actual or intended benefit of the medication is understood by the resident/representative.4. Residents (and/or representatives) have the right to decline treatment with psychotropic medications.a. The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives.R9's care plan focus documents: Resident utilizes antianxiety/antidepressant/ antipsychotic medications r/t (related to) dx (diagnosis) of unspecified dementia, unspecified severity, with psychotic disturbance - initiated 8/31/24, revised 8/19/25. Interventions:Administer psychotropic medications as ordered by physician - revised 3/13/25. Consult with pharmacy, MD (Medical Doctor) to consider dosage reduction when clinically appropriate at least quarterly - revised 3/13/25.Discuss with MD, family re (regarding) ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy - revised 3/13/25.Monitor/document/report PRN (as needed) any adverse reactions of psychotropic medications - revised 3/13/25.Surveyor notes R9 was followed by psychiatric services and was previously prescribed Zyprexa dating back to 2024. The facility completed a Gradual Dose Reduction's (GDR), and the medication was discontinued on 10/20/25. R5's last psychiatric note was dated 8/18/25.R9's Pharmacy note dated 1/27/26 documents: re-admission 11/2025. 7/21/25 discussed during IDT (Interdisciplinary Team) behavior meeting - doing well from reduction of Zyprexa (Olanzapine) - DC (Discontinue) altogether.Olanzapine (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.5 mg (milligrams) q (every) AM and 10 mg q HS (hour of sleep) - Dementia* with Psychotic Disturbance (8/30/24)/ Dose decreased to 10 mg Q HS only on 1/20/25 (AM dose dc'd). 2/2025 reduced to 7.5 mg Q HS (goal is to eventually wean off). 5/2025 Zyprexa reduced to 5mg g HS. 6/2025 Zyprexa reduced to 2.5mg q HS - dc'd 7/21/25. 9/2025 Zyprexa restarted at re-admission at 5 mg q HS. 9/18/25 reduced back to 2.5 mg q HS. 10/20/25 - dc'ding (discontinuing) Zyprexa. 11/19/25 Olanzapine 5mg q HS for psychotic disorder restarted during hospitalization. Per 10/2025 IDT behavior meeting - resident tolerating GDR (gradual dose reduction) of Zyprexa, DC'ing altogether.R9's facility progress notes dated 10/20/25 at 12:41 PM, documents: IDT met for behavioral meeting. Recommendations in place; d/c Zyprexa.R9 was hospitalized on [DATE] and re-admitted to the facility on [DATE].R9's Hospital Discharge summary dated [DATE] included a medication list with an order for Olanzapine (Zyprexa) Tablet 5 mg give 1 tablet by mouth at bedtime.R9's Physician's orders documented an order for Olanzapine Tablet 5 mg give 1 tablet at bedtime for psychotic disorder dated 11/19/25.Surveyor reviewed R9's Point of Care documentation for the past 30 days which documented a check mark under No behaviors observed. R9's progress notes included no documentation of behavior concerns since R9's re-admission to facility.On 02/24/26 at 10:30 AM Surveyor interviewed Director of Nursing (DON) -B to discuss R9's Zyprexa being discontinued in October, R9 was hospitalized in November and she readmitted to the facility on Zyprexa again (per hospital DC summary). Surveyor shared there is no indication of why the medication was restarted and no follow up from the facility and there are no behaviors documented. DON-B stated she is not sure why the hospital put R9 back on the medication - stating I didn't think she needed it anymore, she was doing fine without it. On 2/25/26 at 3:27 PM, Surveyor informed Nursing Home Administrator (NHA)-A of concern the facility completed a successful GDR of R9's Zyprexa and the medication was discontinued on 10/20/25. R9 was hospitalized on [DATE] and re-admitted to the facility on [DATE] with an order for Zyprexa. There is no evidence the facility followed up as to why the medication was restarted in the hospital and there is no evidence of behaviors or clinical indication for use of the medication. No additional information was provided.

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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. **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 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 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure Minimum Data Set (MDS) assessments were coded correctly for 2 (R3 and R5) of 16 residents reviewed for MDS accuracy. *R3's MDS for December 2025 was not coded accurately for receiving dialysis. *R5's quarterly MDS for December 2025 was not coded accurately for receiving an antiplatelet medication. Findings include: 1.) R5 was identified as being prescribed an anticoagulant (inhibits clotting factors reducing blood clot formation) medication on the MDS indicators. Surveyor reviewed R5's medications and noted R5 was not taking an anticoagulant medication. R5 was prescribed Plavix 75mg (milligrams) on 2/8/2018 to take daily. Surveyor noted Plavix is an antiplatelet (prevents blood cells sticking/clumping together) medication, not an anticoagulant. Surveyor reviewed R5's quarterly MDS dated [DATE]. Surveyor noted R5's MDS section N (Medications) documented 'YES for R5 taking an anticoagulant and documented NO for not taking and antiplatelet medication. On 2/26/2026, at 12:44 PM, Surveyor interviewed MDS coordinator (MDS)-J who stated MDS-J just started helping out the facility in January 2026 and does not come to the facility to do assessments. MDS-J stated MDS-J gets information needed by looking through resident's progress notes and assessments in the resident's medical record. Surveyor asked MDS-J if MDS-J was familiar with R5. MDS-J was not familiar with R5. Surveyor asked if R5 was prescribed and taking Plavix, what would be documented in section N of the MDS assessment. MDS-J stated if R5 was prescribed Plavix, antiplatelet would be triggered Yes in section N of the MDS. Surveyor confirmed with MDS-J anticoagulant would NOT be triggered Yes. MDS-J confirmed R5's MDS should have indicated R5 was taking and antiplatelet medication and not an anticoagulant medication. On 2/26/2026, at 1:21 PM, Surveyor shared concerns with nursing home administrator (NHA)-A and regional nurse-D R5's quarterly MDS dated [DATE] was not coded accurately to indicate R5 was taking an antiplatelet. Instead, the MDS was coded indicating R5 was taking an anticoagulant which is inaccurate. No further information was provided at the time of this write up. 2.) R3 was admitted to the facility on [DATE] with diagnosis that include End stage renal disease with dependence on renal dialysis (final stage of kidney disease, where the kidneys can no longer function adequately to sustain life without treatment). R3's Annual Minimum Data Set (MDS) assessment dated [DATE] documents R3 is cognitively intact. On 2/23/26 at 12:50 PM, Surveyor interviewed R3. R3 informed Surveyor R3 goes to an outside dialysis center every Monday, Wednesday and Friday for dialysis treatment. R3's active MD order dated 9/8/25 documents, in part: [Hemodialysis] morning of Monday, (continued on next page)

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	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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wednesday, Friday. Surveyor reviewed R3's Annual MDS assessment dated [DATE]. The assessment does not document that R3 receives dialysis. On 2/26/2026, at 12:44 PM, Surveyor interviewed MDS coordinator (MDS)-J who stated MDS-J just started helping out the facility in January 2026 and does not come to the facility to do assessments. MDS-J stated gets information needed by looking through resident's progress notes and assessments in the resident's medical record. Surveyor asked MDS-J if MDS-J was familiar with R3. MDS-J stated MDS-J does not have MDS-J's computer in front of MDS-J. Surveyor asked if a resident is on dialysis if that should be coded on the MDS assessment. MDS-J indicated it should be on the MDS assessment. Surveyor informed MDS-J that R3's 12/29/25 annual MDS does not document R3 receives dialysis. MDS-J stated this assessment was done by the previous MDS nurse. On 2/26/2026, at 1:32 PM, Surveyor shared concerns with nursing home administrator (NHA)-A and regional nurse-D that R3's annual MDS dated [DATE] was not coded accurately to indicate R3 was receiving dialysis.

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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- 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 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility did not ensure that 1 of 17 residents (R3) reviewed received treatment and care in accordance with professional standards of practice.*On 1/17/26, facility staff found a right buttock abrasion that was not comprehensively assessed when found. On 1/22/26, facility staff documented a new skin issue on R3's upper right gluteus. A treatment order was not placed for this new skin issue until 2/25/26. On 2/2/26, Wound MD-Q assessed R3's wounds for the first time. Wound MD-Q could not assess R3's wounds weekly because R3 is out at an off-site dialysis center when wound rounds take place. Facility staff did not complete comprehensive weekly assessments when wound appointments were missed.Findings include:R3 was admitted to the facility on [DATE] with diagnoses that include Type 2 Diabetes (chronic condition characterized by insulin resistance and high blood sugar levels,) Paraplegia (a form of paralysis, the inability to voluntarily move or control the lower parts of the body,) morbid obesity (severe obesity,) congestive heart failure (chronic condition where the heart is unable to pump blood effectively,) muscle weakness, and end stage renal disease with dependence on renal dialysis (final stage of kidney disease, where the kidneys can no longer function adequately to sustain life without treatment.)R3's Annual Minimum Data Set (MDS) assessment dated [DATE] documents R3 is cognitively intact. R3 is dependent on staff for all other cares, mobility, and transfers. R3 is always incontinent of bowel and bladder.R3's comprehensive care plan documents the following pertinent skin interventions: Pressure relieving mattress and cushion in wheelchair. Encourage [R3] to wear Prevalon boots. [R3] often declines Prevalon boots and prefers pillow under bilateral legs and feet. Remind [R3] to float heels (initiated on 4/13/22). Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness (initiated on 4/9/23). Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning (initiated 4/26/23). Follow facility policies/protocols for the prevention/treatment of skin breakdown (initiated 4/26/23). If the resident refuses treatment, confer with the resident, [Interdisciplinary team (IDT)] and family to determine why and try alternative methods to gain compliance. Document alternative methods (initiated 4/26/23).R3 receives Hemodialysis outside of the facility every Monday, Wednesday, and Friday.R3's potential for pressure ulcer development care plan documents the following intervention initiated on 1/5/26: Resident agreeable to not wear bra until rash area resolves.Surveyor reviewed R3's progress notes, skin assessments, and EMR and did not locate any other documentation regarding R3's rash.R3's skin check assessment dated [DATE] documents: No skin issues.R3's progress note dated 1/17/26 at 9:43 PM documents in part: Writer received order to apply skin prep to right upper buttock abrasion [every day]. Staff educated on making sure resident has the correct brief size on at all times.R3's Skin issue assessment dated [DATE] documents in part: New skin issue: Buttocks, Right; Issue type: Abrasion; Wound acquired in-house.Surveyor noted R3's initial wound assessments for R3's right buttock was not comprehensive and complete. The assessments did not include measurements or the percentage of tissue in wound per facility policy.R3's progress note dated 1/22/26 documents: Writer in to assess a skin tear as reported by [Certified Nursing Assistant (CNA)]. Wound Nurse here and is caring for the wound.R3's skin issue assessment dated [DATE] documents in part: New skin issue: Right gluteus; Issue type: skin tear; Wound acquired in-house; 1 cm x 1.5 cm x 0.1cm (centimeters); Cleansing solution: soap and water. Primary dressing: foam.Surveyor reviewed R3's MD orders, Medication Administration Record (MAR,) and Treatment Administration Record (TAR,) and noted facility staff did not enter a treatment order for R3's new skin issue of the right gluteus.R3's Skin issues assessment dated [DATE] documents in part: Right gluteus; Issue type: skin tear; Overall wound characteristics improved; 1.5 x 1 x 0.1; No undermining. Cleansing solution: Normal saline. Foam. Right Buttocks. Skin issue is resolved.Surveyor noted on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/26/26, Surveyor noted R3's right buttock abrasion was resolved, but Surveyor noted R3's right gluteus skin tear was treated with normal saline and a foam dressing. Surveyor reviewed R3's MD orders, MAR, and TAR and noted R3 does not have an active MD order for R3's right gluteus skin tear. In addition, R3'sSurveyor reviewed R3's MD orders, MAR, and TAR, and noted that facility staff have not entered treatment MD orders for R3's right gluteal skin tear. Surveyor noted that facility staff continue to document completed treatments of skin prep daily on R3's right upper buttock wound that was resolved on 1/26/26. Surveyor noted daily treatments for R3's right gluteal skin tear is not documented as completed daily.R3's Wound MD-Q Wound evaluation note dated 2/16/26, documents in part: Non-pressure wound of the right buttock full thickness; Etiology: trauma/injury. 1 x 3 x 0.1. 100% granulation. Treatment plan: Xeroform gauze apply once daily and as needed. Gauze Island [with border]. Surveyor reviewed R3's MD orders, MAR, and TAR and Surveyor noted that facility staff did not enter treatment MD orders for R3's right gluteal wound. Surveyor noted that facility staff continued to document completed treatments of skin prep daily on R3's right upper buttock wound that was resolved on 1/26/26. Surveyor noted treatments for R3's right gluteal wound are not being documented as completed daily.Surveyor reviewed R3's medical record and noted facility staff did not comprehensively assess R3's wounds when R3's Wound MD was unable to assess R3's right gluteal wound.R3's progress note dated 2/24/26 at 3:51 PM, documents in part: Writer spoke with resident today about not being able to see the wound MD on a consistent basis due to her dialysis appointment every week. MD suggests that resident go out to wound clinic so that [R3] can have a consistent follow up on [R3's] wound treatment. Writer asked resident and [R3] declined to go to an outside wound clinic. Resident states [R3] wants to continue to be seen here at the facility and does not want to go to another wound clinic. Resident states [R3] will try but the difficulty [R3] has on laying on [R3's] right side prevents [R3] but [R3] will call the Dialysis Center. to try to get [R3's] chair time changed on Mondays in order to be seen by the wound MD.R3's Skin check assessment dated [DATE] at 6:04 and 6:11 PM, documents in part: Right gluteus. Issue type: Skin tear. 2 x 2.5 x 0.1. New skin Issue.R3's MD orders with a start date of 2/25/26 include:-Discontinue wound care: Apply skin prep to right upper buttock abrasion.-Right buttocks skin tear: Cleanse with Dakins half strength [followed by] Xeroform and border foam gauze daily and [as needed] when soiled or dislodged.Surveyor noted the skin prep order to R3's right upper buttock abrasion was discontinued on 2/25/26. Facility staff had been documenting completion of this treatment to a resolved wound from 1/18/26 to 2/24/26. This is 34 days after the facility had documented this wound as resolved.Surveyor noted R3's right gluteal skin tear was found by facility staff on 1/22/26 and first assessed by Wound MD-Q on 2/2/26. The first treatment MD order was placed to start on 2/25/26. R3's right gluteal wound was not documented as treated daily per Wound MD-Q's treatment plan recommendations for 23 days.On 2/23/26 at 12:50 PM, Surveyor observed and interviewed R3 while she was seated in her wheelchair. Surveyor asked if R3 has any wounds. R3 stated she has a wound on her butt, and they have been there for about a month. Surveyor asked how often facility staff change the dressings. R3 stated that it is supposed to be every day, but it depends on what staff is working. R3 stated that the wound doctor has come to see her but not as often as the facility wants. R3 stated she went to dialysis later last week so she could see the Wound MD.On 2/25/26 at 11:55 AM, Surveyor interviewed and observed WC RN-G complete wound treatments on R3's wounds. WC RN-G moved R3 to her left side to do the treatment on R3's buttock. WC RN-G stated that this wound occurred after a CNA was pulling off R3's brief and the rough part of the brief tore R3's skin on her buttock. WC RN-G was at the facility and was able to assess the wound and send the information to Wound MD-Q to get treatment orders. WC RN-G then used half strength Dakins to cleanse the wound. Surveyor noted a half-dollar sized area on R3's right upper buttock. The wound bed is pink with no slough or eschar noted. WC RN-G then placed Xeroform and bordered gauze to cover the wound.On 2/26/2026 at 8:28 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-Y. LPN-Y stated that if a wound is found, the nurse needs to do an assessment, call the doctor, and get a treatment order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN-Y stated that they would also let WC RN-G know of any new wound. LPN-Y stated whoever gets the treatment order should enter it as an MD order in the resident's medical record.On 2/26/26 at 10:33 AM, Surveyor interviewed Wound Care Registered Nurse (WC RN)-G about R3's right gluteus wound. WC RN-G stated that WC RN-G was called to R3's room after CNAs had changed her brief and noted an area of missing skin. WC RN-G stated that the skin tear happened when a CNA was removing R3's brief. Surveyor asked if this is the same wound that was discovered on 1/17/26 and labeled as a right buttock abrasion. WC RN-G stated that this was a new wound. Surveyor asked why a treatment order was not placed for the right gluteus wound. WC RN-G stated WC RN-G forgot to put the order in.On 2/26/26 at 11:23 AM, Surveyor interviewed Wound MD-Q. Wound MD-Q stated that seeing and assessing R3's wounds was challenging because of R3's dialysis appointments. R3 is typically out to dialysis on Monday mornings when Wound MD-Q comes weekly for wound rounds at the facility. Wound MD-Q stated that Wound MD-Q is chasing R3 for weekly wound rounds.On 2/26/26 at 1:32 PM, Surveyor informed Nursing Home Administrator (NHA)-A of the concerns that facility staff did not always complete a comprehensive wound assessment when new wounds were found on R3 and Wound MD-Q's treatment orders are not always followed. On 1/22/26, facility staff documented a new skin issue on R3's upper right gluteus. A treatment order was not placed for this new skin issue until 2/25/26.No additional information was provided.

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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 record review and staff interview, the facility did not ensure that 1 (R7) of 2 residents reviewed for bladder incontinence received the appropriate care and services to help restore continence, prevent urinary tract infections, and receives appropriate treatment and services to restore continence to the extent possible.R7's urinary incontinence was not assessed and care plan interventions for care and treatment of R7's incontinence needs were not accurately documented. This is evidenced by:The facility's catheter care, urinary policy and procedure with a review date of 11/2025 documents:Catheter Evaluation1. Review and document the clinical indications for catheter use prior to inserting. 2. Nursing and the interdisciplinary team should assess and document the ongoing need for a catheter that is in place. Use a standardized tool for documenting clinical indications for catheter use.3. Remove the catheter as soon as it is no longer needed.ComplicationsObserve the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately:If the resident indicates that his or her bladder is full or that he or she needs to void;If urine has an unusual appearance (i.e. color, blood, etc);In the event of bleeding, or if the catheter is accidently removed;If the resident complains of burning, tenderness, or pain in the urethral area; orIf signs and symptoms of urinary tract infection or urinary retention occur.R7 was originally admitted to the facility on [DATE] with diagnosis that included muscular dystrophy, and dependence on ventilator.A review of the most recent quarterly MDS (Minimum Data Set), dated 1/21/26 documents R7 has a catheter in place and urinary continence has not been rated (no data).On 1/21/26, the facility conducted a Quarterly Bowel and Bladder Evaluation which documented R7 is always incontinent of urine and has functional incontinence due to her/his diagnosis of MS (muscular dystrophy).Surveyor conducted a review of previous MDS assessments and noted the last full/annual MDS was completed on 4/20/25 and documented R7 did not have an indwelling catheter and was always incontinent of urine. R7's individual plan of care documents R7 is incontinence r/t (related to) Impaired Mobility, Date Initiated: 04/15/2024. This plan of care was revised on 05/16/2024 to state R7 will be free from skin breakdown due to incontinence and brief usage. Interventions included:*Monitor/document for s/sx (signs/symptoms) UTI (urinary tract infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp (temperature), urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Date Initiated: 04/15/2024. *Monitor/document/report PRN (as needed) any possible causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects. Date Initiated: 04/15/2024.Surveyor noted R7's plan of care did not indicate R7 had an indwelling catheter or recently had the discontinued use of a foley catheter.The CNA (Certified Nursing Assistant) care card documented R7 has urinary incontinence - PRN (as needed, as situation arises). R7 needs the assistance of 1 staff for toileting and wears a medium brief. Provide bedpan/bedside commode.Nursing Note dated 1/26/2026 at 6:08 PM, documents follow up with dc (discontinuation) of foley. R7 voided, wet briefs noted throughout shift. Incontinence care provided prn. No c/o (complaint of) pain or discomfort. Continue plan of care.Nursing note dated 1/27/2026 at 06:00 AM, documents R7 continue being monitored r/t (related to) foley removal. Resident voiding w/o (without) difficulties. Incontinent X's (times) 3. No s/s of Abd (abdominal) distention or discomfort with palpation. Will continue to monitor.Nursing note dated 1/29/2026 at 5:58 AM, documents R7 continues being monitored for Foley removal. R7 continue to void w/o difficulties. Incontinent X's 3. No s/s of Abd pain or discomfort. Will continue to monitor.Surveyor continued to review R7's medical record and did not find evidence there was a physician's order for the use of an indwelling catheter or that the physician have given orders to discontinue the use of the foley catheter for R7. The facility did not (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conduct any further assessment of R7's voiding patterns after the foley was documented as removed.R7's medical record contained a progress note from the Nurse Practitioner who works on behalf of R7's primary physician. The progress note dated 2/14/26 documents Foley catheter is in place. R7 remains hemodynamically stable and continues to require full assistance with all activities of daily living.MD Progress note dated 2/23/26; R7 is seen today resting in bed and appears comfortable. R7 denies pain. Vitals have been reviewed in the EMR (electronic medical record) and respiratory status remains stable. Foley catheter is in place. R7 remains hemodynamically stable and continues to require full assistance with all activities of daily living.Assessment and Plan: * Z99.11 - Dependence on respirator [ventilator] status *: Remains ventilator-dependent on assist-control setting with rate of 12, tidal volume 350, PEEP 5. PEG and Foley catheter in place. Continue respiratory therapy oversight with routine monitoring and pulmonary hygiene. On 2/25/26 at 1:50 PM, Surveyor interviewed Agency RN (Registered Nurse)-S who was working on R7's unit. Agency RN- S stated she is familiar with R7 and R7 does have a catheter in place. Surveyor and Agency RN-S then proceeded to go to R7's room and she lifted the bedding and stated no, I guess R7 doesn't have a catheter, R7 use to. Surveyor also did not observe any catheter bag. Agency RN- S then stated maybe something has changed and it was discontinued but I don't know when.On 2/25/26 at 3:00 PM, Surveyor interviewed Nursing Home Administrator- A regarding R7 and if the facility could confirm if R7 has a catheter, previously had a catheter and when it was removed, if there were orders to remove the catheter and if there was any type of comprehensive assessment of R7's urinary continence since the removal. Nursing Home Administrator- A stated that they would need to follow-up.On 2/26/26 at 12:55 PM, Surveyor interviewed Regional Nurse-D who stated she conducted a review of R7's medical record and when R7 was readmitted to the facility on [DATE], the hospital discharge paperwork did not make any mention of a catheter. On 1/6/26, facility admission paperwork indicated R7 has a catheter in place upon admission. Regional Nurse- D stated she was no able to find any evidence for a physician order for the use of a catheter or for the catheter to be discontinued. Regional Nurse- D stated she questions if R7 ever had a catheter although she confirmed she also read documentation of the catheter being in place.As of the time of exit on 2/26/26, the facility was unable to provide evidence that they had comprehensively assessed, and accurately care planned for R7's urinary continence status.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 2Number of residents cited: 2Kristine Based on Concerns with weight loss and no interventions, inconsistent weightsBased on observation, interview, and record review the Facility did not ensure 2 (R33 and R9) of 2 residents received the necessary services for weight loss and acceptable nutrition. * R33 had a 5.14% weight loss in one month that was not desired. A comprehensive assessment was not completed regarding the weight loss. The physician and dietitian were not notified regarding R33's weight loss. R33's care plan was not updated, and interventions were not implemented. * R9's weights were inconsistent with documented weights indicating significant weight loss and/or gain. There is no evidence that the facility or Dietitian questioned the accuracy of the weights entered. No re-weights were completed, the physician was not notified, and no interventions were implemented. Findings include: The Facility policy entitled, Weight Assessment, dated 8/1/25, documents, Policy Statement: Resident weights are monitored for undesirable or unintended weight loss or gain. Policy Interpretation and Implementation: Weight Assessment: 1. Residents are weighed upon admission and at intervals established by the interdisciplinary team. 2. Weights are recorded in each unit's weight record chart and in the individual's medical record. 3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. A. If the weight is verified, nursing will immediately notify the dietitian in writing. 4. Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time. 5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight – actual weight)/(usual weight) x 100]: a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months - 7% weight loss is significant, greater than 7.5% is severe. c. 6 months – 10% weight loss is significant; greater than 10% is severe. 6. If the weight loss change is desirable, this is documented. Evaluation: 1. Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. The evaluation includes: d. the resident's target weight range (including rationale if different from ideal body weight); e. the resident's calorie, protein, and other nutrient needs compared with the resident's current intake; f. the relationship between current medical condition or clinical situation and recent fluctuations in weight; and g. whether and to what (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extent weight stabilization or improvement can be anticipated. 2. The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss. For example: h. cognitive or functional decline; i. chewing or swallowing abnormalities; j. pain; k. medication-related adverse consequences; l. environmental factors (such as noise or distractions related to dining); m. increased need for calories and/or protein; n. poor digestion or absorption; o. fluid and nutrient loss; and/or p. inadequate availability of food or fluids. Care Planning: 3. Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, dietitian, the consultant pharmacist, and the resident or resident's legal surrogate. 4. Individualized care plans shall address to the extent possible: q. The identified causes of weight loss; r. goals and benchmarks for improvement; and s. time frames and parameters for monitoring and reassessment. Interventions: 5. Interventions for undesirable weight loss are based on careful consideration of the following: a. Resident choice and preferences; b. Nutrition and hydration needs of the resident; c. Functional factors that may inhibit independent eating; d. Environmental factors that may inhibit appetite or desire to participate in meals; chewing and swallowing abnormalities and the need for diet modifications; f. Medications that may interfere with appetite, chewing, swallowing, or digestion; g. The use of supplementation and/or feeding tubes; and h. End of life decisions and advance directives. 6. Interventions for undesired weight gain consider resident preferences and rights. A weight loss regimen will not be initiated for a cognitively capable resident without his/her approval and involvement. 7. If a resident declines to participate in a weight loss goal, the dietitian will document the resident's wishes, and those wishes will be respected. 1.) R33 was admitted to the facility on [DATE] with pertinent diagnoses that include rhabdomyolysis (muscle breakdown where toxins are released into the bloodstream), asthma, multiple sclerosis, hypertension (HTN), gastroesophageal reflux disease (GERD), anxiety and other cognition impairments. R33's admission Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 15, indicating that R33 is cognitively intact. R33's Care Plan, date initiated 1/15/26, documents, Focus Area: Resident is at risk for nutritional deficit r/t (related to) dx (diagnosis) MS (Multiple Sclerosis); HTN (Hypertension); GERD; FX (fracture). Date Initiated: 01/22/2026. Goal: Nutritional Status General. Date Initiated: 01/22/2026. Interventions: Resident Will Consume 75% of ordered Diet Each Day. Date Initiated: 01/22/2026 Revision on: 02/18/2026 Target Date: 05/24/2026, Monitor medications and interactions PRN (as needed). Date Initiated: 01/22/2026. Diet, Obtain and honor preferences as able. Date Initiated: 01/22/2026 Diet, Obtain and monitor weights per policy. Date Initiated: 01/22/2026. Diet, Prepare and serve diet per MD (Medical Doctor) order. Date Initiated: 01/22/2026. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R33's Physician Order dated 1/15/26, documents, Regular diet, Regular texture, Regular/Thin consistency. R33's Malnutrition Risk Assessment, dated 1/19/26, documents, Unable to assess for malnutrition at this time. R33's documented weight, dated 1/15/2026 at 5:19 PM, is 177.1 pounds using a Mechanical Lift charted by Registered Nurse (RN)-LL. R33's documented weight, dated 1/21/2026 at 7:54 AM, is 177.5 pounds using a Wheelchair charted by Director of Nursing (DON)-B. R33's documented weight, dated 1/26/2026 at 12:55 PM, is 172.8 pounds using a wheelchair charted by DON-B. R33's documented weight, dated 2/10/2026 at 11:11 AM, is 173.8 pounds using a wheelchair charted by Licensed Practical Nurse (LPN)-E. On 2/19/2026 at 2:00 PM, DON-B documents R33's weight as 168.0 pounds using a wheelchair. R6's chart flagged: MDS: -5.0% change over 30-day(s) Comparison Weight 1/21/2026, 178 pounds, -5.6%, -10 pounds. -3.0% change from last weight. Comparison Weight 2/10/2026, 173.8 pounds, -3.3%, -5.8 %. Surveyor noted, on 01/15/2026, R33 weighed 177.1 pounds upon admission. On 02/19/2026, R33 weighed 168.0 pounds which is a -5.14% weight loss, indicating significant weight loss in one month. On 02/23/2026 at 10:55 AM, Surveyor interviewed R33 who stated R33 has lost about 10 pounds in a few weeks. R33 stated the staff have told R33 they know R33 has lost weight but R33 feels staff have done nothing to address it. On 2/24/2026 at 1:00 PM, Surveyor interviewed LPN-E, who stated weekly and monthly weights are taken by a nurse or certified nursing assistant (CNA). The Director of Nursing (DON) is provided weight sheets and DON records the weights in the computer and communicates with the dietitian. Weights are taken on Mondays. LPN-E stated CNA's record amount of food consumed. R33's Progress Note documents a Mini Nutrition (MNA) Summary completed on 1/21/2026 at 7:01PM with R33's weight as 177.5 pounds using a wheelchair. Resident had no decrease in food intake in the last 3 months. Does not know if any weight lost in the last 3 months. Bed or chair bound. Has suffered psychological stress or acute disease in the past 3 months. Resident has no psychological problems. Resident BMI is 23 or greater.Mini Nutrition Score: The score is: 8.0. 12 - 14 points: Normal nutritional status 8 - 11 points: At risk of malnutrition 0 - 7 points: Malnourished. R33's Nutritional Assessment Progress Note documents on 1/21/2026 at 6:44 PM Note Text: admission Review PMH: MS; HTN; GERD; FX HEIGHT:67 WEIGHTS: #177.5 (1/21)WEIGHT CHANGES AND CONTRIBUTING FACTORS: None known BMI:27.7 DIET: Reg/Reg/Thin FOOD ALLERGIES OR CULTURAL CONSIDERATIONS: N/ASUPPLEMENTS: N/A EATING ABILITY: Set up P.O. INTAKES:50-100% FLUID INTAKE: 1500-2000 ml/daily PERTINENT MEDICATIONS: MVI; folic acid; baclofen; iron SKIN INTEGRITY: No known areas of pressure ESTIMATED NUTRIENT NEEDS: Calories: 2022cal (25 cal/kg) Protein: 81g (1g/kg) fluids: 2022ml (25 ml/kg) REVIEW: Resident admits to facility, PMHx: MS; HTN; GERD; FX. Diet: Reg/Reg/thin, tolerating w/out noted concerns. Appetite (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fair. Resident allergy to dairy products. Weight #177.5 (1/21). No new labs for review. No known areas of pressure. Will continue to follow with RD consult available PRN. PES STATEMENT:PLAN: continue current plan of care. R33's Progress Notes on 2/17/2026 at 9:30 AM, documented by Nurse Practitioner- (NP)-MM, states, Weight on 2/10/2026 was 173.8 pounds, which is stable. Patient is seen today sitting up in wheelchair. She denies shortness of breath or nausea and reports adequate pain relief with current regimen. No present concerns per patient or nursing. On 02/26/2026 at 9:34 AM Surveyor interviewed Regional Nurse-D who stated NP-MM documented in a progress note on 2/17/26 R33's weight was stable. Surveyor stated R33's weight loss was declining on 2/17/26 when NP-MM assessed R33's weight as stable. Regional Nurse-D agreed and stated Regional Nurse-D did not know why NP-MM documented that statement. Surveyor could not find documentation to support the physician or dietitian were notified regarding R33's weight loss documented on 2/19/26. On 2/23/26 Surveyor observed R33's lunch meal ticket and observed it documents R33 is to receive a regular diet, regular texture, THIN. No allergies, dislikes or preferences listed. Surveyor noted, R33's meal ticket does not document any allergies but progress notes document R33 is allergic to dairy products. On 02/24/2026 at 12:36 PM, Surveyor interviewed R33 who stated R33 does not like the facility food and does not eat much of it. R33 stated R33 does complain to the staff but no one does anything about it. Surveyor asked if R33 has provided any likes or dislikes to dietary and R33 stated, no one has ever asked R33 what R33 likes or dislikes. Surveyor asked R33 if the dietitian or anyone else had spoken to R33 about R33's weight loss and R33 stated no and R33 has concerns regarding R33's continual weight loss. Surveyor asked R33 if R33 has ever been offered any nutritional supplements and R33 stated, no. On 02/26/2026 at 9:34 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Regional Nurse-D. Surveyor asked NHA-A and Regional Nurse-D, what is the process when a resident has a significant weight loss. Regional Nurse-D stated, one of the nurse managers contacts the dietitian and the dietitian follows up. Dietitian also has access to review the weight dashboard for any potential weight loss. Surveyor asked Regional Nurse-D when would the dietitian get involved. Regional Nurse-D stated the dietitian will get involved when there is any area of concern or significant weight loss. Regional Nurse-D stated, a significant weight loss would be considered a 5% weight loss in a month. This is resident specific, as a resident may have a desired weight loss. Regional Nurse-D stated the weight policy documents weekly weights for 4 weeks and then monthly unless otherwise indicated. Surveyor asked Regional Nurse-D if the frequency for taking the residents weights needed to be documented in physician orders and Regional Nurse-D stated, yes. Surveyor asked Regional Nurse-D if Regional Nurse-D could verify R33 does not have physician orders for weights as Surveyor could not locate an order. Regional Nurse-D stated R33 does not have any weight orders. NHA-A stated there is a weekly meeting for residents who are at risk for nutrition. DON-B and Registered Dietitian-I attend the NAR (Nutrition at Risk) meeting and stated R33 is being reviewed at this meeting. Surveyor asked NHA-A if NHA-A can provide any documentation and NHA-A stated NHA-A will check and respond to Surveyor. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/2026 at 9:55 AM, Surveyor notified Regional Nurse-D and NHA-A of concerns regarding R33's weight loss of 5.14% identified on 2/19/26. Surveyor stated no documentation was found for care plan updates or interventions, physician orders for weights or other dietary changes. There is no documentation the physician or dietitian was notified or an assessment of R33 following significant weight loss. 2.) R9 admitted to the facility on [DATE] and has diagnoses that include Protein-Calorie Malnutrition, unspecified dementia, unspecified severity with psychotic disturbance, cerebral infarction, depression, acute kidney failure and hypertension. R9 was hospitalized and readmitted to the facility on [DATE]. Surveyor review of R9's weights documented: 11/19/25 174 lbs. (pounds) wheelchair 11/21/25 214 lbs. wheelchair. Surveyor noted the weight entered indicated a gain of 40 pounds. There was no documentation by the facility or Registered Dietitian (RD)-I that anyone questioned the accuracy of the weight, no re-weight was completed, and no interventions were implemented. 12/2/25 220 lbs. wheelchair. Surveyor noted the weight entered indicated an additional weight gain of 6 pounds. There was no documentation by the facility or RD-I regarding this weight and no interventions implemented. 12/8/25 220 lbs. wheelchair 1/4/26 222.4 lbs. wheelchair. 2/5/26 192.6 mechanical lift. Surveyor noted the weight entered indicated a loss of 29.8 lbs. There was no documentation by the facility or RD-I that anyone questioned the accuracy of the weight, no re-weight was completed, and no interventions were implemented. Surveyor located no orders or documentation of how often R9 was to be weighed. R9's first Nutritional Assessment Progress Note dated 12/8/25 documented: Weights: 220 # (pounds) (12/2), 1mo: +24.3% gain. Ht (height): 64 in (inches). Weight changes: Gain x 30 d (days). BMI (Body Mass Index): 34.5 obese. Plan: Continue with current plan of care. RD to monitor and make recommendations PRN (as needed). Surveyor noted there were no other entries by RD-I after the weight entered on 2/5/26 and no physician notification. On 2/26/26 at 2:10 PM, Surveyor spoke with RD-I and asked how she is notified of weight loss or gains. RD-I stated, Usually by the 5th of the month, I see the monthly weights. I will check to see if the weight is off and ask for a re-weight that should be done by the 10th. Then I can decide if the weight is true or if it was an error. RD-I told Surveyor that she wasn't the Dietitian in November, as she started working for the facility in December 2025. RD-I stated, I always thought the weights entered were an error, but they kept entering them as she was being weighed in the wheelchair. The Director of Nursing or Assistant Director of Nursing can communicate with me anytime with concerns (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of weight loss or poor intake. Surveyor asked about the weight entered on 2/5/26 which indicated a weight loss of 29.8 pounds and no documentation after. Surveyor asked RD-I if she was aware of that weight entry. RD-I stated, I was. I figured it was probably an error, so I wanted a re-weight. It's been challenging to get weekly weights completed. I got a call today from a nurse or an aide saying that her weight is 175 which made me happy. On 2/25/26 at 3:27 PM, Surveyor advised Nursing Home Administrator (NHA)-A of concern regarding inconsistencies of R9's documented weights indicating significant weight loss and/or gain. There is no evidence that the facility or Dietitian questioned the accuracy of the weights entered. No re-weights were completed, the physician was not notified, and no interventions were implemented. On 2/26/26 at 10:30 AM, NHA-A met with Surveyor to discuss the concern regarding R9's weights. NHA-A stated, We have looked into it and believe there may be discrepancies, but regardless someone should have recognized the weight changes and intervened. No additional information was provided.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 2 (R5 and R6) of 2 residents reviewed for post-traumatic stress disorder (PTSD) received trauma informed care in accordance with professional stands of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization. R5 and R6 were admitted to the facility with a diagnosis of PTSD. The facility did not complete a trauma assessment or develop a person-centered care plan identifying triggers, interventions, or monitoring for PTSD for R5 or R6. Findings include: The facility policy titled Trauma-Informed and Culturally Competent Care with revised date August 2022 documents: . Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers . Resident Care Planning . Develop individualized care plans that address past trauma in collaboration with the resident and family . Identify and decrease exposure to triggers that may re-traumatize the resident. 1). 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), adjustment disorder with mixed anxiety and depressed mood (a temporary mental health condition leading to struggles coping), and unspecified disorder of adult personality and behavior (a mental health condition that causes significant personal distress or social problems). 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, and R6 did not demonstrate any behavior concerns within the lookback period. R6's psychosocial well-being care plan documented R6 has a psychosocial well-being problem related to ineffective coping evidenced by diagnosis of PTSD. The care plan documented the following interventions with initiated date 8/5/22 and revised date 2/15/23:-Allow the resident time to answer questions and to verbalize feelings, perceptions, and fears.-Consult with pastoral care, social services, psych services, or any other sources per resident's preference.-Monitor/document resident's feelings relative to isolation, unhappiness, anger, loss. Surveyor notes the care plan did not include individualized interventions to identify ways to decrease the resident's exposure to triggers or identify ways to mitigate or decrease the effect of triggers on the resident. R6's screening assessment to determine the presentation of abuse and/or neglect factors dated 1/12/26 documented the following: 1. History of abuse and/or neglect (including physical, sexual, verbal, emotional, financial) and/or unexplained injuries prior to admission; Surveyor notes this question was answered no. 2. Factors that increase the resident's vulnerability (e.g. dementia, confusion, disorientation, poor insight/judgment, poor communication skills, poor ambulation or inability to ambulate/propel wheelchair, frailty/weakness, history of being exploited); Surveyor notes this question was answered yes. 3. History of substance abuse (alcoholism, drug abuse, including (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescription drug abuse/narcotic seeking) and/or compulsive behavior (uncontrolled or poorly controlled gambling, overeating, exercise, obsessions); Surveyor notes this question was answered no. 4. Psychiatric history and/or present mental health diagnosis, including psychotic symptoms (e.g. delusional thinking, hallucinations) and possible misinterpretation of events and the intentions of others; Surveyor notes this question was answered no. 5. Denial and/or evasiveness when discussing mental health issues; minimizing significance of mental health/psycho-social issues; Surveyor notes this question was answered no. 6. Diagnosis of depression and/or history of depressive illness and/or present signs/symptoms of depression/mood distress. Low self-esteem, isolation and withdrawn behavior. Complaints of chronic pain, illness, fatigue and/or persistent anger, fear, and/or anxiety; Surveyor notes this question was answered yes. 7. History or presence of dysfunctional behavior (e.g. provoking, aggressive, manipulative, derogatory, disrespectful, obnoxious, abhorrent, insensitive, attention-seeking, and/or otherwise abrasive/inappropriate behavior) including roaming/wandering into peer's rooms/personal space; Surveyor notes this question was answered no. 8. The resident admits to a history of mistreating others (i.e. verbal/physical/sexual abuse) and/or information presented by a reliable source indicates a history of mistreating others; Surveyor notes this question was answered no. Surveyor notes the assessment did not identify triggers which may re-traumatize R6. Surveyor could not locate any other trauma assessment identifying R6's PTSD triggers in R6's electronic health record (EHR). On 2/25/26 at 9:38 AM, Surveyor interviewed director of social services (DSS)-L who stated DSS-L has been working at the facility for about 9 – 10 months. DSS-L stated if a resident has a diagnosis of PTSD, a [name of contracted psychiatric services] form is brought to a care conference to determine if the resident would like to receive behavioral health services, and the care plan is revised. DSS-L stated an initial trauma screening is completed for all residents on admission which contains questions about PTSD and this screening tool is supposed to be triggered quarterly with the quarterly MDS if it needs to be completed for a resident. DSS-L stated DSS-L also completes the assessments titled screening assessment to determine the presentation of abuse and/or neglect factors and social history and assessment which touch on PTSD. DSS-L stated R6 did not want behavioral health services and has not had any recent behaviors. DSS-L was not aware of what R6's specific PTSD triggers were. DSS-L stated a trauma screening has not been triggered for R6 in the EHR system. DSS-L stated it has been hard to keep up with assessments because DSS-L is the only social worker and when DSS-L is not in the facility, no one helps with the workload. DSS-L stated in addition to evaluations, DSS-L is in charge of completing all the admissions of new residents and discharges of residents, and it is hard to keep track of resident trauma assessments. On 2/25/26 at 2:59 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A on how PTSD triggers are determined for a resident with a diagnosis of PTSD. NHA-A stated a PTSD assessment would be completed to understand the resident's triggers and then the care plan would be updated with those triggers accordingly. NHA-A stated DSS-L completes these assessments quarterly. Surveyor shared concern that R6's PTSD triggers were not identified by the facility, and R6's care plan was not individualized with R6's PTSD triggers. No additional information was provided. 2.) R5 was admitted to the facility in 6/28/2017 and has diagnoses that include major depressive disorder, post-traumatic stress disorder (PTSD), personality disorder, . and aphasia following cerebral infarction (lack of oxygen to the brain caused by blockage/ stroke). R5 is able to make needs known by staff asking Yes and No questions, R5 answers questions by shaking R5's head Yes and No. R5 is oriented to person, place, and time. R5 has an activated power of attorney to assist with decision (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	making. R5 has a mood problem care plan related to diagnosis of insomnia, initiated on 8/3/2022. R5 has a depression care plan related to disease process for cerebrovascular accident, initiated on 6/6/2022. Surveyor noted R5 does not have a care plan related to R5's PTSD or what R5's triggers are, what kind of monitoring or interventions are in place for R5's PTSD. Surveyor reviewed R5's medical chart and noted R5 did not have any trauma assessments completed to indicate what R5 experienced related to R5's PTSD. On 2/24/2026, at 8:23 AM, Surveyor observed R5 sitting in R5's wheelchair watching TV. R5 was smiling and answering surveyor's questions appropriately. Surveyor asked R5 if staff sat down with R5 to talk about past events or traumas. R5 shook R5's head indicating No. On 2/25/2026, at 9:38 AM, A Surveyor interviewed director of social services (DSS)-L who stated has been working at the facility for about 9 – 10 months. DSS-L stated if a resident has a diagnosis of PTSD, in the care conferences a [name of psychiatric consulting company] form is completed, and care plan is revised. DSS-L stated it has been hard to keep up with completed evaluation forms because DSS-L is the only social worker and when DSS-L is not in the facility, no one helps with the workload. DSS-L stated in addition to evaluations, DSS-L is in charge of completing all the admission of new residents and discharged of residents and is hard to keep track of everyone's trauma assessments. DSS-L will go over the completed evaluations in the morning stand up meetings. DSS-L stated if the evaluation triggers in the medical system, then evaluations are completed, otherwise DSS-L does not know if one has to be completed or not. DSS-L was not aware of R5 requiring trauma assessments or having PTSD diagnoses. DSS-L stated R5 is stable and has good family support so never looked into further assessments and is not aware of what triggers, monitoring or interventions R5 would require. On 2/25/2026, at 10:29 AM, Surveyor interviewed registered nurse (RN)-F who was not aware of R5's triggers or if any monitoring or interventions needed to be implemented for monitoring of R5's history of PTSD. Surveyor asked how staff know if someone has a history of PTSD or requires assessments to determine what monitoring and interventions would be. RN-F was not aware of what assessments or what staff were to complete the required assessments for someone with a history or diagnosis of PTSD. On 2/25/2026, at 2:59AM, Surveyor interviewed nursing home administrator (NHA)-A who stated residents with PTSD diagnoses should be evaluated on admission, quarterly, and with any changes to identify possible triggers and what staff should monitor for and implement interventions wise. NHA-A stated social services is responsible for completing trauma assessments and completing evaluations for residents. Surveyor shared concern R5 has not had any trauma assessments completed and has a diagnosis of PTSD. Surveyor shared R5 does not currently have a care plan for PTSD documenting R5's triggers or what monitoring or interventions need to be implemented. No further information was provided.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the facility implemented monitoring or support of 1 (R6) of 2 sampled residents psychosocial well-being and ongoing safety after an allegation of abuse violation of abuse was made.On 2/24/26 R6 alleged Certified Nursing Assistant (CNA) BB was abusive to R6 during cares. R6 alleged the abuse was physical and verbal in its nature. R6 has a history of post traumatic stress disorder.Findings include:The facility policy titled Identifying Types of Abuse with revised date September 2022 documents: . Psychosocial outcomes . abuse may result in psychological, behavioral, or psychosocial outcomes including, but not limited to, the following: . fear of a person or place, of being left alone, of being in the dark, and/or disturbed sleep and nightmares; . extreme changes in behavior, including aggressive or disruptive behavior toward a specific person; . running away, withdrawal, isolating self, feelings of guilt and shame, depression, crying, talk of suicide or attempts. the following situations are recognized as those that are likely to cause psychosocial harm which may take months or years to manifest and have long-term effects on the resident and his/her relationship to others: . any staff to resident physical . or mental/verbal abuse.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 2/25/26 at 8:53 AM, Surveyor interviewed CNA-GG regarding how a resident is monitored after an incident of alleged abuse. CNA-GG stated the resident would be added to the 24-hour board to monitor and CNA-GG would perform 1-2 hour checks on the resident. Surveyor conducted a review of R6's electronic health record (EHR) and did not locate any documentation regarding ongoing monitoring or increased checks performed for R6 after the alleged incident of abuse occurred on 2/9/26. Surveyor was unable to locate any psychosocial assessments in R6's EHR after the alleged incident on 2/9/26. Surveyor reviewed the 24-hour nursing board for the vent unit, the unit R6 resides in, for dates 2/9/26-2/21/26 and did not locate R6's name documenting the alleged incident of abuse or ongoing monitoring of R6's psychosocial well-being. On 2/25/26 at 9:38 AM, Surveyor interviewed Director of Social Services (DSS)-L who stated if there is an allegation of abuse involving a resident with PTSD, DSS-L would expect a psychosocial assessment and trauma assessment to be completed after the incident. Surveyor asked DSS-L if these assessments were completed for R6 after the allegation of abuse on 2/9/26. DSS-L responded DSS-L was not even aware of the alleged incident with R6, so no assessments were completed. 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. Surveyor also shared concern with NHA-A that the facility did not have evidence of ongoing monitoring or assessment of R6's psychosocial well-being after the incident. NHA-A stated monitoring and assessments after an (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegation of abuse would depend on the condition of the resident during NHA-A's initial conversation, and when NHA-A spoke with R6 on 2/10/26 after the incident, R6 told NHA-A R6 was comfortable and felt safe so no further assessments or monitoring was completed. 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, or why measures such as monitoring and assessments were not implemented to ensure R6's well-being and safety after the allegation of abuse.

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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 ensure the physician acted upon recommendations by the pharmacist for 1 (R33) of 5 residents reviewed with pharmacy recommendations.R33 had no documented physician response to pharmacist recommendations after medication regimen review on 1/26/26. Findings include:The facility policy titled Medication Regimen Review with effective date 8/1/25 documents: The consultant pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication.The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example: . duplicative therapies or omissions of ordered medications . Within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physicians for each resident identified as having a non-life threatening medication irregularity. The report contains: . the resident's name; . the name of the medication; . the identified irregularity; and . the pharmacist's recommendation. The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it. Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record. R33 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis (a chronic disease that disrupts communication between the brain and body causing fatigue, vision problems, numbness, and mobility issues), polyneuropathy (nerve damage), neuromuscular dysfunction of bladder (nerve damage disrupts the signals between the brain and bladder), and injury of brachial plexus (damage to the nerves connecting the neck to the shoulder, arm, and hand).R33's admission Minimum Data Set (MDS) documented R33 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Surveyor reviewed R33's electronic health record (EHR) and located a pharmacist medication regimen review dated 1/26/26. R33' MRR documented the pharmacist recommendation to reevaluate duplication of Baclofen 10 milligrams (mg) three times a day (TID) and Tizanidine 4 mg every 8 hours (Q8H) as needed (prn). Surveyor was unable to locate a physician response to the pharmacist MRR in R33's EHR dated 1/26/26. On 2/26/26, Surveyor reviewed R33's active physician orders and located the following orders with a start date of 1/15/26: Baclofen oral tablet 10 mg, give 1 tablet by mouth three times a day for muscle spasms; Tizanidine HCl oral capsule 4 mg, give 1 capsule by mouth every 8 hours as needed for muscle spasms. On 2/26/26 at 9:46 AM, Regional Nurse-D informed Surveyor the facility did not receive an email with pharmacist recommendations for R33, so there is no record of a physician response. On 2/26/26 at 10:25 AM, Surveyor interviewed Pharmacist-X, whom confirmed Pharmacist-X completes monthly medication reviews for the facility. Pharmacist-X stated if a recommendation is made after completing the MRR, the recommendation is documented on the MRR form in the assessments tab of the resident's EHR. Pharmacist-X stated any recommendations are emailed to the Director of Nursing (DON) at the facility the next day. Pharmacist-X confirmed a MRR was completed for R33 on 1/26/26 with the recommendation to review duplication of Baclofen and Tizanidine medications. Pharmacist-X stated Pharmacist-X included this recommendation on an email to the DON dated 1/27/26. On 2/26/26 at 1:32 PM, Surveyor shared concern with Nursing Home Administrator (NHA)-A and Regional Nurse-D that there was no documented response from R33's physician after pharmacist recommendations on 1/26/26. No additional information was provided.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 1 (R72 and R57) of 5 residents were offered/administered the influenza vaccine.R72 was admitted to the facility on [DATE]. There is no documentation indicating R72 was offered or administered the influenza vaccine.Findings include:R72 was admitted to the facility on [DATE]. R72 is an [AGE] year old with diagnoses that include Type 2 Diabetes (chronic disorder where the body develops insulin resistance), Osteomyelitis (infection of the bone), colostomy (a surgical opening connecting part of the intestines to the outside of the body), anemia (decreased blood cells), quadriplegia (permanent partial or total loss of motor and sensory function in the legs and arms), and cognitive deficit (disruptions in mental processes).Surveyor reviewed R72's Electronic Medical Record (EMR) and was unable to locate whether R72 was offered, received, or declined the influenza immunization.On 2/26/26, at 12:19 PM, Surveyor interviewed Director of Nursing (DON)-B who stated she was responsible for the Infection Control Program for the facility and managed the immunizations for residents within the facility. DON-B stated she will offer immunizations including the influenza immunization upon admission. DON-B stated this is included in the admission packet when reviewing with the residents. DON-B stated she will also check the Wisconsin Immunization Registry (WIR) for history of the resident's immunizations and enter the history into the EMR. DON-B stated she has 45 residents that are current with the influenza immunization and will be offering an immunization clinic soon. DON-B stated she has 16 residents who are not current with their influenza immunization.On 2/26/26, at 11:13 AM, Surveyor notified Nursing Home Administrator (NHA)-A of concerns listed above. Surveyor requested additional information if available. None was provided.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not provide a working call light system for 1(R3) of 16 sampled residents.*R3 informed Surveyor that R3's call light above R3's room door does not light up when R3 pushes the call light for help. R3 stated that the light has been like this since last week.Findings include:The facility policy with an effective date of 8/1/25 and titled, Answering Call Lights, documents: The purpose of this procedure is to ensure timely responses to the resident's requests and needs. Upon admission and periodically as needed, explain and demonstrate use of the call light to the resident. Be sure that the call light is plugged in and functioning at all times. Report all defective call lights to the nurse supervisor promptly .R3 was admitted to the facility on [DATE] with diagnosis that include Paraplegia (a form of paralysis. The inability to voluntarily move or control the lower parts of the body), Muscle weakness and End stage renal disease with dependence on renal dialysis (final stage of kidney disease, where the kidneys can no longer function adequately to sustain life without treatment).R3's Annual Minimum Data Set (MDS) assessment dated [DATE] documents R3 is cognitively intact. R3 requires set up and clean up assistance for eating and oral hygiene. R3 is dependent on staff for all other cares, mobility and transfers.On 2/23/2026 at 12:50 PM, Surveyor interviewed R3. R3 was sitting at R3's doorway (room [ROOM NUMBER]) and stated that R3 had recently returned from the dialysis center. R3 informed Surveyor that R3's call light is not working properly. R3 stated that R3 will push the call light, and it will light up in R3's room but will not light up above R3's door in the hallway. R3 stated that at times, R3 will have to call the front desk secretary in order to get help. R3 stated that this problem started last week. R3 stated she has told multiple staff members.On 2/23/26 at 1:15 PM, R3 pushed R3's call light. Surveyor noted that a small red light appeared behind R3's bed indicating that R3's call light was on. Surveyor observed R3's call light above R3's door in the hallway of the facility. Surveyor noted R3's call light is not lit up above R3's door. Surveyor heard a bell alarm at the nurse's station. Surveyor noted that the box behind the nurse's station is lit indicating that R3's call light is on.On 2/23/26 at 1:19 PM, Licensed Practical Nurse (LPN)-Y entered R3's room. LPN-Y stated that the call light was on. Surveyor asked why the light above R3's door does not work. LPN-Y pointed at the box under the clock at the nurse's station. LPN-Y stated that it does not light above R3's door but it does alarm at the nurse's station.On 2/24/26 at 11:18 AM, Surveyor overheard Receptionist-DD pick up a phone call. After hanging up, Receptionist-DD informed a facility staff member that R3 had called Receptionist-DD and asked for help.On 2/24/26 at 11:20 AM, Surveyor arrived at R3's room. Surveyor asked if R3 had R3's call light on. R3 stated that R3 had the call light on for about 10 minutes but no one came so R3 called Receptionist-DD for help. R3 stated that R3 wanted to get cleaned up and dressed so that R3 could go to a Resident Council meeting at 1:30 PM. R3 wanted to get ready before lunch because staff get busy at lunch time and R3 did not want to miss the meeting. R3 then pushed R3's call light again at 11:21 AM. Surveyor noted the small red light appeared behind R3's bed indicating the call light is on. Surveyor looked in the hallway and noted the light above R3's door was not working. Surveyor heard the alarm at the nurse's station but noted no staff were at the nurse's station.On 2/24/26 at 11:30 AM, Surveyor observed the nurse's station and noted no staff members were at the nurse's station, but the alarm continued to ring.On 2/24/26 at 11:35 AM, Surveyor observed Director of Nursing (DON)-B and another staff member walk past R3's room.On 2/24/26 at 11:37 AM, Surveyor observed a facility staff member walk by R3's room.On 2/24/26 at 11:39 AM, Certified Nursing Assistant (CNA)-EE entered R3's room. CNA-EE turned off R3's call light and stated that CNA-EE will get the supplies and another CNA to help get R3 up and get ready for the day.On 2/24/26 at 11:41 AM, Surveyor interviewed CNA-EE. Surveyor asked if R3's call light was working. CNA-EE stated that it does alarm at the nurse's station, but it does not light up above R3's door. Surveyor asked if it was supposed to be lit up above R3's door. CNA-EE stated yes but R3's doesn't work.On 2/24/26 at 11:54 (continued on next page)

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM, Surveyor interviewed Receptionist-DD. Surveyor asked if resident's call Receptionist-DD if they need help. Receptionist-DD stated that sometimes residents do use the telephone and call Receptionist-DD for help. Receptionist-DD will then let the unit nurse or staff member know what the resident needs. Receptionist-DD stated sometimes they call because they cannot reach the call light and sometimes, they call even if the call light is on. Surveyor asked if R3 has to call Receptionist-DD for help. Receptionist-DD stated that R3 has called for help in the past.On 2/24/26 at 12:38 PM, Surveyor interviewed Maintenance Director- N. Surveyor asked how the resident call light system works. Maintenance Director-N stated that the resident will push the call light button in the room. The alarm will sound at the nurse's station, and a light will appear above the resident's door in the hallway. Surveyor asked how staff make Maintenance Director-N aware of any issues with call lights. Maintenance Director-N will receive a TELS message for any work order that needs to be addressed. In addition, staff and/or residents will verbally tell Maintenance Director-N of any issues as well. Surveyor asked if Maintenance Director-N was aware of any call lights that do not work. Maintenance Director-N stated that Maintenance Director-N was not aware of any call lights that do not work. Maintenance Director-N stated that there was a room (room [ROOM NUMBER]) that had a non-functioning call light but that was fixed. Maintenance Director-N stated that Maintenance Director-N did not have any TELS work orders regarding call lights. Surveyor walked with Maintenance Director-N to R3's room. R3 pushed R3's call light at 12:45 PM. Maintenance Director-N confirmed that R3's call light above R3's door did not light up. Maintenance Director-N thanked Surveyor for letting Maintenance Director-N know of R3's call light.On 2/24/26 at 12:46 PM, Surveyor asked why R3 had pushed R3's call light. R3 stated that R3 had not had lunch and wanted to eat and get into R3's wheelchair so R3 could go to the resident council meeting.On 2/24/26 at 12:52 PM, Surveyor observed Licensed Practical Nurse (LPN)-FF sitting at the nurse's station. Surveyor asked if there were any issues with call lights not working. LPN-FF stated that the only call light that is not working is R3's. LPN-FF helped Surveyor test other rooms on R3's hallway without concern.On 2/24/26 at 1:07 PM, R3's call light stopped alarming at the nurse's station. R3's tray was delivered and R3 was eating.On 2/25/26 at 11:53 AM, Surveyor asked R3 if R3 got to go to the resident council meeting. R3 stated that R3 did not get put up and in chair in time for the meeting so did not get to go to the meeting.On 2/24/26 at 2:35 PM, Surveyor informed Nursing Home Administrator (NHA)-A of the concern that R3's call light that is supposed to light up outside of R3's door was not working properly and multiple staff walked by R3's room when call light was alarming.On 2/28/26, Surveyor received additional information from NHA-A. The additional documentation included:A facility wide call light system test was run on 2/18/26. At this time, only three rooms (166, 128, 132) needed lightbulbs changed. All changes were completed on 2/18/26.The light for room [ROOM NUMBER] on the panel at the nurse's station was illuminated and alarming, informing facility staff that room [ROOM NUMBER] needed assistance. This indicates that the system was compliant with immediately alerting staff that the resident required assistance.Important Note: Upon discovery of the burnt-out bulb on 2/24/26, it was immediately corrected.Surveyor acknowledged the facility call light test occurred on 2/18/26.Surveyor noted that at the start of Survey on 2/23/26, R3's call light was not lighting up outside of R3's door. Surveyor had observations and interview that staff were aware that R3's call light was not working on 2/23/26 but the call light malfunction was not addressed by facility staff until 2/24/26 when Surveyor brought it to Maintenance Director-N's attention.No additional information was provided.