STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525504	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Greenfield	5790 S 27th St Milwaukee, WI 53221

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not resolve a grievance as outlined in the facility policy for 1 (R105) of 2 residents reviewed for grievances.On 1/27/26 R105's family member sent an email correspondence to the Nursing Home Administrator (NHA)-A requesting that the content of the email regarding concerns with R105's discharge planning and a pressure injury be processed as a formal complaint.The facility did not have any evidence of R105's complaint being submitted as a grievance nor any resolution to the complaint.Findings include:The facility policy titled Resident and Family Grievances, date implemented 4/30/26, documents, in part, .Policy: It is the policy of this facility to support each resident's and family right to voice grievances, without discrimination, reprisal or fear of discrimination or reprisal.Definitions: Prompt efforts to resolve include facility acknowledgement of complaint/grievance and actively working toward resolution of that complaint/grievance.Policy Explanation and Compliance Guidelines:1. (Name and Title) (sic) has been designated as the Grievance Official and can be reached at (list contact information). (sic)2. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with the state and federal agencies as necessary in light of specific allegations.4. A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their LTC (Long Term Care) facility stay.8. Grievances may be voiced in the following forums:Verbal complaint to a staff member or Grievance Official.Written complaint to a staff member or Grievance Official.Written complaint to an outside party.Verbal complaint during resident or family council meetings.Via the company toll free Customer Service Line (if applicable). 10. Procedure:This facility will not retaliate or discriminate against anyone who files a grievance or participates in the investigation of a grievance.The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form, or assist the resident or family member to complete the form.Forward the grievance form to the Grievance Official as soon as practicable.The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form.The Grievance Official or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances.12. The facility will make prompt efforts to resolve grievances.R105 was admitted to the facility on [DATE] and discharged on 1/30/26 with diagnoses to include cerebral infarction (stroke), dementia with other behavioral disturbances, and hypertension. R105's comprehensive MDS, dated [DATE], documents R105 has a brief mental status (BIMS) score of 12, indicating moderate cognitive impairment.On 06/03/26 at 11:05 AM, Surveyor reviewed facility grievance log and there is no grievance documented on the grievance log for R105 on 1/27/26 or any date in January 26 or to date.On 6/03/26 at 11:09 AM, Surveyor asked Assistant Director of Nursing (ADON)-C if ADON-C ever received a grievance from R105 or R105's family. ADON-C stated ADON-C did not recall who R105 was and did not receive any (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	grievances from R105 or R105's family.On 06/09/26 at 7:44 AM, Surveyor asked Director of Nursing (DON)-B if DON-B ever received a grievance from R105 or R105's family. DON-B stated they did not recall who R105 was and DON-B had not received any grievances from R105 or their family. DON-B stated if DON-B would have received a grievance DON-B would have submitted the concern on a grievance form.On 06/09/26 at 8:50 AM, Surveyor asked Social Worker (SW)-L if SW-L could find any evidence of a grievance filed by R105 or their family. SW-L could not find any evidence of a grievance being filed. Surveyor asked SW-L what the grievance process was. SW-L stated, anyone can come to SW-L to file a grievance and SW-L will follow up or have the appropriate staff member follow up. If the grievance is shared with another staff member, it is their responsibility to complete the grievance form and either the staff member follows up or submits to SW-L to follow up. Either way, the grievances are tracked and logged by SW-L. 06/09/26 8:55 AM Surveyor asked Nursing Home Administrator (NHA)-A if NHA-A ever received a grievance from R105 or their family. NHA-A stated NHA-A did not recall R105 but if NHA-A had received a grievance, NHA-A would have submitted a concern on a grievance form. Surveyor notified NHA-A that there is evidence of an email correspondence sent to NHA-A, dated 1/27/26, with the sender requesting sender's concerns regarding discharge planning and pressure injury concerns to be addressed as a formal complaint. NHA-A stated this email may have gone to NHA-A's junk folder as NHA-A never received an email. Surveyor notified NHA-A that NHA-A did reply to sender on 1/30/26 as evidenced by the email correspondence that documented by NHA-A, the sender can be assured this is considered a grievance from the family and will be investigated. NHA-A stated NHA-A did not recall receiving or responding to this email. Surveyor asked if NHA-A had access to her past emails and NHA-A stated NHA-A no longer has access to any emails prior to April of 2026.No further information was provided as to why the facility did not document a thorough investigation and did not resolve grievances as outlined in the facility policy.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 4 (R2, R91, R4, & R5) of 5 sampled residents reviewed for unnecessary medications received psychotropic medications that were ordered properly, had appropriate indications for use, were monitored and care planned. * R2's as needed lorazepam medication used for anxiety did not have an end date. * R91 did not have an up to date Abnormal Involuntary Movement Scale (AIMS) assessment completed while receiving a psychotropic medication and as needed lorazepam medication did not have an end date. * R4 was receiving a psychotropic medication without an indication for use and no monitoring of behaviors. * R5 started a hypnotic medication for insomnia. The facility did not complete a sleep assessment. R5 did not have a care plan related to their insomnia. Findings include: The facility policy titled Use of Psychotropic Medication(s) implemented on 1/15/2026 documented: It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint.Policy Explanation and Compliance Guidelines: .2. Psychotropic medications are to be used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). 3. Other medications not classified as antipsychotic, antidepressant, antianxiety, or hypnotic medication but can affect brain activity should not be used as a substitution for another psychotropic medication unless prescribed with a documented clinical indication for use consistent with accepted clinical standards of practice.13. Residents who receive antipsychotic medication will have an Abnormal Involuntary Movement Scale (AIMS) test performed on admission, quarterly, with a significant change in condition, change in antipsychotic medication, as needed (PRN) or as per facility policy. 14. The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: .c. During Minimum Data Set (MDS) review (quarterly, annually .)d. In accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care.16. a. PRN orders for psychotropic medications . shall be limited to no more than 14 days . 1.) R2 admitted to the facility on [DATE]. R2 has diagnoses that included anxiety disorder, and chronic respiratory failure with tracheostomy. R2's quarterly Minimum Data Set (MDS) dated [DATE] indicated R2 has severely impaired cognition with a Brief Interview for Mental Status score of 3. Surveyor reviewed R2's physician orders and noted an order for:-Lorazepam (anti-anxiety medication) oral tablet 1 mg- Give 1 tablet by mouth every 1 hour as needed for Anxiety. With an order date of: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/27/2026 and no end date ordered. Surveyor noted there is not an end date for the as needed lorazepam. Surveyor also noted the order is for oral medication administration when R2 takes medications via percutaneous endoscopic gastrostomy (PEG tube). On 6/8/2026, at 3:41 PM surveyor interviewed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and Assistant Director of Nursing (ADON)-C. NHA-A stated there should be a 14 day stop date on as needed orders for psychotropic medications and would look into getting an end date for R2's lorazepam medication. Surveyor confirmed R2 should have medications via PEG tube and not orally. NHA-A and DON-B agreed R2 should have medications via PEG tube and would look into R2's physician orders to ensure accuracy. 2.) R91 has diagnoses that included anxiety disorder, vascular dementia, and major depressive disorder. R91's quarterly Minimum Data Set (MDS) dated [DATE] indicated R91 has severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 0. Surveyor reviewed R91's physician orders and noted an order for:- Lorazepam (anti-anxiety medication) oral tablet 1 mg- Give 1 tablet by mouth every 1 hour as needed for Anxiety. With an order date of: 3/6/2026 and no end date ordered. Surveyor reviewed R91's assessments and noted the last documented Abnormal Involuntary Movement Scale (AIMS) assessment for R91 was on 11/10/2025. On 6/8/2026, at 3:41 PM surveyor interviewed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and Assistant Director of Nursing (ADON)-C. NHA-A stated there should be a 14 day stop date on as needed orders for psychotropic medications and would look into getting an end date for R91's lorazepam medication. Surveyor shared concerns R91 did not have a recent AIMS assessment completed. ADON-C stated residents should have AIMS assessments completed on admission, change in status, medication adjustment if the resident is on a prescribed psychotropic medication. ADON-C stated any of the nursing staff and management can do an AIMS test on a resident however, the facility noted a problem with Point Click Care (PCC- electronic medical record system) that it was eliminating the reminders for some of the required assessments such as the AIMS assessment. ADON-C stated they are trying to catch up with the assessments that were due. NHA-A stated nursing is catching up to the required assessments. 3.) R4 admitted to the facility on [DATE] and had diagnoses that included Major Depressive Disorder, and dementia with agitation. R4's care plan documented: Uses psychotropic medications Buspar, Depakote and Quetiapine r/t (related to) depression - date Initiated 10/21/25. Interventions: Administer psychotropic medications as ordered by Physician. Monitor for side effects and effectiveness every shift. Monitor/document/report PRN (as needed) any adverse reactions of psychotropic medications: Unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	muscle cramps, nausea, vomiting, behavior symptoms not usual to the person. Behavior problem r/t Dementia e/b (evidenced by) not recognizing limitations and safety concerns so will self-transfer/ambulate, resistive to staff redirection when doing so/staff assistance, wanders unit at times with attempts to enter other rooms when looking for her own - date Initiated 7/23/25. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Caregivers to provided opportunity for positive interaction, attention. Stop and talk with him/her as passing by. Explain all procedures to the resident before starting. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Minimize potential for the resident's potential disruptive behaviors (wandering) by offering activities and tasks which divert attention such as (groups, 1:1s, TV, reading material, music etcetera). Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. R4's admission orders included an order for Quetiapine Fumarate oral Tablet 25 mg (milligrams) by mouth at bedtime for restlessness - dated 7/10/25. Surveyor noted the diagnosis for Quetiapine was changed to dementia with associated psychotic and/or agitated behaviors on 12/8/25. Surveyor noted Depakote Sprinkles delayed release 125 mg by mouth two times a day for dementia with agitation was ordered on 7/30/25. Surveyor noted Buspirone HCl (hydrochloride) 5 mg by mouth three times a day for anxiety was ordered on 7/17/25. The Buspirone was increased to 10 mg three times a day related to major depressive disorder on 7/30/25. R4 was followed by psychiatry. Progress note dated 4/30/26 at 1:30 PM documented: GDR (gradual dose reduction) of psychotropics not clinically indicated at this time. Resident continues to be followed by psych services for her anxiety and dementia. Surveyor reviewed R4's July 2025 Medication Administration Record (MAR) which documented: Enter the number that coincides with the behavior: 0-None, 1-Hitting, 2- Restlessness, 4-Withdrawal, 5-Combativeness, 6-Verbal outbursts, 8-Tearfulness, 9-Crying, 10-Paranoia, 11-Yelling, 12-Other (Describe) every shift for Behaviors. Surveyor noted that before Buspirone was ordered on 7/17/25, there was only 1 entry of 2 (restlessness) on 7/15/25 during the hours of 11 pm – 7 am. All other entries were 0. Surveyor noted before Depakote was ordered and Buspirone was increased on 7/30/25, there were only 4 entries of 2 (restlessness) on 7/19/25, 7/28/25 and 7/31/25 during the hours of 11 pm -7 am and on 7/29/25 during the hours of 7 am – 3 pm. All other entries were 0. There were no entries of agitation, hitting or combativeness. On 6/9/26 at 7:39 AM, Surveyor asked Nursing Home Administrator (NHA)-A why the Quetiapine and Buspirone diagnoses were changed. NHA-A reported R4 was initially seen by psychiatry and then the facility switched providers, who then changed the diagnoses. Surveyor asked why R4 was started on Buspirone and Depakote within a month after admission. Surveyor was unable to locate (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation of behaviors and told NHA-A there is no documentation of behaviors to support the use of the medications. NHA-A stated, There isn't any, I looked, the sheets are blank. But I can tell you she had behaviors, and she is much better now. Surveyor informed NHA-A of concern R4 was prescribed Buspirone for anxiety and major depressive disorder and Depakote for dementia with agitation within 1 month of admission and there is no evidence to support the clinical use of these medications, there was no specific behavior monitoring identified. No additional information was provided 4.) R5 was admitted to the facility on [DATE] with a diagnoses of obsessive-compulsive disorder, depression and anxiety. The admission physician orders included trazodone HCl (hydrochloride) Oral Tablet 150 MG. Give 150 mg orally at bedtime for Anxiety DepressionStarted on 1/13/2026 and discontinued on 3/4/2026. On 3/6/26 the trazadone was switched to Daridorexant HCl Oral Tablet 50 MG. Give 1 tablet by mouth at bedtime for Insomnia starting 3/6/26. This remains a current medication. On 3/4/26 a Psych Consult Assessment was completed. The assessment documented (R5's) sleep has been terrible. They receive trazadone at night and do not fall asleep for about 2 and 1/2 hours and then they often only sleep 3 or 4 hours at a time. Discussed risk and benefit of switching from Trazodone to Quviviq (Daridorexant). (R5) would like to try this. We'll begin weaning off Trazodone and start Quviviq tonight. R5's medical record did not include documentation of a sleep assessment and care plan for insomnia. The Quarterly Minimum Data Set (MDS) assessment completed on 5/14/26. Indicated a Hypnotic medication is administered daily. On 6/04/2026, at 10:46 AM, Surveyor requested additional information from Nursing Home Administrator-A. Nursing Home Administrator-A stated Director of Nurses (DON) -B does the sleep assessments and they are on paper. The Medical Record staff at the time was not scanning them in stating there are no paper charts. On 6/04/2026, at 11:40 AM. Surveyor interviewed Minimum Data Set Coordinator (MDSC)-M. MDSC reviewed the care plans for R5 and did not see a care plan for R5's insomnia or hypnotic medication. MDSC-M shared they typically complete them and it must have been missed. On 6/04/2026, at 11:51 AM, MDSC-M spoke with Surveyor. MDSC-M clarified a hypnotic medication would be addressed in the psych medication care plan. This would be because of the classification of the medication and not for what it is treating. MDSC-M did not have a care plan for insomnia. On 6/04/2026, at 12:46 PM, Medical Records (MK) -K supplied a Sleep Pattern for 1/14/26 - 1/15/26. There were no additional documents to address an assessment of R5's insomnia. On 6/08/2026, at 7:35 AM, Surveyor interviewed DON-B. DON-B stated the sleep assessment forms are a 3-day sleep diary. There are no additional sleep assessment documents. There was no care plan for insomnia developed based on a comprehensive sleep assessment.

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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 record review and staff interview, the facility did not ensure allegations of neglect, misappropriation of property, and injuries of unknown origin, were thoroughly investigated. This was observed with 3 (R106, R32 and R21) of 3 sampled residents. * R106 nurses notes included documentation on, 3/21/26 and 3/31/26, on care concerns provided by the facility. There is no further documentation of these concerns being investigated. * On 1/12/26 R32 reported his wallet containing $1000.00 was missing. The facility did not conduct a thorough investigation as the facility did not interview any ancillary staff such as housekeeping & activities who worked the floor from the time R32 went to the bank until R32's money was discovered missing. The facility does not have any evidence residents were interviewed to determine if there were any additional concerns regarding misappropriation of residents property. * R21 had an eye doctor appointment outside of the facility on 10/27/25. When R21 returned to the facility, R21 had an injury to the left lower leg. This injury of unknown origin was not fully investigated. Findings include: The facility policy and procedure Abuse, Neglect and Exploitation dated 1/8/2026. The Policy documents: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures. That prohibits and prevents abuse, neglect, exploitation and misappropriation of resident property.IV. Identification of Abuse, Neglect and Exploitation.B. Possible indicators of abuse include but are not limited to.1. Resident, staff or family report of abuse.2. Physical marks such as bruises or patterned appearances such as a handprint, belt or ring mark on a resident's body.3. Physical injury of a resident, of unknown source.4. Resident reports of theft of property, or missing property.V. Investigation of Alleged Abuse, Neglect and Exploitation.A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.B. Written procedures for investigations include:1. Identifying staff responsible for the investigation;2. Exercising caution in handling evidence that could be used in a criminal investigation;3. Investigating different types of alleged violations;4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator. Witnesses and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation and or mistreatment has occurred, the extent and cause; and6. Providing complete and thorough documentation of the investigation. 1.) R106 was admitted [DATE] with congestive heart failure and right foot wound with toe amputation. R106 was transferred to the hospital on 4/6/26 for a change in condition and has not returned to the facility. R106's medical record was reviewed. R106 is their own person. The admission Minimum Data Set (MDS) assessment completed 2/18/26; R106 requires assistance from staff for Activity of Daily Living (ADL). A Nurses Note dated: 3/21/2026 at 11:02 PM, documented by Licensed Practical Nurse (LPN) – DD indicated: Writer was informed by CNA (Certified Nursing Assistant) that a family member of noted (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident called to the community to place a complaint. CNA stated that resident's family member made claims of photos being sent and noted resident not being cleaned after an incontinent (sic) episode. CNA stated the family member made claims to come up here to deal with the staff. At around 11:40 PM, one woman and one man entered the doors at subacute and walked past the nurse's station and headed to noted resident room. The nurse that was passing medications was present at time of entry into room (room number listed). After about 15 minutes both the man and women emerged from the room and exited the building. On 6/03/2026, at 9:57 AM, Surveyor interviewed Director of Nurses (DON)-B. DON-B stated they were not aware of any care concerns with R106. R106's family members were involved with direct care needs. DON-B stated they do not recall much about R106. DON-B indicated If they were aware of any concerns they would have written up a grievance. On 6/03/2026, at 2:31 PM, Surveyor interviewed the Assistant Director of Nurses (ADON)-C. ADON-C was not aware of any concerns with R106. ADON-C stated DON-B's number is posted everywhere for staff to call with any concerns. On 6/03/2026, at 3:13 PM, Surveyor requested any additional information related to the allegation referenced in the nurses note on 3/21/2026. Administrator-A stated they were not aware and did not have any further information. On 6/04/2026, at 10:57 AM, Surveyor interviewed LPN-DD via phone. LPN-DD stated R106's family had grievances with the facility that may have involved back and forth with DON-B and ADON-C. The family member did not feel R106 was being cared for properly. That evening R106 felt the CNA was taking too long. R106 can toilet themselves, but had c-diff (clostridium difficile) . R106 called their family member. The family member and a man came to the facility. They took pictures. The family member was very upset. LPN-DD told the supervisor about it. LPN-DD does not recall who was supervising that evening. A second Nurses Note dated: 3/31/2026 at 6:18 AM, by Agency Registered Nurse (RN) -P, documented: Resident could not be patient for a chance to attend to her towards close of shift amidst other duties (sic), (R106's) family member came into facility and writer calmed them down. Writer got (R106) cleaned. Family member furious with threat to report to state. On 6/03/2026, at 9:57 AM, Surveyor interviewed DON-B about the second allegation of care concerns. DON-B stated they were not aware of any care concerns with R106. R106's family members were involved with direct care needs. DON-B stated they do not recall much about R106. DON-B indicated If they were aware of any concerns they would have written up a grievance. On 6/03/2026, at 2:31 PM, Surveyor interviewed the Assistant Director of Nurses (ADON)-C. ADON-C was not aware of any concerns with R106. ADON-C stated the DON-B number is posted everywhere for staff to call with any concerns. On 06/04/2026, at 11:15 AM, Surveyor interviewed Agency RN-P via phone regarding the allegations of neglect from 3/31/26. RN-P could not recall any details and did not remember anything. 2.) R32 was discharged from the facility on 5/10/26. R32's quarterly MDS (minimum data set) with an assessment reference date of 1/8/26 has a BIMS (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(brief interview mental status) score of 15 which indicates cognitively intact. On 1/12/26, R32 reported to Certified Nursing Assistant (CNA)-SS he was missing money. CNA-SS reported R32's missing money to Unit Manager (UM)-BB. On 1/12/26 UM-BB informed Social Worker (SW)-L R32 was missing his black wallet containing $1000.00. On 6/9/26, at 10:40 a.m., Nursing Home Administrator (NHA)-A provided surveyor with the facility's misappropriation investigation for R32's missing $1000. Surveyor asked NHA-A if this was the facility's complete investigation. NHA-A replied yes. On 6/9/26, at 10:59 a.m., surveyor reviewed the facility's misappropriation investigation. The investigation revealed R32 had gone to a bank on 1/9/26 wanting to withdraw $2000 but the bank would only allow R32 to withdraw $1000. Surveyor noted during the investigation the facility interviewed R32 & searched R32's room, interviewed R32's roommate, and some facility staff. Surveyor noted that the facility's investigation did not include interviews or statements from housekeeping and activities staff who worked on the unit after R32 went to the bank and R32's money was discovered missing. The investigation also did not include interviews with residents. On 6/9/26, at 11:36 a.m., Surveyor interviewed Social Worker (SW)-L regarding the facility's process when a resident voices an allegation of misappropriation. SW-L informed surveyor when there is an allegation of misappropriation she will go up to speak with the resident, get the specific information, inform Nursing Home Administrator (NHA)-A, do an online report and follow up with an investigation. Surveyor asked SW-L what their investigation consisted of. SW-L informed surveyor they pull schedules for the time frame, talk to staff that were on, interview other residents and if needed the police would be contacted. Surveyor inquired when the facility would contact the police. SW-L informed surveyor if there is misappropriation or abuse. Surveyor inquired about how they determine which staff to interview. SW-L informed surveyor it is based off the schedules for the time frame. Nursing and housekeeping are interviewed and depending on the allegation sometimes they could even be talking to therapy as well. On 6/9/26, at 11:40 a.m., surveyor informed SW-L surveyor reviewed the facility's investigation and noted during the investigation R32, R32's roommate, Receptionist-UU, and nursing staff were interviewed. Surveyor asked SW-L if she knew why she didn't interview any housekeeping or activities staff who worked on the unit after R32 withdrew $1000 from the bank until R32's money was discovered missing. SW-L replied I don't. Surveyor asked SW-L if she would normally interview housekeeping and/or activities. SW-L replied yes. Surveyor informed SW-L surveyor did not note any resident interviews in the facility's investigation. SW-L informed surveyor she only writes a resident interview if there is a concern. 3.) On 6/1/26 at 9:48 AM, Surveyor interviewed R21. R21 informed Surveyor that a few months ago, R21 obtained a large bruise on the way back from an eye appointment outside of the facility. R21 stated that R21 thinks the transport driver placed the bottle of oxygen on R21's legs and R21 got a large dark purple bruise. R21 stated that it took a while to heal. R21's progress note dated 10/27/25 at 8 AM, documented: Resident is being pick[ed] up via (name of transport company). R21's progress note entered by Licensed Practical Nurse (LPN) /Unit Manager (UM)-BB, dated 10/27/25 at 11:45 AM, documented, in part: Upon returned writer noted to [R21's] Left shin is (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Greenfield	5790 S 27th St Milwaukee, WI 53221

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bluish-purple to colored, oval in shape, skin is intact, skin is raised and pain to touch, updated [Assistant Director of Nursing (ADON)-C], [Director of Nursing (DON)-B] and administrator . Will have scheduler contact the transit (name of company) staff for statement. On 6/4/26, Surveyor requested all Facility Reported Incidents (FRI) for the month of October 2025. Surveyor noted the facility did not complete or document a thorough investigation into R21's injury that was first documented by facility staff on 10/27/25. On 6/4/26 at 9:28 AM, Surveyor interviewed UM-BB. Surveyor asked what happened to R21 on 10/27/25. UM-BB stated that R21 was injured during transport from an eye appointment outside of the facility. UM-BB stated that the transport company employee took an O2 tank and rested it on R21's leg. UM-BB stated that R21 got the injury from that. UM-BB stated that they thought that statements were collected from the transport company. UM-BB stated that UM-BB will check and get back to Surveyor. On 6/4/26 at 11:36, UM-BB returned to Surveyor and stated that UM-BB checked with Nursing Home Administrator (NHA)-A. NHA-A informed UM-BB that the transport company would not send any statements because they did not want to be sued. On 6/4/26 at 12:38 PM, Surveyor interviewed the transport service Office Manager (OM)-XX. Surveyor asked if there had ever been a break in the company providing transport services to the facility related to a resident injury. OM-XX indicated that there was not a break in service for a reason like that. Surveyor asked if OM-XX had heard that R21 had returned from an appointment with a transport employee and R21 had an injury to their lower left leg. OM-XX stated that they remembered the facility staff stated that a transport employee put an oxygen tank on R21's leg. OM-XX stated that they completed an incident report. OM-XX stated that they liked to get documentation right away when an accusation is made. OM-XX provided the written statements to Surveyor. Transport employee-ZZ's incident report statement dated 10/27/25 documented: Picked client up on 10/27/25. [R21] was lifted by Hoyer. Nurses at [Name of facility], placed client on cot. Placed oxygen machine on client's legs. On the return ride we put machine on stomach. Where the bruises [were] the machine wasn't even in that area. Nurses told us to, make sure y'all don't bruise [R21]. Transport employee-YY's incident report statement dated 10/27/25 documented: On [10/27/25 at] 8:00 AM, I and another driver picked up [R21] at [Name of facility]. While picking [R21] up, the ladies who work at facility used a Hoyer lift to lift [R21] up. [R21] didn't want that. [R21] said it hurts [their] leg. [R21] said bruises came from oxygen tank but oxygen was nowhere near where the bruises were. Injuries: Two bruises on legs which looked old black/blue. Surveyor noted different accounts by facility staff and transport employee staff of how [R21's] injury occurred. Surveyor noted OM-XX did have transport employee's completed statements and the facility did not obtain these statements. On 6/4/26 at 3:46 PM, Surveyor asked NHA-A if there was any investigation or report into what happened after R21 returned to the facility with an injury to R21's left leg. NHA-A stated that NHA-A would have to look into that and get back to Surveyor. NHA-A provided Surveyor with a form titled Other Skin Alteration, dated 10/27/25 at 11:30 AM completed by UM-BB. The form documented, in part. Resident states, during transportation, the driver placed portable oxygen tank on top of [R21's] left leg. [R21] told the driver [they] are experiencing pain to [their] leg, and the driver came and removed the portable oxygen tank. No statements found. People Notified: Administration [NHA-A], Physician [NP-G] and [DON-B]. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted that the facility did not collect and document statements from any facility staff members that were with R21 before and after the outside eye appointment. Surveyor noted that the facility did not collect statements from other residents who use the same transport company to see if any other residents had concerns with transport drivers or facility staff. Surveyor noted that there was no education completed on how to prevent an injury like this from happening again. For example, if investigation proved that an oxygen tank caused the injury, education on placement or use of oxygen tanks during transportations. Surveyor concluded that there is not a thorough investigation documented by facility staff. On 6/9/25 at 11:28 AM, Surveyor interviewed ADON-C and NHA-A. Surveyor asked when they became aware of R21's leg injury. ADON-C stated that they were aware of the injury on the same day that it occurred. NHA-A stated that NHA-A was not told anything. Surveyor asked when NHA-A became aware of R21's leg injury. NHA-A indicated that they found out about it when Surveyor brought it to their attention. Surveyor shared the concern that this injury of unknown origin was not investigated or reported to the State Agency. ADON-C stated that the injury occurred from an oxygen tank during transfer. Surveyor asked if statements were collected and was told by NHA-A that Surveyor had everything. Surveyor asked how the facility could know exactly what happened without completing a thorough investigation. NHA-A stated that in the past NHA-A has had a hard time getting statements from the transport company because they do not want to be held liable. Surveyor shared continued concern that R21's injury was not thoroughly investigated. Statements were not obtained from facility staff, transport staff or residents. Education was not completed to prevent reoccurrence. No further 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 upon transfer or discharge of 6 (R105, R103, R13, R8, R14 and R66) of 7 sampled residents the resident was provided proper notices related to transfer and bed hold, and a process was established to ensure the Ombudsman was notified of the resident transfers and discharges in the facility. * R105 was discharged home 1/30/26. The facility did not notify the Ombudsman of this discharge. * R103 was discharged home 3/6/26. The facility did not notify the Ombudsman of this discharge. * R13 was transferred to the hospital on 5/31/26 and has not yet returned to the facility. The facility did not have documentation of providing bed-hold information, a transfer notice and notification to the Ombudsman regarding the transfer. * R8 did not receive a bed hold or transfer notice in writing from the facility when sent to the hospital on 2/26/26 and 3/18/26, the Ombudsman was not notified of the discharges. * R14was transferred to the hospital on [DATE] and 2/3/26. The facility did not have documentation that bed-hold information and transfer notice was provided to R14 or R14's representative. The facility did not notify the Ombudsman of R14's transfer. * R66 was transferred to the hospital on 5/13/25, 6/25/25, 7/18/25, 8/6/25, 12/23/25 and 2/15/26. The facility did not have documentation that bed-hold information and transfer notice was provided to R66 or R66's representative. The facility did not notify the Ombudsman of R66's transfer. Findings include: The facility policy titled, Transfer and Discharge, date implemented 4/15/26, documented, in part, . Policy: It is the policy of this facility to permit each resident to remain in the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source.Policy explanation and Compliance Guidelines: . 3. The facility's transfer/discharge notice will be provided to the resident and/or representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: The specific reason and basis for the transfer or discharge. The effective date of transfer or discharge. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged . An explanation of the right to appeal the transfer or discharge to the State. The name, address (mailing and email) and telephone number of the State entity which receives such (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appeal hearing requests. Information on how to obtain an appeal form. Information on obtaining assistance in completing and submitting the appeal hearing request. The name, address (mailing and email), and phone number of the representative of the Office of the State Long-term Care Ombudsman. 5. The facility will maintain evidence that the notice was went to the Ombudsman. 1.) R105 was admitted to the facility on [DATE] and discharged on 1/30/26. R105's Progress Note, dated 1/30/26 at 15:30 (3:30 PM), documented, Health Status Note, Note Text: discharged home from facility. Left via private vehicle accompanied by son. Took discharge paperwork, remaining belongings, and remaining meds (medications) home. Alert and responsive skin warm and dry. Lungs clear, no complaints of sob (shortness of breath) or dyspnea. Abdomen soft non-tender with bowel sounds present x 4. No complaints of pain noted. On 06/09/26 at 8:37 AM, Surveyor asked Nursing Home Administrator (NHA)-A if NHA-A could provide evidence of Ombudsman notification for R105's discharge on [DATE]. NHA-A stated that Business Office Manager (BOM)-AA was responsible for Ombudsman notification and NHA-A discovered BOM-AA was not providing the notifications. Surveyor notified NHA-A of concern regarding no ombudsman notification for R105's discharge. 2.) On 2/26/2026, at 5:57PM, R8's progress note documents writer spoke with. R8 was admitted for Acute Respiratory Failure and is in ICU (Intensive Care Unit). Surveyor noted R8 returned to the facility on 3/4/2026 from the hospital. On 3/18/2026, at 06:32 AM, R8's progress note documents R8 continues to have hypotension and lethargy, difficult to arouse, new order to send to ER (emergency room) for eval/treat. Surveyor noted R8 returned to the facility on 3/27/2026 from the hospital. Surveyor reviewed R8's medical record. Surveyor noted the facility did not document that they provided R8 or R8's representative with bed-hold information or transfer notices for either of R8's hospitalizations. On 6/03/2026, at 3:13 PM, at the facility exit meeting with Nursing Home Administrator (NHA)-A, Director of Nursing-B and Assistant Director of Nursing-C, NHA-A stated the Ombudsman has not been notified monthly of discharges. The Business Office staff (Business Office Manager -BOM-AA) left and was not doing this task. On 6/8/26 at 9:44 AM, Surveyor interviewed NHA-A. Surveyor asked if R8 was provided bed-hold information or transfer notice when R8 was transferred to the hospital on 2/26/2026 and 3/18/2026. NHA-A stated that they did not have the bed-hold or transfer notices for R8. Surveyor asked if the Ombudsman was notified of R8's transfers to the hospital. NHA-A indicated the Ombudsman was not notified. 3.) R13's medical record was reviewed. R13 has resided in the facility since 8/19/20 and has an (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activated Power of Attorney for Healthcare (POAHC). R13 is currently on hospice services A Nurses Note on 5/31/26 documented R13 was sent to the hospital for a change in condition. This change in condition was discussed with the POAHC and Hospice. R13 was admitted to the hospital and has yet to return. R13's medical record did not include documentation of bed-hold information and transfer notice requirements. On 6/03/2026, at 12:48 PM, Surveyor requested additional information from Nursing Home Administrator (NHA)-A. NHA-A stated they don't have the paperwork. This includes the Bed-Hold and Transfer Form. On 6/03/2026, at 3:13 PM, at the facility exit meeting with Administrator-A, Director of Nurses (DON)-B and Assistant Director of Nurses (ADON)-C, Administrator-A stated the Ombudsman has not been notified monthly. The Business Office staff left and did not do this task. 4.) R103's medical record was reviewed. R103 had a planned discharge home on 3/6/26. Surveyor requested the Ombudsman notification related to R103's discharge from Nursing Home Administrator (NHA)-A. On 6/03/2026, at 3:13 PM, at the facility exit meeting with NHA-A, Director of Nurses (DON)-B and Assistant Director of Nurses (ADON)-C, NHA-A stated the Ombudsman was not notified of R105'w discharge. NHA-A stated the Business Office staff left and did not do this task. 5.) R14 was admitted to the facility on [DATE]. R14 experienced a change of condition on 12/16/25. R14 was transferred to the hospital and returned to the facility on [DATE]. R14 experienced a change of condition on 2/3/26. R14 was transferred to the hospital and returned to the facility on 2/6/26. Surveyor reviewed R14's medical record. Surveyor noted the facility did not document that they provided R14 or R14's representative with bed-hold information or transfer notices for either of R14's hospitalizations. On 6/3/26 at 3:22 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A informed Surveyor that the business office does not have a business office manager at the present time. On 6/8/26 at 9:44 AM, Surveyor returned to NHA-A. Surveyor asked if R14 was provided bed-hold information or transfer notice when R14 was transferred to the hospital on [DATE] and 2/6/26. NHA-A stated that they did not have the bed-hold or transfer notice for R14. Surveyor asked if the Ombudsman was notified of R14's transfers to the hospital. NHA-A indicated that the person in charge of the business office was not doing their job. The Ombudsman was not notified. 6.) R66 was admitted to the facility on [DATE]. R66 experienced a change of condition on 5/13/25. R66 was transferred to the hospital and returned to the facility on 5/22/25. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R66 experienced a change of condition on 6/25/25. R66 was transferred to the hospital and returned to the facility on 7/2/25. R66 experienced a change of condition on 7/18/25. R66 was transferred to the hospital and returned to the facility on 7/28/25. R66 experienced a change of condition on 8/6/25. R66 was transferred to the hospital and returned to the facility on 8/11/25. R66 experienced a change of condition on 12/23/25. R66 was transferred to the hospital and returned to the facility on [DATE]. R66 experienced a change of condition on 2/15/26. R66 was transferred to the hospital and returned to the facility on 2/20/26. Surveyor reviewed R66's medical record. Surveyor noted that the facility did not document that they provided R66 or R66's representative with bed-hold information or transfer notices for any of R66's hospitalizations. On 6/3/26 at 3:22 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A informed Surveyor that the business office does not have a business office manager at the present time. Surveyor asked for evidence that the facility provided bed-hold information and transfer notices to R66 or R66's representative. NHA-A stated good luck with that. We do not have them. The previous person in charge of the business office was not doing their job. Surveyor asked if the Ombudsman was notified of R66's transfers. NHA-A indicated that the Ombudsman was not notified.

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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 ensure residents who are unable to carry out activities of daily living received the necessary services to maintain good grooming/hygiene for 1 (R31) of 19 sampled residents reviewed for bathing.*R31 did not consistently receive showers or bed baths. Findings include:The facility's Resident Showers implemented 4/15/26 documented:Policy:.It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice.Policy Explanation and Compliance Guidelines:.1.Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety.3.The Certified Nursing Assistant (CNA) will report skin changes to nursing staff while performing bathing and inform the nurse of any changes.R31 was admitted to the facility on [DATE] with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction(complete paralysis on one side of body and partial/incomplete weakness on one side following stroke), Protein-Calorie Malnutrition Moderate(significant, but not severe, deficiency in nutrient intake), Chronic Pain Syndrome(a condition where pain persists for longer than 3-6 months and accompanied by emotional and physical symptoms like depression, anxiety, and sleep disturbance, Functional Quadriplegia(complete inability to move all four limbs due to severe disability or frailty), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Chronic Obstructive Pulmonary Disease(lung disease that block airflow and make it difficult to breathe), and Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities).R31's Quarterly Minimum Data Set (MDS) assessment, dated 4/2/26, indicated that R31's Brief Interview for Mental Status (BIMS) score was documented as 15, which indicated R31 was cognitively intact for daily decision making. R31's MDS also documented R31 had range of motion (ROM) impairment on both upper and lower extremity on one side and was dependent for dressing, mobility, and transfers. R31 was dependent on staff assistance for showers. R31's documented R31 had no depressive or behavioral symptoms. R31's comprehensive care plan documented:R31 had an activities of daily living (ADL) self-care performance/mobility deficit due to left-sided hemiplegia, impaired balanceInitiated 7/26/19Revised 3/29/22Interventions documented:-Bathing/Showering: R31 required assistance by 1 staff with bathing/showering every Friday nights(NOC), but required mechanical lift and total assist of 2 for transfer into shower chair/tubInitiated 7/30/19Revision 3/17/23-Bathing/Showering: Provide sponge bath when a full bath or shower cannot be toleratedInitiated 7/26/19Revision 3/17/23Surveyor noted there was no care plan that documented R31 refused any activities of daily living (ADL) assistance.Surveyor reviewed R31's electronic medical record (EMR). Under tasks the question: Was a bath given or a shower? Surveyor reviewed R31's record from December-June and noted the answer given stated Not Applicable. Surveyor noted showers are not documented as being provided to R31. On 6/4/2026, at 11:50 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-U. CNA-U stated that CNA-U does not work on R31's shower days so CNA-U would not know if R31refused. CNA-U stated that if a resident was to refuse, CNA-U would tell the nurse, that was what we are supposed to do.On 6/4/2026, at 11:01 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-Z. LPN-Z stated LPN-Z was the regular nurse working Monday-Friday and assigned to R31. LPN-Z explained that skin/body checks were done on shower days. If a resident refused a shower, then a bed bath needed to be given. LPN-Z stated that LPN-Z did not think LPN-Z could get R31 in the shower because R31 was set in R31's ways. On 6/4/2026, at 3:12 PM, Surveyor interviewed Wound Nurse (WN)-E. WE-E confirmed that a body check needs to be completed on every resident. WN-E gets updated information on a resident from nurse reports, completed body checks, 24-hour board, morning shift report and CNAs inform WN-E of any new skin issues with a resident. On 6/8/2026, at 10:25 AM, Surveyor interviewed Social Worker (SW)-L in regard to R31's preferences. SW-L stated R31 did not like to get (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out of bed and did not like to get into the shower room. This had been from R31's admission. SW-L confirmed that nursing staff should had been completing bed baths if R31 did not want a shower.On 6/8/2026, at 10:46 AM, Surveyor interviewed Unit Manager (UM)-BB. UM-BB informed Surveyor that if a resident did not want a shower, a bed bath should be offered. UM-BB confirmed that a body check should be completed. The body checks were completed by the regular nurse or by UM-BB and on the PM shift the supervisor would complete. UM-BB would monitor the body checks and notify WN-E. UM-BB was not aware of R31 refusing bed baths. On 6/9/2026, at 7:16 AM, Surveyor reviewed R31's completed body checks from December-June. December12/5, 12/12, 12/26Missed 12/19January 1/2/, 1/23, 1/30Missed 1/2, 1/16February2/13, 2/20, 2/27Missed 2/6March3/13, 3/27Missed 3/6, 3/20April4/3, 4/17Missed 4/10, 4/24The facility provided no documented completed body checks for May or June.On 6/9/26, at 9:21 AM, R31 informed Surveyor that R31 did not like to get out of bed because of the mechanical lift was needed to get into the shower room. R31 stated R31 will get a bed bath but it was not on a regular basis. R31stated R31 does not even know what R31's shower day was. R31 stated, of course I would like a regular bed bath since I don't get in the shower.On 6/9/2026, at 11:24 AM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that there was no documented completed bed baths provided to R31 on a consistent basis. The facility did not provide any additional information at this time in regard to R31 not receiving bed baths on a consistent basis.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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 interview and record review, the facility failed to ensure 4 (R21, R66, R109, and R7) of 19 sampled residents received treatment and care based upon a comprehensive assessment and a comprehensive person centered plan of care and in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act.) *R21 returned from an appointment outside of the facility on 10/27/25 with a large hematoma on the front of R21's left shin. R21's leg wound opened and needed to be debrided on 11/19/25. On 11/26/25, R21's left leg wound became infected. Facility staff did not follow Wound Nurse Practitioner (NP)-F's treatment orders. R21's wound required placement of a midline IV (intravenous) and 2 different IV antibiotics to treat the infection. *R66 experienced a respiratory change of condition in the early morning of 2/15/26. Facility staff contacted a doctor and received orders for a STAT (immediate) X-ray, 2 Duo-neb treatments (prescription inhalation solution), Oxygen (O2), Vital signs every hour for 3 hours and O2 saturation monitoring. The STAT X-ray, Duo-neb treatments, Vital signs and O2 saturation monitoring were not completed or documented by facility staff. R66's condition worsened. R66 was sent to the hospital and diagnosed with Pneumonia and Sepsis. *R109 was admitted to the facility with wounds initially identified as pressure injuries that were reclassified as vascular in nature. The facility did not ensure an assessment of R109's individual needs and risk factor was completed to develop an individualized plan of care to prevent deterioration of R109's wounds. R109 developed additional wounds and had wounds that developed systemic infections requiring treatment with antibiotics. R109 did not receive care and treatment to prevent the development of additional vascular wounds. R109's wounds became infected and required antibiotic treatment. The facility's failure to provide R21, R66, and R109 with the necessary care and treatment per current standards of practice by not following provider treatment orders and/or not implementing treatment orders, not completing RN assessments of newly discovered wounds, not updating care plans timely with new interventions, and not obtaining an x-ray order as ordered (STAT) created a finding of immediate jeopardy. The immediate jeopardy began on 11/26/25 when R21's left leg wound developed an infection that required IV antibiotics. Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Assistant Director of Nursing (ADON)-C were notified of the immediate jeopardy on 6/9/26 at 4:08 PM. The immediate jeopardy was removed on 6/15/26 when the facility implemented their action plan, however, the deficient practice continues at a scope/severity of D (potential for harm/isolated) based upon the example for R7. *R7 had an unwitnessed fall on 4/13/2026 and the facility could not provide evidence that neurological checks were completed post fall. Findings include: On 6/9/26, Surveyor asked for the facility's Change of condition policy and a non-pressure related wound care policy. Surveyor was not provided with either. The facility policy dated 3/20/26 and titled, Diagnostic Testing Services, documents, in part: This (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility will provide the appropriate diagnostic services (laboratory and radiology) required to maintain the overall health of its residents and in accordance with State and Federal guidelines . According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. 1.) R21 was admitted to the facility on [DATE] with diagnoses to include Spinal stenosis of the lumbar region, Chronic Obstructive Pulmonary Disease (COPD), Hypertensive heart and kidney disease, dependence on supplemental oxygen, and Coronary Artery Disease. R21's Annual Minimum Data Set (MDS) assessment dated [DATE] documents R21 is cognitively intact and is dependent on staff for all cares, mobility, and transfers. R21 does not have any pressure injuries, skin ulcers, wounds, or skin problems. R21's skin integrity care plan initiated 4/18/23 documents the following pertinent interventions: Keep skin clean and dry. Follow facility protocols for treatment of injury. Follow MD (Medical Doctor) order for wound cares. Obtain and follow MD orders for treatment of wound. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. On 6/1/26 at 9:48 AM, Surveyor interviewed R21. R21 informed Surveyor that a few months ago, R21 obtained a large bruise on her way back from an appointment outside of the facility. R21 stated she thinks the transport driver placed the bottle of oxygen on her legs and she got a large dark purple bruise. R21 stated the facility staff had to open it up and it took months to heal the wound. R21's progress note dated 10/27/25 at 8 AM documents: Resident is being pick[ed] up via [name of transport company] transportation. R21's progress note entered by Licensed Practical Nurse (LPN)/Unit Manager (UM)-BB, dated 10/27/25 at 11:45 AM, documents, in part: Upon return writer noted [R21's] Left shin is bluish-purple to colored, oval in shape, skin is intact, skin is raised and pain (sic) to touch, updated ADON (Assistant Director of Nursing) [C], DON (Director of Nursing) [B] and administrator. No drainage noted. Measurements is [sic] 4 (centimeters) x 3.5 x 0.1 . Notified NP (Nurse Practitioner) [G] new order obtained to HOLD anticoagulant for days and apply skin prep 2 times a day and as needed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed R21's medical record and did not find evidence of a Registered Nurse assessment completed and documented by facility staff on 10/27/25. R21's MD order with a start date of 10/27/25 documents, in part: Apply skin prep to left . shin hematoma 2 times a day and as needed. Surveyor reviewed R21's skin integrity care plan and noted facility staff added the following intervention on 10/27/25: Hold Eliquis for 3 days. Surveyor did not find evidence that any other care plan updates were added to R21's care plan. Surveyor noted there were no new interventions to address the care of R21's new skin wound or identify interventions to prevent worsening of the wound. On 6/9/26 at 11:02 AM, Surveyor interviewed DON-B. Surveyor asked when a resident's care plan should be updated with new interventions to address new skin concerns. DON-B indicated it is usually within a day or two. DON-B stated the Interdisciplinary Team (IDT) will talk about new wounds and talk about what should be added to the care plan. R21's Wound Nurse Practitioner (NP)-F note dated 10/29/25 documents, in part: [R21] is being seen for evaluation and treatment recommendation regarding a hematoma to left leg. 0.4 x 4 x 0.1. 100% epithelial . No intervention needed at this time. Recommend Every shift neurovascular assessment. On 6/9/26 at 9:40 AM, Surveyor interviewed Wound NP-F. Surveyor asked what Wound NP-F was looking for in every shift neurovascular assessments. Wound NP-F stated they wanted to monitor for compartment syndrome (a painful and potentially dangerous medical condition caused by a dangerous buildup of pressure within a muscle compartment) in the setting of a hematoma. Wound NP-F stated staff should be looking for the 6 Ps (pain, pallor, pulses, paresthesia, paralysis, poikilothermia [temperature]). Surveyor reviewed R21's Electronic Medical Record (EMR) and noted facility staff did not implement neurovascular assessments every shift as Wound NP-F had recommended. Surveyor reviewed R21's Treatment Administration Record (TAR) and noted facility staff continued to treat R21's left leg hematoma with skin prep 2 times a day even though Wound NP-F documented in their note on 10/29/25 that no intervention was needed. On 11/5/25 and 11/12/25, Wound NP-F notes document, in part: R21's left leg hematoma 4 x 4 x 0.1. No intervention needed at this time. Recommend every shift neurovascular assessment . Surveyor reviewed R21's EMR and noted facility staff did not implement neurovascular assessments every shift as Wound NP-F had recommended on 10/29, 11/5, and 11/12/25. Surveyor reviewed R21's TAR and noted facility staff continued to treat R21's left leg hematoma with skin prep 2 times a day even though Wound NP-F documented in Wound NP-F's note on 11/5 and 11/12/25 that no intervention was needed. R21's skin integrity care plan was updated on 11/18/25 with the following pertinent interventions: Maintain communication with [Named] wound care [Provider] for wound care orders and evaluation. Follow wound Provider orders for wound treatment. Use draw sheet for all repositioning to reduce (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	friction and protect skin integrity. Encourage and assist resident to reposition every 2 hours while in bed. Build rapport with resident to ease anxiety and support cooperation for dressing changes . Surveyor noted R21's care plan was not updated with wound specific interventions until 3 weeks after R21's new skin issue was identified. On 6/9/26, Surveyor interviewed DON-B and asked if it typically takes over 3 weeks to update a care plan with wound specific interventions. DON-B stated 3 weeks is not typical. R21's Wound NP-F note dated 11/19/25 documents in part: Wound is deteriorating. Upon assessment today, hematoma spontaneously dislodged requiring intervention. Wound debrided today without complications. Treatment plan updated. No new concerns . 5.5 x 5.5 x 0.3. Treatment recommendations: Adaptic covered with calcium alginate and border foam daily and as needed. R21's MD order dated 11/19/25 documents: Wound Care Left Leg: Cleanse with normal saline and pat dry, cover with an adaptic and calcium alginate. Then cover with bordered foam. Every day shift for wound care AND as needed. Surveyor reviewed R21's TAR and noted that facility staff entered orders for the new recommended treatment, but facility staff did not discontinue the first treatment order of skin prep to the hematoma. Surveyor noted facility documentation indicates R21's left leg was being treated with skin prep to an open wound 2 times a day as well as the new treatment order. On 6/9/26 at 9:40 AM, Surveyor interviewed Wound NP-F and asked if Wound NP-F ordered the skin prep 2 times a day to R21's hematoma. Wound NP-F stated skin prep to the hematoma was used for protection. Wound NP-F stated the top of the hematoma was very thin and superficial. Wound NP-F wanted to maintain the skin and have the hematoma absorb. When skin prep was put in place, the wound was not opened. Surveyor asked if R21 needed the skin prep 2 times a day after the wound opened. Wound NP-F stated R21 would not need it after it unroofed. Surveyor asked if Wound NP-F was aware facility staff continued to treat the wound 2 times a day with skin prep. Wound NP-F stated skin prep would not harm the wound if staff used it on the peri wound. Wound NP-F stated there would be nothing wrong with that. Surveyor asked if skin prep was placed on an open wound could that cause harm or cause bacteria to grow in the wound. Wound NP-F stated Wound NP-F did not think facility staff were putting the skin prep on the open wound. R21's Weekly Non-Pressure Wound Tracking note dated 11/26/25 documents in part: Left leg hematoma 5.5 x 5.5 x 0.3. Treatment ordered: Normal saline/pat dry/half strength Dakins moistened gauze/kerlix . Hematoma-90% granulation tissue, 10% slough. Moderate purulent exudate. No pain or discomfort . R21's progress note dated 11/26/25 at 2:36 PM, documents: Wound [NP-F] notified of purulent drainage of left leg wound. [NP-F] ordered wound culture. Wound culture collected. [NP-F] ordered Bactrim until wound culture results come back. New treatment orders received from [NP-F]. R21's MD order with a start date of 11/26/25 documents: Wound Care Left Leg: Cleanse with normal saline and pat dry, cover with Half strength Dakins moistened gauze. Cover with ABD (abdominal pad) and wrap with Kerlix/gauze roll. Every day shift for wound care AND as needed. R21's MD order with a start date of 11/26/25 documents: Bactrim DS oral tablet 800/160 mg (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	during the look back period. The MDS documents R109 has one stage III pressure injury and five venous and arterial ulcers. R109's care plan documents R109 has actual impaired skin integrity to the Right Lower Leg (Vascular), Right Heel (Vascular), Right Back (Vascular), Right 2nd Toe (Vascular), Left 4th Toe (Vascular), Left 3rd Toe (Vascular), Left 5th toe (vascular) related to limited mobility, alterations in circulation, alterations in sensation, and fragile skin. Contributing factors include right lower extremity peripheral arterial disease with prior occlusion of the superficial femoral artery and dorsalis pedis artery requiring vascular intervention including stenting and angioplasty, hemiplegia affecting the left nondominant side, muscle wasting and atrophy, rheumatoid arthritis, osteoporosis, neuritis, and heart failure which may increase risk for impaired tissue perfusion, delayed wound healing, and skin breakdown. Resident is pleasant, cooperative with care, and able to make needs known. Date Initiated: 02/25/2026. Pertinent interventions include: Check, change, and reposition every 2 hours, offer and assist with toileting. Date Initiated: 02/25/2026 Elevate heels off the bed using pillows or pressure-relieving devices to prevent skin breakdown. Date Initiated: 02/25/2026 Encourage and assist resident to reposition every 2 hours while in bed. Date Initiated: 02/25/2026 Ensure air mattress is in place while resident is in bed. Date Initiated: 02/25/2026 Keep skin clean and dry; apply House Barrier Cream after each incontinence episode. Date Initiated: 02/25/2026 Surveyor noted R109 admitted to the facility with three pressure injuries on 1/9/2026 and the impaired skin integrity care plan was not initiated until 2/25/2026 and new interventions were not added after new wounds developed. R109's Weekly Wound Assessment dated 1/9/2026, the date of admission, documents three deep tissue injuries (DTI,) one on R109's right second toe measuring 0.3 x 0.3 x 0 cm, one on right heel, measuring 3.8 x 2.5 x 0 cm, and one on sacrum measuring 2.3 x 8 x 0 cm. On 1/20/2026, R109 developed two new wounds. The right buttock was assessed as a DTI. The right lower leg was assessed as vascular and measured 1.1 x 1.2 x 0.1 cm, it was documented as dark maroon and nonblanchable. On 1/26/2026, R109 developed 2 more wounds. The left fourth toe was assessed as an unstageable pressure injury measuring 0.5 x 0.7 x 0.2 cm, with 100% slough. The left third toe was assessed as an unstageable pressure measuring 0.7 x 1.1 x 0.2 cm with 100% slough. On 1/29/2026, R109's right buttock wound was reclassified as right back by the Wound Nurse Practitioner (NP)-F and was then assessed as a device associated pressure injury, unstageable with 100% eschar. Surveyor notes R109 had a life vest (a wearable cardioverter defibrillator that continuously monitors heart rhythms and automatically delivers a shock if in life threatening (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	arrhythmia is detected) ordered. On 1/29/2026, a lab specimen was collected from R109's right heel wound. On 2/2/26, the results were reported as infected with methicillin resistant staphylococcus aureus, proteus mirabilis, and mixed skin flora. On 1/30/2026, R109 was admitted to the hospital due to no pedal pulses and diagnosed with a vascular occlusion. R109 returned to the facility on 2/12/2026. R109 returned with a physician order for doxycycline hyclate (antibiotic) 100 MG (milligrams) capsule. Take 1 capsule by mouth every 12 hours for wound infection for 5 days. On 2/18/2026, Wound NP-F ordered a 3 view Xray of left foot, toes and ankle to rule out osteomyelitis. On 2/19/2026, a lab specimen was collected from R109's toe wound (onset 1/26/2026). On 2/23/26, the results were reported as infected with enterococcus faecium and mixed skin flora. On 06/04/2026, at 7:44 AM, Surveyor asked Wound NP-F how R109 eventually developed osteomyelitis. Per Wound NP-F they were doing iodine to help with skin flora, but the wound progressed to the bone being exposed. Imaging was done and R109 had osteomyelitis. On 2/20/26, Wound NP-F assessed and changed R109's left fourth toe, left third toe, right second toe, right heel, and right back to being classified as vascular wounds. On 06/04/2026, at 7:44 AM, Surveyor interviewed Wound NP-F and asked why the pressure wounds were reclassified to vascular from pressure. Wound NP-F stated per communication with the collaborating physician, it was agreed the wounds should be classified as vascular given R109's history. On 2/23/2026, R109's progress note documents: Reported left toe wound culture results with sensitivities to Wound NP. New order received for Doxycycline for 14 days per culture results. NP also notified that right back wound culture remains pending at this time.&r

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents with pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 7 (R66, R109, R34, R10, R33, R5 and R8) of 13 residents reviewed for pressure injuries from a sample of 19. *R66 has a history of a healed stage 4 pressure injury to the sacrum and is at high risk for pressure injuries. R66's sacral pressure injury reopened on 1/17/25 and again on 6/10/25. On 11/21/25, R66's sacral pressure injury showed signs of infection and a wound culture was ordered. Results on 11/24/25 documented a staph infection. Wound Nurse Practitioner (NP)-F ordered an MRI to the sacrum to rule out osteomyelitis. The MRI was not completed until 2/25/26. After the MRI diagnosed osteomyelitis of the sacrum, R66 received intravenous (IV) antibiotics to treat the wound infection. R66 developed multiple other stage 2 and 3 pressure injuries between January and September 2025. Facility staff did not always update R66's care plan when a pressure injury developed or worsened. A comprehensive assessment was not always completed when a new or reopened pressure injury developed. At times, R66's pressure injuries were staged incorrectly. Facility staff did not always follow Wound NP-F's recommendations for treatment of R66's wounds. Surveyor observed care plan interventions not in place while on Survey. *R109 did not receive care to prevent the development of a stage 3 pressure injury to R109's coccyx. R109 also developed a device associated pressure injury to R109's right back that developed staph aureus and staph lugdunensis infections. *R34 developed 3 facility acquired, stage 3 pressure injuries. R34's care plan was not revised. R34's Left heel pressure injury became infected requiring intravenous antibiotics. Surveyor observed R34's care plan interventions not being implemented during the survey. *R10 developed 2 stage 3 pressure injuries in the facility. R10 did not have a comprehensive assessment for causative factors contributing to the onset of wounds. R10's care plan was not revised to prevent worsening or further development of pressure injuries. Surveyor observed R10's care plan interventions not being implemented during the survey. One of R10's pressure injuries became infected twice and required antibiotics twice. The facility's failure to provide prevention, care, and treatment to R66, R109, R34, and R10 created findings of immediate jeopardy for these resident examples. The finding of immediate jeopardy began on 11/21/25 when R66's sacral pressure injury became infected. Surveyor notified the Nursing Home Administrator (NHA)-A of the immediate jeopardy on 6/9/26 at 4:05 PM. The facility removed the immediacy on 6/16/26 when it implemented an action plan. The deficient practice continues at a scope and severity of G (actual harm/isolated) related to an additional example regarding R33. *R33 is at risk for developing pressure injuries. On 3/29/26, facility staff found a stage 3 pressure injury to the right buttocks that was not comprehensively assessed when identified. On 4/28/26, facility staff found a stage 2 pressure injury that was not comprehensively assessed when identified. Observations of care plan interventions were observed to not be in place throughout the onsite survey. The finding of a facility acquired stage 3 pressure injury created actual harm to R33. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	There are additional examples regarding R5 and R8 that are examples of noncompliance with a potential for harm. *R5 did not receive care to prevent the development of two new pressure injuries to R5's feet. *R8 returned from the hospital with three new wounds, two were pressure injuries. The wounds were not assessed until the next day. New interventions were not added to R8's care plan, and a nutrition assessment was not completed until four weeks after admission. Findings include: The facility policy dated 2/1/26 and titled, Pressure Injury Prevention and Management, documents, in part: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings should include type of wound, wound measurements., other wound characteristics (color, exudate, odor, pain, tissue type in wound bed), and treatment and interventions implemented. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate intervention. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.); Minimize exposure to moisture and keep skin clean.; Provide appropriate pressure-redistributing, support surfaces; Maintain or improve nutrition and hydration status, where feasible. Interventions will be documented in the care plan and communicated to all relevant staff. Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include: Changes in resident's degree of risk for developing a pressure injury. New onset or recurrent pressure injury development. Lack of progression towards healing. 1.) R66 was admitted to the facility on [DATE] with diagnosis that include Parkinson's disease), Quadriplegia, Chronic Kidney disease, Neuromuscular dysfunction of the bladder and Gastrostomy tube. R66's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents R66 is severely cognitively impaired. R66 is dependent on staff for all cares, mobility and transfers. R66 has a catheter and is always incontinent of bowel. R66 is at risk of developing pressure ulcers. R66 does not have a pressure ulcer/injury. R66's Pressure Injury Care Area Assessment (CAA) dated 6/17/24, documents, in part: [R66] has alteration in skin integrity [related to] pressure, immobility, history of pressure ulcers. [Body mass index (BMI)] 22.1. Braden score of 14 moderate risk of skin breakdown. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R66's Braden Scale assessment dated [DATE] documents that R66 is at high risk for developing pressure injuries. R66's Wound MD note dated 7/2/24 documents R66's stage 4 pressure injury to their sacrum has resolved. R66's skin integrity care plan initiated on 11/8/24 documents the following pertinent interventions: Alternating air mattress to bed. Apply bilateral Prevalon boots while in bed. Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Encourage good nutrition and hydration in order to promote healthier skin. Follow MD orders for treatment of wounds. Follow facility protocols for treatment of injury. Identify/document potential causative factors and eliminate/resolve where possible. Keep skin clean and dry. Use lotion on dry skin. Provide assistance with turning and repositioning [every] 2 hours. Provide brief change and peri cares after each incontinent episode. R66's MD order with a start date of 12/20/24 documents: Apply barrier cream to [bilateral] groins and [bilateral] buttocks daily and [as needed]. Every shift. R66's progress note dated 12/21/24 at 1:53 PM documents: Resident being [monitored] for excoriated bottom, zinc oxide cream applied per wound care nurse orders, repositioned [every 2 hours] and incontinence cares provided by assigned [Certified Nursing Assistant (CNA)] [every 2 hours]. R66's progress note dated 12/25/24 at 9:46 PM documents, in part: Resident being monitored for excoriated buttocks. [Treatment] applied as ordered. Repositioned throughout the shift per staff. R66's progress note dated 1/1/25 at 6:59 AM documents: Resident monitored for new excoriation to buttocks and peri area; barrier cream applied with incontinence cares. Surveyor noted multiple documentations of an excoriated buttocks starting on 12/21/24. R66's Advanced Practice Nurse Practitioner (APNP) note dated 1/3/25, documents, in part: . complaining of buttocks excoriation. has previous history of sacral pressure ulcers to the area. Relies upon staff for pressure reduction efforts and turning. Currently laying on back/buttocks. Unable to position/reposition self. Skin- redness and erythema buttocks area. No open areas noted.Stage 1 pressure ulcer coccyx, acute on chronic.Plan-Follow with wound. Strict pressure offloading and wound cares. Calazime paste twice daily. Aggressive peroneal care to avoid recurrence of pressure wounds. Surveyor noted that R66's APNP documented that R66 had a stage 1 pressure ulcer. R66's MD order with a start date of 1/3/25 documents:: Calmoseptine External Ointment 0.44-20.6 % (Menthol-Zinc Oxide) Apply to [bilateral] Buttocks and Groin topically every shift for dermatitis. Surveyor reviewed R66's medical record and noted that facility staff did not comprehensively assess R66's newly diagnosed stage 1 pressure injury on 1/3/25 and did not document an assessment weekly from 1/3/25 through 1/17/25. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surveyor reviewed R66's skin integrity care plan and noted that R66's care plan was not updated with an intervention to prevent worsening after R66 developed a new area of excoriation on 12/21/24 and the care plan was not updated after R66's APNP diagnosed a stage 1 pressure injury on 1/3/25. R66's progress note dated 1/17/25 at 3:22 PM, documents, in part: Writer summoned to [R66's] room per floor staff to assess [resident] buttocks for skin concern. [R66] noted with 3 new wounds: 1) Stage 3 to Sacrum- 1.0 x 1.0 x 0.1, 50% slough and 50% granulation to wound bed. scant serosanguinous drainage, no odor noted. peri wound inflamed but stable. 2) Stage 2 to Left Buttock- 1.0 x 1.0 x 0.1, 100% granulation, light serosanguinous drainage without odor. peri wound with inflammation. 3) Stage 2 to Right Buttock- 9.0 x 2.0 x 0.1, 100% granulation, light serosanguinous drainage without odor. peri wound is normal skin. NP made aware with [treatment] orders initiated. [Resident] will return to being seen weekly by wound MD and wounds will be treated and followed until all wounds are resolved. [Resident] is on a Low Air loss mattress and does wear [bilateral] heel boots at all times. Surveyor noted R66 had a healed stage 4 pressure injury to their sacrum. Surveyor noted facility staff incorrectly staged R66's sacrum pressure injury as a stage 3 to R66's sacrum. On 6/4/26 at 1:42 PM, Surveyor interviewed Wound NP-F. Surveyor asked if a previous stage 4 pressure injuries should be down staged to a stage 3. Wound NP-F stated that they do not typically down grade wounds. Surveyor reviewed R66's care plan and noted facility staff did not document that they reviewed or revised R66's care plan with an intervention after the sacrum pressure injury re-opened or after 2 new pressure injuries were found. R66's weekly wound assessment dated [DATE] documented that R66's Left buttock pressure injury had resolved. R66's Wound MD note dated 2/4/25 documents, in part: Stage 3 sacrum 2.4 x 1.9 x 0.2. 40% slough. 60% granulation. Stage 2 right buttock 3.5 x 2.2 x 0.1. Stage 3 left upper buttock 2.1 x 2.5 x 0.1. 80% granulation. 20% slough. Surveyor noted that the Wound MD incorrectly staged the sacrum pressure injury and noted that the sacrum pressure injury increased in size. Surveyor noted that R66's left buttock pressure injury re-opened and is now a stage 3 pressure injury. On 2/6/25, R66's care plan was updated with the following intervention: Encourage [R66] to be up for 1.5 hours for breakfast, and 1.5 hours at lunch, and 1.5 hours for dinner every day. Lay [R66] back down after 1.5 hours or as tolerated. R66's Wound MD note dated 2/11/25 documents Stage 2 pressure wound of the right buttock resolved. Stage 3 pressure wound of the left upper buttock resolved. R66's Wound MD note dated 2/25/25 documents Stage 3 pressure wound sacrum resolved. Surveyor noted by 2/25/25, R66's 3 pressure injuries had been resolved. R66's MD order with a start date of 2/25/25 documents: Apply barrier cream to [bilateral] buttocks (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and Sacrum [every] shift and [as needed] as preventative. R66's progress note dated 4/7/25 at 7:25 PM documents, in part: . Writer noting a skin tear on [right] lower buttock and pink bottom. Writer cleaned with [normal saline], applied Medi honey, and covered with dry bordered gauze. Barrier cream applied to coccyx. Surveyor noted that facility staff documented a new open area to R66's lower buttock. Surveyor reviewed R66's medical record and noted facility staff did not document a comprehensive assessment with measurements or wound characteristics when the wound was found on 4/7/25. R66's progress note dated 4/8/25 at 8:30 AM, documents: Wound team followed up [related to] reports of new open area to right buttock. [Resident] is noted with open area to right ischium/right lower buttock. Wound appears to be pressure in nature. Wound bed noted with slough and granulation. Inflammation to peri wound. Light serosanguinous drainage. [Resident] will be seen by Wound MD today. R66's Wound MD note dated 4/8/25 documents, in part: Stage 3 pressure wound of the right ischium. 2.6 x 3.1 x 0.1. 40% slough. 60% granulation. Surveyor reviewed R66's medical record and noted that facility staff did not document the possible cause of R66's new stage 3 pressure injury. Surveyor reviewed R66's comprehensive care plan and noted that facility staff did not document that they reviewed or revised R66's care plan with an intervention after R66 developed a new stage 3 pressure injury. On 6/3/26 at 11:48 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C. Surveyor asked why ADON-C thinks R66 developed this new pressure injury on 4/7/25. ADON-C stated that R66 moves a lot in bed due to R66's Parkinson's disease. This is R66's baseline. This movement causes friction. ADON-C stated that R66 is on medication for the constant movement. ADON-C stated that R66 will be repositioned and then will wiggle out of the position. Surveyor asked if the friction is what caused R66's right ischium pressure injury. ADON-C stated that they started working at the facility in May of 2025 and ADON-C did not have a good answer for that. R66's Wound MD note dated 4/29/25 documents, in part: Stage 3 pressure wound of the right ischium resolved. Surveyor noted R66's stage 3 pressure injury was resolved and R66 has no pressure injuries at this time. On 5/13/25, R66 experienced a change in condition. R66 was sent to the hospital on 5/13/25. R66 was hospitalized until 5/22/25 due to bladder and renal stones that caused Urosepsis. R66 was readmitted to the facility on [DATE]. R66's progress note dated 5/22/25 at 10:35 PM documents, in part: Arrived via Ambulance. Resident lying comfortably in bed with [bilateral] Prevalon boots on. Writer completed a head-to-toe assessment. Foley [discontinued] during hospital stay. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surveyor noted that R66's foley catheter was removed while in the hospital. Surveyor noted that the increase in moisture from bladder incontinence would put R66 at great risk skin breakdown. R66 comprehensive care plan documents the following interventions initiated on 5/22/25: Clean peri-area with each incontinent episode. R66's admission skin assessment dated [DATE] did not document any areas of pressure on R66's skin. R66's Wound MD note dated 6/10/25 documents, in part: Stage 3 pressure wound sacrum 1.7 x 1.5 x 0.2. 50% slough. 50% granulation. Stage 3 pressure wound of the left buttock. 1 x 0.8 x 0.1. 100% granulation. Stage 3 pressure wound of the right buttock. 0.8 x 0.8 x 0.1. 100% granulation. Surveyor noted that 2 weeks after readmission to the facility, facility staff found 3 reopened pressure wounds. Surveyor noted R66's sacrum was incorrectly staged as a stage 3 pressure injury when it had previously been staged as a stage 4. Surveyor reviewed R66's medical record and noted that facility staff did not document the possible cause of R66's 3 pressure injuries that had reopened. Surveyor reviewed R66's comprehensive care plan and noted that facility did not document that they reviewed or revised R66's care plan after R66's 3 pressure injuries had reopened. On 6/4/26 at 1:08 PM, Surveyor interviewed ADON-C. Surveyor asked why R66's sacrum pressure and 2 other pressure injuries reopened on 6/10/25. ADON-C stated that R66 had an overall decline in health and did require multiple hospitalizations. ADON-C stated that R66's movements and friction also played a part because when R66 is sick, R66 will have more movements in bed. Surveyor reviewed R66's care plan and did not locate a new care plan intervention to address R66's increased movements and friction. R66's Wound MD note dated 6/17/25 documents, in part: Stage 4 pressure wound sacrum. 1.7 x 1.2 x 1.3. 50% slough. 50% granulation. Stage 3 pressure wound of the left buttock resolved . Stage 3 pressure wound of the right buttock 0.6 x 0.8 x 0.1. 100% granulation. Surveyor noted that R66's left buttock pressure injury was resolved. Surveyor noted that R66's sacrum pressure injury had increased in depth. In one week, the depth increased from 0.2 to 1.3. Surveyor noted that R66's sacrum pressure was now staged correctly as a stage 4 pressure injury. R66's care plan was updated with the following intervention on 6/18/25: Use draw sheet for all repositioning. R66 experienced a change of condition due to continued urological issues and was hospitalized from [DATE] through 7/2/25. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R66's Weekly wound assessment dated [DATE] documents, in part: Right heel pressure Suspected Deep Tissue Injury (DTI) Present on admission. 2.3 x 2.9. Purple/maroon in color. Left buttock stage 3 pressure injury 11.5 x 7.5 x 0.1. 100% granulation. Right buttock stage 3 pressure injury 12.3 x 8.8 x 0.1. 100% granulation. Sacrum stage 4 pressure injury. 2.3 x 2.5 x 2.3. 50% granulation, 50% slough. Surveyor noted that R66 developed a Right heel DTI while hospitalized . Surveyor noted R66's left buttock reopened while hospitalized . Surveyor reviewed R66's care plan and noted that facility staff did not document that they reviewed or revised R66's care plan when R66 returned from the hospital with a new heel pressure injury and a reopened left buttock pressure injury. R66's Weekly Wound assessment dated [DATE] documents: R66's Right heel DTI and Stage 3 left buttock pressure injury had resolved. R66's Wound MD note dated 7/8/25 documents, in part: Stage 4 pressure sacrum 5.5 x 7.6 x 1.9. 50% slough. 50% granulation. Stage 3 right buttock 3.2 x 1 x 0.1. 100% granulation. Surveyor noted R66's Stage 4 sacrum injury width more than doubled in size. Surveyor reviewed R66's care plan and noted that facility staff did not document that they reviewed or revised R66's care plan when R66's stage 4 pressure injury worsened and doubled in size. R66's Wound MD note dated 7/15/25 document, in part: 6 x 9 x 1.9. 50% slough. 50% granulation. Stage 3 right buttock 4 x 2 x 0.1. Stage 3 pressure wound of the left buttock 10 x 3 x 0.1. 100% granulation. Re-opening of previously healed wound. Surveyor noted that R66's sacrum and right buttock pressure injury grew and R66's left buttock pressure injury reopened. Surveyor reviewed R66's care plan and noted that facility staff did not document that they reviewed or revised the care plan when R66 pressure injuries grew, and the left buttock reopened. Surveyor reviewed R66's skin integrity care plan and noted R66's care plan intervention of Apply bilateral Prevalon boots while in bed was canceled and no longer on the care plan starting on 7/21/25. On 6/4/26 at 1:08 PM, Surveyor interviewed ADON-C about the Prevalon boot intervention. ADON-C indicated that the electronic health system had a glitch, and the intervention was canceled by the system. ADON-C confirmed that the heel boot intervention was not on R66's care plan starting on 7/21/25. R66 experienced a change of condition related to continued urological issues. R66 was hospitalized from [DATE] through 7/28/25 and again on 8/6/25 through 8/11/25. R66's weekly wound assessment dated [DATE] documents, in part: Stage 4 sacrum 2.9 x 2 x 2. 60% granulation. 40% slough . Right buttock pressure stage 3. 1 x 0.6 x 0.1. 100% granulation. Left buttock pressure injury resolved. R66's Wound MD note dated 8/19/25 documents, in part: Stage 4 pressure wound sacrum 2.9 x 2 x 2. (continued on next page)

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Autumn Lake Healthcare at Greenfield	5790 S 27th St Milwaukee, WI 53221

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	40% slough. 60% granulation. Stage 3 pressure wound of the right buttock resolved. Surveyor noted as of 8/19/25 R66 had one stage 4 pressure wound to the sacrum and all other pressure injuries had resolved. Surveyor reviewed R66's care plan and noted that facility staff had not entered an intervention for off-loading of R66's heels after it had been cancelled on 7/21/25. R66's Wound MD note dated 9/30/25 documents, in part: Stage 4 pressure wound sacrum 2.9 x 1.6 x 1. 100% granulation. Unstageable DTI of the right heel. 5.2 x 3.8. Recommendation: . Float heels in bed. Surveyor noted R66 developed a new DTI to the right heel. Surveyor reviewed R66's care plan and noted that facility staff did not document that they reviewed or revised the care plan when R66 developed a new right heel DTI. Surveyor noted that the Wound MD recommended heel offloading and facility staff did not add an intervention to prevent the worsening of R66's new wound. R66's Wound NP-F note dated 10/17/25, documents, in part: Stage 4 sacrum 3 x 3.1 x 0.6. 25% bone. 75% granulation. Stage 3 pressure ulcer right heel. 2 x 2.5 x 0.1. 100% granulation. Seen today for sacral pressure ulcer stage 4, and DTI now stage 3 pressure ulcer. Surveyor noted R66's sacrum pressure injury grew, and bone is seen in the wound. Surveyor noted R66's heel DTI had opened and is now a stage 3 pressure injury. Surveyor reviewed R66's care plan and noted that facility staff did not document that they reviewed or revised the care plan when bone was seen in R66's sacrum wound and when the heel DTI progressed to a stage 3 pressure injury. R66's Wound NP-F note dated 10/31/25 documents, in part: Stage 4 pressure ulcer Sacrum 2.5 x 2.2 x 0.5. 50% slough. 50% granulation. Stage 3 pressure ulcer right heel 0.5 x 0.5 x 0.1. 100% dermis. Medical Device related pressure injury. Light serous exudate. 100% dermis. R66's Weekly wound assessment dated [DATE] documents, in part: Right buttock stage 2 pressure. 100% dermis. Medical device related. Surveyor noted that Wound NP-F and Facility staff documented a new medical device-related pressure injury to R66's right buttock. Facility staff documented this as a stage 2 pressure injury. Surveyor noted that no measurements were completed of the new stage 2 pressure injury. On 6/4/26 at 1:42 PM, Surveyor interviewed Wound NP-F and Wound Nurse-E. Surveyor asked what medical device caused R66's new stage 2 pressure injury on 10/31/25. Wound NP-F stated that R66's Foley catheter got stuck under R66's buttocks. Wound NP-F stated that R66's skin breaks down so fast but indicated that they had caught it right away. Surveyor asked if Wound NP-F would measure a medical device-related stage 2 pressure injury. Wound NP-F stated that they typically would measure that and did not have an answer why it was not measured. Surveyor reviewed R66's care plan and noted that facility staff did not document that they reviewed or revised the care plan to include an intervention to prevent recurrence when R66's catheter caused (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a pressure injury. R66's Wound NP-F note dated 11/7/25 documents, in part: . [Medical device related pressure injury] to right buttock has resolved. [Pressure ulcer] to sacrum and right heel are improving. Treatment plan updated. No new concerns. Stage 4 pressure ulcer sacrum 2 x 2.2 x 0.5. 10% slough. 90% granulation. Heavy serous exudate. Macerated edges. Treatment recommendation: Collagen to wound bed, layer with calcium alginate, fill remaining depth with dry gauze. Cover with [border foam]. Change daily and [as needed]. Surveyor noted R66 had an increase in heavy drainage to the wound and noted that the treatment plan for R66's sacrum changed to Collagen, then calcium alginate. R66's MD order with a start date of 11/7/25 documents, in part: Wound Care Sacrum: Cleanse with [Normal Saline]. Pat Dry. Apply collagen to wound bed then layer with calcium alginate with silver. Fill remaining void with dry gauze and cover with bordered foam. Every, day shift for Wound Management. Surveyor noted that facility staff put Collagen, then calcium alginate WITH silver in the wound treatment order. Surveyor noted that facility staff added silver to the treatment of R66's wound and this is not documented as part of the recommendation from Wound NP-F. R66's Wound NP-F note dated 11/14/25 documents, in part: Pressure ulcer Sacrum 2 x 2.5 x 0.5. Moderate Serosanguinous exudate. 100% granulation. Macerated edges. Treatment recommendations: Collagen to wound bed, layer with calcium alginate, fill remaining depth with dry gauze. Cover with [border foam]. Change daily and [as needed]. Pressure ulcer heel right 0.5 x 0.5 x 0.1. 100% dermis. Wounds are stable. Surveyor noted Wound NP-F documented the same treatment recommendations as the week prior. Surveyor reviewed R66's Treatment Administration Record (TAR) and noted that facility staff continue to treat R66's sacrum wound with calcium alginate WITH silver which was not part of Wound NP-F's recommendation. R66's Wound NP-F note dated 11/21/25 documents, in part: Pressure ulcer Sacrum 2.5 x 2.5 x 0.5. Heavy purulent exudate. 80% granulation. 20% slough. Treatment recommendations: Sacrum- Collagen to wound bed, followed by Hydrofera blue. Cover with [border foam]. Change daily and [as needed]. Add wound culture to [rule out] superficial infection. Pressure ulcer to sacrum has deteriorated. Pressure ulcer to right heel is improving. Treatment plan updated. Surveyor noted that R66 sacrum wound was worsening. A wound culture and a new treatment was ordered. R66's MD order with a start date of 11/21/25 documents: Wound Care Sacrum: Cleanse with [Normal Saline]. Pat Dry. Apply Hydrofera Blue to wound bed. Cover with bordered foam. Every, day shift for Wound Management Surveyor noted that Wound NP-F recommended Collagen to wound bed followed by Hydrofera blue. Facility staff entered the MD order and did not include Collagen in the treatment order. R66 went from 11/21/25 to 11/24/25 treating R66's sacrum wound without the recommended (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	collagen. On 6/4/26 at 1:42 PM, Surveyor interviewed Wound Nurse-E and Wound NP-F. Surveyor asked if the treatment listed in Wound NP-F's note is what the facility should follow. Wound NP-F indicated yes. Surveyor asked if Wound NP-F was aware that R66's wound was not treated as Wound NP-F ordered. Wound NP-F stated that their notes can take 3 days to get to the facility. Wound NP-F stated that facility started with Hydrofera blue and added collagen after seeing Wound NP-F note. Wound Nurse-E stated that Hydrofera blue is what was done at the bedside. Wound Nurse-E entered that as the order after completing wound rounds with Wound NP-F. Surveyor asked if Wound NP-F wanted collagen as part of the treatment. Wound NP-F indicated that they wanted Collagen. R66's MD orders dated 11/24/25 documents: Wound Care Sacrum: Cleanse with [Normal Saline]. Pat Dry. Apply collagen and Hydrofera Blue to wound bed. Cover with bordered foam. Every, day shift for Wound Management Surveyor noted facility staff updated R66's sacrum treatment orders to reflect Wound NP-F's recommendations. R66's Wound culture results dated 11/24/25 document, in part: Staphylococcus Aureus, Enterococcus faecalis. R66's progress note dated 11/24/25 at 5:30 PM, documents: Notified Wound NP of culture results and sensitivities. NP has ordered that a midline be placed. NP also ordered cefepime IV. NP has ordered an x-ray of the sacrum. R66's X-ray results dated 11/25/25 document, in part: Impression: . No obvious evidence of osteomyelitis is seen. MRI of sacral region is suggested clinically indicated. R66 MD order dated 11/25/25 documents: MRI of Sacrum dx follow-up from x-ray results, Osteomyelitis rule out, stalled wound healing and ESR (lab test that will indicate the presence of inflammation in the body) elevation. Surveyor noted that Wound NP-F ordered a midline, IV antibiotics and a MRI after R66's wound culture resulted as positive. Surveyor reviewed R66's progress notes and noted R66 had symptoms of a Urinary Tract infection (UTI) while the sacrum wound was being worked up for infection. R66's MD-I note dated 11/25/25 documents, in part: I was called to evaluate [R66] for possible. wound infection. [R66] seems to be at [their] baseline mental status: No fevers, clinically does not show any signs infection. Urine culture showing Proteus, Staph and Vanco sensitive enterococcus lesion, likely contaminated. Proteus is sensitive to multiple antibiotics including Amoxicillin. Wound cultures also reviewed, given lack of systemic signs of infection, may not need IV antibiotics as suggested previously by the provider, may [discontinue] PICC line placement transfer to hospital and IV cefepime. Augmentin for 10 days to cover for UTI as well as wound infection. R66's progress note dated 11/25/25 at 1 PM documents, in part: Notified by floor nurse that [MD-I] was here to see [R66] and disagrees with wound provider's recommendation for IV antibiotics to manage infection. [MD-I] recommends switching from Keflex to Augmentin to manage both wound (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	infection and UTI. Notified wound NP. Wound NP chooses to defer to primary in Augmentin choice, pending wound condition at next follow-up by NP or if the resident's status deteriorates, antibiotics will be escalated to IV. Notified NP of sacrum x-ray results. NP recommends the resident get an MRI of sacrum. On 6/4/26 at 1:42 PM, Surveyor interviewed Wound NP-F. Surveyor asked about the wound culture completed on 11/21/25. Wound NP-F stated that R66's wound was deteriorating and stated that if the things that they are doing are not working, Wound NP-F would ask if t

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure each resident received adequate supervision and assistance devices to prevent accidents for 4 (R11, R33, R7 and R108) of 7 sampled residents reviewed for accidents. *On 3/27/26, at 6:15 AM, R11 sustained an unwitnessed fall that resulted in a right hip fracture requiring surgery. R11 was found lying on their fall mat next to their bed by facility staff. R11 was assessed as having difficulty with performing Range of Motion (ROM) with their right leg and increased pain. Facility staff used a mechanical lift to get R11 back into bed even though R11 had changes with their right leg ROM and increased pain. The facility did not complete a thorough fall investigations. *On 4/4/25, at 10:45 AM, R33 sustained a fall during cares. Certified Nursing Assistant (CNA)-LL transferred R33 independently with a Hoyer lift resulting in R33 falling and sustaining a head abrasion. R33 was assessed as requiring a hoyer lift with total assistance with 2 staff members for transferring. On 11/4/25, at 9:45 PM, R33 sustained an unwitnessed fall from bed. R33 was getting cleaned up at 8:30 PM with staff documenting R33 kept trying to roll towards the window and would get upset when staff tried to reposition R33. Staff left the room with R33 moving around restlessly in their bed. *R7 had a fall on 4/13/2026 that was not investigated thoroughly. R7 had a smoking assessment done on 5/12/2026. The assessment and the conclusion were contradictory. *On 11/10/25, at 3:30 PM, R108 was documented as having an unwitnessed fall and was found by staff on the floor. A Registered Nurse (RN) assessment was not completed; the facility did not complete a thorough fall investigation and the new intervention implemented was not consistent with the factors surrounding R108's fall. Findings include: The facility's policy titled Fall Prevention Program, dated 4/15/26, documents the following: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. When any resident experiences a fall, the facility will: Assess the resident. Complete a post fall assessment. Complete an incident report. Notify the Physician and family. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review the resident's care plan and update as indicated. Document all assessments and actions. Obtain witness statements in the case of injury. 1.) R11 was admitted to the facility on [DATE]. R11's diagnoses include right femur fracture, osteoarthritis, cataracts, left humerus fracture, anxiety, right tibia fracture and mild cognitive impairment. R11 was admitted to the facility on [DATE], due to a mechanical fall at home resulting in a right tibia fracture. R11 was admitted with a right lower extremity (RLE) immobilizer with orders to not bear weight on R11's right leg. Surveyor reviewed R11's admission Baseline Care Plan dated 3/11/26, that is documented on paper, which documents the following: (R11) is at risk for falls related to history of fall with fracture, cognitive impairment and NWB RLE. Interventions include: Complete a fall risk evaluation on admission. Place call light within easy reach. Cue for safety awareness. Assist with toileting and transfers. Anticipate needs. Keep environment clutter free/safe. (R11) has potential for behavioral problems related to cognitive impairment. Interventions include: Administer medications as ordered monitoring for side effects and effectiveness. Intervene as needed to protect the rights and safety if others; approach in a calm manner; divert attention; remove from situation/provide decreased stimulation. (R11) has impaired ADLs/mobility related to tibial plateau fracture and NWB RLE. Interventions include: NWB RLE. Maximum assistance is needed with bed mobility, transfers, bathing, ambulation, toileting, eating, dressing and hygiene until evaluation is completed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(R11) uses a walker. (R11) has a knee immobilizer and wears glasses. R11's care plan dated 3/11/26, documents the following: (R11) has an ADL self-care performance deficit and is at risk for falls related to activity intolerance, limited mobility, unaware of safety needs, Weight Bearing As Tolerated (WBAT) on Right Lower Extremity (RLE) and cognitive impairment. Date initiated 3/11/26, revised on 5/1/26. Interventions include: Anticipate and meet (R11's) needs. Date initiated 3/11/26. Be sure (R11's) call light is within reach and encourage (R11) to use it for assistance as needed. Date initiated 3/11/26. Ensure (R11) is wearing appropriate footwear. Date initiated 3/11/26. Bed mobility – Reposition every 2 hours as resident allows. Date initiated 3/11/26, revised on 3/13/26. Toilet use – Offer toileting assistance every 2 hours and as needed. Provide set-up assistance for toileting hygiene. Date initiated 3/11/26, revised on 3/13/26. Transfer – Discontinue Sara Steady lift. (R11) requires a gait belt, 2 wheeled walker and caregiver assist/stand by assist for all functional transfers in the room. WBAT on RLE. Must have on off-loading shoes when up and may require focus on heel weight bearing on Left Lower Extremity (LLE). Date initiated 3/11/26, revised 4/29/26. Review of R11's medical record indicated R11 sustained unwitnessed falls (UWF) on the following dates/times post admission: 3/11/26 at 11:05 PM UWF with no injury 3/19/26 at 9:30 PM UWF with no injury 3/24/26 at 7:25 AM UWF with no injury 3/27/26 at 7:25 AM UWF with hip fracture requiring surgical intervention (hemiarthroplasty) 4/9/26 at 6:15 PM UWF with no injury 4/17/26 at 9:39 AM UWF with no injury 4/18/26 at 7:05 PM UWF with no injury 5/28/26 at 5:03 AM UWF with no injury (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	6/1/26 at 5:00 AM UWF with no injury Surveyor reviewed R11's fall investigation for R11's unwitnessed fall on 3/11/26, at 11:05 PM, which documents the following: R11 was documented as being found crawling on the floor in their room calling out for help. R11 stated they put on the call light, and nobody answered R11's call light. R11 then went on to the floor and crawled across the room. R11 was assessed as having no change in pain, negative neurological exam and alert and oriented. R11 was transferred to a wheelchair and brought out to the nurse's station as the immediate safety intervention. R11's care plan was updated on 3/12/26 indicating - Sleep study, encourage to be in common areas when awake. Surveyor notes R11's fall investigation did not document an Registered Nurse (RN) assessment, when R11 was last checked or toileted, there was no staff statement to clarify if the call light was on or not as R11 stated and there was no call light audit to try to determine how long R11's call light was activated. There wasn't a comprehensive root cause analysis. R11's admission Minimum Data Set (MDS) completed on 3/16/26, documents R11 has difficulty focusing attention that fluctuates, verbal behaviors that occur 1-3 days a week and behaviors not directed towards others that occur 1-3 days a week. R11's behavioral symptoms are assessed as putting R11 at significant risk for physical illness and/or injury. R11's lower extremities have range of motion impairment to one side. R11 uses a walker and wheelchair. R11 requires supervision when rolling left to right, partial/moderate assistance with toileting hygiene, sit to lying position, lying to sitting position, sitting to standing, and chair/bed transfers. R11 requires substantial/maximal assistance with showering self and putting on footwear. R11 is dependent on staff for toileting transfers. R11 is frequently incontinent with bowel and bladder and was documented as having a fall with a fracture in the last 6 months prior to admission/entry. R11 was documented as having a Brief Interview for Mental Status (BIMS) score of 7, indicating R11 has severe cognitive impairment. R11's Care Area Assessment (CAA) documents the following: Cognitive CAA – (R11) was admitted for a short-term stay. (R11) has an Activated Power of Attorney (APOA) in place. (R11) scores indicate severe impairment on the BIMS with both orientation and recall deficits. (R11) is diagnosed with mild cognitive impairment and anxiety, and a care plan will be created. Functional Abilities CAA – was triggered related to assistance needed with Activities of Daily Living (ADL) tasks. (R11) was admitted status post (s/p) hospitalization following a fall at home with a fracture and multiple other diagnoses with a decline in functional ability. Staff assist (R11) with ADL tasks as necessary and encourage participation in rehab to reach their maximum level of function. Urinary Incontinence CAA – was triggered related to assistance needed with toileting and incontinence. Staff assist (R11) with toileting and incontinence cares as necessary, keeping (R11) clean and dry. (R11's) prompted/assisted toileting plan is in place. Refer to ADL functional CAA/care (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	plan. Falls CAA – was triggered related to a fall prior to (R11's) admission as well as post admission. (R11) is at risk for further falls secondary to unsteady balance and use of antianxiety medications. Staff anticipate (R11's) needs and assist (R11) as necessary. Medications are given as ordered monitoring for side effects and effectiveness. Surveyor reviewed R11's fall investigation for R11's unwitnessed fall on 3/19/26, at 9:30 PM, which documented the following: R11 was noted to be sitting on the floor in R11's room on the left side of the bed when the Certified Nursing Assistant (CNA) answered R11's call light. R11 was noted to have gripper socks on and stated they were going to the bathroom and could not wait for assistance. The root cause for R11's fall was documented as R11 self-transferring trying to go to the bathroom. The immediate safety intervention was documented as, offer R11 to be toileted before going to bed. R11's care plan was updated on 3/20/26 indicating Staff to offer toileting before going to bed. Surveyor noted R11's fall investigation did not document if an RN assessment was completed, staff statements, when R11 was last checked or toileted and whether R11 was continent or not. There wasn't a review to try to determine how long R11's call light was activated before R11 self-transferred and staff responded to the call light. Surveyor reviewed R11's fall investigation for R11's unwitnessed fall on 3/24/26, at 7:25 AM, which documented the following: R11 was overheard calling out and noted to be sitting on the floor in front of R11's wheelchair with legs extended out next to R11's bed. R11 stated they wanted to go to the bathroom and get dressed. Range of Motion (ROM) and neurological checks were noted to be at baseline. R11 was assisted by 2 staff members back to their wheelchair and assisted with toileting. R11 was noted to be last seen at 7:00 AM in bed. The root cause of the fall was documented as R11 self-transferred to the toilet. R11's care plan was updated on 3/24/26 with the intervention: Upon getting (R11) up for the day, complete all ADLs including toileting and dressing. Surveyor noted R11's fall investigation did not document when R11 was last toileted and if an RN completed an assessment. R11's care plan was updated on 3/25/26, documenting (R11) has mixed bladder incontinence. Date initiated 3/25/26. Interventions included: Ensure (R11) has an unobstructed path to the bathroom. Date initiated 3/25/26. Surveyor reviewed R11's fall investigation for R11's unwitnessed fall on 3/27/26, at 6:15 AM, which documented the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R11 was documented as being found lying flat on the floor next to their bed by the phlebotomist. R11 stated they wanted to get up, get dressed and use the bathroom, and fell. R11 was noted to have normal LLE (left lower extremity) ROM and neurological check. R11 was documented as having difficulty attempting to perform RLE (right lower extremity) ROM. R11 was documented as being hoyer lifted back to bed and documented as having increased pain rated as 7 out of 10. Staff contacted the on-call provider services and R11 was sent out to the emergency room (ER) for evaluation. Surveyor noted R11's fall investigation did not document when R11 was last observed by staff and offered to be toileted by staff. The investigation did not include a review to determine if care planned interventions were implemented or not. The investigation to not review whether R11's call light was within reach and/or activated to complete a comprehensive root cause analysis. R11 was documented as returning back to the facility on 3/31/26. R11's hospital records dated 3/31/26, documented R11 having the following imaging results: A displaced right femoral neck fracture requiring a right hip hemiarthroplasty performed on 3/28/26 and a large right knee effusion with possible hemarthrosis. R11's care plan was updated on 4/1/26 to include: Offer toileting before going to bed. On 6/8/26, at 9:24 AM, Surveyor left a message for Registered Nurse (RN)-MM who was present during R11's UWF with injury on 3/27/26. RN-MM did not return Surveyor's call. On 6/9/26, at 9:43 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-JJ about R11's falls. LPN-JJ stated staff are to perform an assessment on residents who experience a fall. LPN-JJ stated if a resident has a change with ROM and/or pain, staff are to contact the provider before trying to move the resident. LPN-JJ stated staff have the ability to video chat with the provider if a resident experiences a fall after hours. The provider will then provide direction/orders to contact Emergency Medical Services (EMS) or move the resident. LPN-JJ stated RN-MM was the night shift nurse for R11 on 3/27/26. LPN-JJ stated she was coming on shift to take over care for R11 when LPN-JJ was notified that R11 had a fall and RN-MM was working on getting R11 sent out for evaluation. LPN-JJ stated she does not recall seeing R11 prior to them being sent out. Surveyor asked LPN-JJ if she recalls if staff hoyer lifted R11 back to bed. LPN-JJ reviewed R11's EMR and stated it looks like they hoyer lifted R11 back to bed. LPN-JJ then stated she does not recall seeing R11 and this happened before LPN-JJ came on shift. R11's care plan was updated on 4/6/26 to include a new intervention of when (R11) is calling out, respond to (R11's) room and meet needs. Remind (R11) to use the call light. Provide positive reinforcement when using the call light appropriately. R11's care plan was further updated on 4/6/26 documenting, (R11) has a behavior problem related to anxiety, Obsessive Compulsive Disorder (OCD), Normal Pressure Hydrocephalus (NHP), mild cognitive impairment and Activated Power of Attorney (APOA) in place. (R11) yells out and/or calls out from room, verbal aggression with staff/family and (R11) will self-transfer, placing (R11) at risk for falling with an injury. Date initiated 4/6/26. Interventions include: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	When (R11) is calling out, respond to (R11's) room and meet needs and remind (R11) to use the call light. Provide positive reinforcement when using the call light appropriately. Date initiated 4/6/26. Surveyor reviewed R11's fall investigation for R11's unwitnessed fall on 4/9/26, at 6:09 PM, which documented the following: R11 was documented as found scooting across the floor by facility staff. R11 stated they were trying to scoot to the wheelchair. R11 was documented as having stable vital signs and assessment. R11's care plan was updated on 4/10/26, to include a new intervention to ask psychiatry to see (R11) earlier than 6 – 8 weeks. Surveyor noted R11's fall investigation does not document a comprehensive root cause, when R11 was last seen and toileted, staff statements, if R11's call light was within reach and/or activated and if fall interventions were in place. Surveyor reviewed R11's fall investigation for R11's unwitnessed fall on 4/17/26, at 7:30 AM, which documented the following: R11 was documented as being on the floor, on knees crawling to the door. Skin assessment and vital signs were completed and R11 was unable to relay to staff why they were on the floor. An RN assessment was performed and R11 was transferred back to the wheelchair. R11's care plan was updated on 4/20/26 with the intervention Re-educate (R11) to call for help and reeducate staff to get (R11) up out of bed if R11 is awake. Place a sign reminder to call for help using the call light. Surveyor noted R11's fall investigation does not document a comprehensive root cause, when R11 was last seen or toileted, staff statements, if R11's call light was activated or in reach, and if fall interventions were in place at the time of R11's fall. On 6/2/26, at 8:08 AM, Surveyor interviewed R11 in their room. R11 was sitting in their wheelchair with a cushion, dressed in personal clothes with laced shoes on. R11 stated they slept well and denied any concerns. Surveyor observed R11's room had a low bed in the lowest position with bilateral floor mats on the floor on each side of the bed. R11 is noted to independently, self-propel in wheelchair. Surveyor noted R11's care plan intervention dated 4/20/26, indicated R11 is to have a sign placed in R11's room reminding R11 to call for help by using the call light. Surveyor noted there are no signs in R11's room with reminders for R11 to use the call light for help. On 6/9/26, at 8:07 AM, Surveyor observed R11's room and noted R11's bed was in the lowest position, with a bolstered mattress, bilateral fall mats against the bed on the floor. Surveyor noted there are no signs in R11's room reminding them of safety interventions. R11 was observed self-propelling in the common television. R11's care plan was updated on 5/23/26to indicate- Distract (R11) from wandering by offering pleasant diversions, structured activities, food, conversation, television or book. (R11) prefers conversations and Television, including I love [NAME]. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R11's care plan was updated on 5/27/26to indicate Move (R11) to room closer to nurses station. Surveyor reviewed R11's fall investigation for R11's unwitnessed fall on 5/28/26, at 3:35 AM, which documented the following: R11 was documented crawling on the floor by facility staff. R11 stated they crawled out of bed onto the floor mat and needed to get up now. R11 was last checked and asked to be toileted at 2:30 AM. An assessment was performed including neurological check, vital signs and skin check. The on-call provider was contacted and provided new orders for R11 was to follow up with their Primary Care Provider (PCP) later that day (5/28/26). R11 was assisted into the wheelchair and brought to the nursing station to talk with staff. Fall interventions were documented being in place at the time of R11's fall. Root cause was documented as R11 recently had an environment change from subacute to long-term care, which can take some adjustment to the unit. R11's care plan was updated on 5/28/26 to include a fall mat on floor beside the bed. Repeat a 3-day sleep study due to a change in environment. Do not wake up (R11) if sleeping for vital signs. Surveyor notes R11's fall investigation does not document if R11's call light was activated. Surveyor noted R11 did not follow up with R11's PCP per new order from the on-call provider. Surveyor reviewed R11's fall investigation for R11's unwitnessed fall on 6/1/26, at 5:00 AM, which documented the following: R11 was documented being found down on the fall mat next to the bed. Staff statement indicated R11's call light was noted to be activated at the time of the fall. Assessments included skin check, neurological check, vital signs, and ROM. R11 was continent of urine at the time of the fall and R11 stated they were trying to get up. The root cause was documented as the following: falls are going to be unavoidable for R11 due to cognitive impairment. R11 likes to lay on the floor mat and crawl around. The facility will try to keep R11 safe and free from injury. R11 loves to watch I Love [NAME], but I Love [NAME] is not on 24/7. R11's care plan was updated on 6/1/26 to include a Bolster mattress to define bed border. Surveyor noted R11's fall investigation does not document when R11 was last seen and toileted. On 6/4/26, at 8:04 AM, Surveyor interviewed Medication Technician (Med-Tech)-KK who stated R11 was previously on the subacute unit and recently moved to the Long-Term Care (LTC) unit. R11 is very anxious and needs things right away. R11 is known for crawling around on the floor in their room. Med-Tech-KK stated R11's call light would be activated and 10 second later, R11 would be crawling around the room. Med-Tech-KK stated R11 is more anxious on the LTC unit due to having a friend that resides on the subacute unit. Surveyor asked Med-Tech-KK how the facility prevents falls with R11. Med-Tech-KK stated they placed a regular mattress on the side of R11's bed facing the door that faces the center of the room and a fall mat in between R11's bed and window. Facility staff will often take R11 over to the subacute unit for R11 to eat with their friend. Med-Tech-KK stated R11 was noted to be looking for their daughter the other day and Med-Tech-KK took R11 outside as a distraction to look for R11's daughter. Med-Tech-KK stated they do lots of reminders for R11. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/4/26, at 12:51 PM, Surveyor asked Nursing Home Administrator (NHA)-A if there were any additional documents to go with R11's fall investigations that also included a root cause analysis of each fall. NHA-A stated the root cause analysis is at the bottom of the fall investigation sheet. On 6/8/26, at 9:51 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who stated if a resident falls, nursing staff will assess the resident, look for obvious things wrong, such as a leg that looks different or an injury. ADON-C stated the resident will be sent out for evaluation automatically if they hit their head. Staff will assess pain, notify the Medical Director (MD)-H, complete an incident report and document a progress note. ADON-C stated each tab in the fall incident report prompts the nurse on what to complete and what to do. Surveyor asked ADON-C what facility staff do if changes are noted with ROM or increased pain. ADON-C stated staff will notify the MD and send the resident to the hospital. ADON-C stated staff are not to move a resident back to bed if a leg injury is noted. ADON-C stated if the resident has ROM abnormalities and/or a change in pain, facility staff are to ask EMS or the MD what the recommendation is to see if they are okay to move the resident back to bed. ADON-C stated it's situational if staff move the resident. Fall incident reports are reviewed in morning meetings and they think about why the fall is happening and nail it on the head and try to figure out why, if repeated falls keep happening. Morning meetings are used to discuss root causes of falls. ADON-C stated NHA-A is the final person to close out fall investigations. Surveyor asked ADON-C about R11, and ADON-C stated R11 is very impulsive. R11 waxes and wanes with impulsivity and can become behavioral at times. ADON-C stated they keep R11 engaged. ADON-C stated a lot of falls happen in bed and we try to keep R11 out of bed and toileted. R11 likes to be engaged and if facility staff note R11 awake in the middle of the night, staff will offer R11 a snack and toilet them. ADON-C stated the facility talked with R11's family after multiple falls, and family indicated R11 has a variable sleep pattern where R11 will get up and down and up and down. Surveyor notified ADON-C of the following concerns: R11 sustained an UWF on 3/27/26, with documented ROM and pain changes. Facility staff hoyer lifted R11 back into bed prior to being sent out for an evaluation of the ROM and pain changes. R11 sustained a displaced right femoral neck fracture requiring a right hip hemiarthroplasty performed on 3/28/26. Surveyor observed no fall sign in R11's room on 6/2/26, at 8:08 AM and 6/9/26 at 8:07 AM, as indicated on the care plan. The facility did not complete a thorough fall investigation for each fall as noted above. The facility did not complete a thorough root cause analysis for R11's falls to help determine possible causes and develop interventions based on the possible root cause. R11 had a bolster mattress applied on 6/1/26, after R11 experienced 9 falls. Surveyor notified ADON-C of these concerns identified and requested additional information if available. 2.) R33 was admitted to the facility on [DATE]. R33's diagnoses include spondylosis, cognitive deficit, hearing loss, anxiety and Altered Mental Status (AMS). On 6/2/26, at 7:58 AM, Surveyor observed R33 lying in bed supine in a low bed with the bed in the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	lowest position. Surveyor observed R33's call light on the floor on left side of the bed out of reach. Bilateral fall mats were present on each side of the bed. On 6/2/26, at 1:09 PM, Surveyor observed R33 lying in bed supine with head of bed at approximately 45 degrees and call light hanging behind the bed on the floor out of reach from R33. The bed was in the lowest position with fall mats on each side of the bed. On 6/3/26, at 8:11 AM, Surveyor observed R33 lying in bed supine with bed in the lowest position and bilateral fall mats on each side of the bed. Surveyor observed a call light laying on the floor out of reach from R33. On 6/4/26, and 8:01 AM, Surveyor observed R33 lying in bed supine with the bed in the lowest position. Surveyor observed the right side of the bed with no fall mat present and one a fall mat on the left side of the bed. R33's call light was located out of reach on the floor. On 6/8/26, at 7:49 AM, Surveyor observed R33 lying in bed supine with the low bed in the lowest position, a fall mat on the left side of the bed and no fall mats present on the right side of bed. R33's Broda chair was observed pushed up to the right side of the bed with the feet of the chair touching the bed. R33's call light was laying on the floor behind the bed out of reach of R33. On 6/9/26, at 7:58 AM, Surveyor observed R33 lying in bed supine with head of bed approximately 15 degrees . R33's call light was observed laying on the floor behind the bed out of reach. Surveyor notes R33's call light appears to be in the same position as the previous day on 6/8/26 at 7:49 AM. Surveyor observed R33's Broda chair pushed up to the right side of the bed with the feet of the chair touching the bed and a fall mats on the left side of the bed only. On 6/4/26, at 8:04 AM, Surveyor interviewed Medication Technician (Med-Tech)-KK who stated R33 wiggles a lot. Med-Tech-KK stated R33's family requests R33 be up in the Broda chair throughout the day. R33's care plan documents the following: (R33) is at risk for falls related to deconditioning, dementia, balance problems and incontinence. Date initiated 7/4/21, revised on 12/1/25. Interventions include: Educate staff on bed positioning during cares. Date initiated 2/24/25. Bed is to be in lowest position. Date initiated 11/8/21, revised on 10/24/24. Offer (R33) to lay down for bed in between 8:00 PM and 9:00 PM. Date initiated 12/1/25. Anticipate and meet (R33's) needs. Date initiated 7/4/21, revised on 10/24/24. Neuro-checks to be completed per policy. Date initiated 7/4/21, revised on 10/24/24. Pharmacy consult to evaluate medications. Date initiated 7/4/21. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Physical therapy evaluate and treat as ordered or as needed. Date initiated 7/4/21. Position (R33) in the center of the bed and two staff members for all cares. Date initiated 11/6/25. (R33) has bowel incontinence related to impaired mobility and dementia. Date initiated 7/4/21, revised on 1/21/22. Interventions include: Check (R33) every 2 hours and assist with check and change as needed. Date initiated 7/4/21, revised on 11/30/24. (R33) has an Activities of Daily Living (ADL) self-care performance deficit related to dementia and impaired balance. Date initiated 7/4/21, revised on 12/1/25. Interventions include: (R33) uses a Broda chair and is an assist of one. Date initiated 11/8/21, revised on 4/17/26. (R33) requires two staff members for assistance with bed mobility. Date initiated 10/24/23, revised on 10/24/24. Check and change every 2 hours and as needed. (R33) is incontinent of bowel and bladder. Provide Peri cares following episodes of incontinence. Date initiated 7/4/21, revised on 11/30/24. (R33) requires a Hoyer lift with total assistance of two staff members. Date initiated 7/4/21, revised on 5/24/23. Surveyor reviewed R33's Electronic Medical Record (EMR) which documents the Fall Risk Assessments: 9/11/25 – moderate risk 11/4/25 – moderate risk 11/28/25 – moderate risk Surveyor reviewed R33's fall investigation dated 11/4/25, which documents the following: On 11/4/25, at 9:45 PM, R33 was found lying on the floor mat next to their bed. R33 was lying on their left side naked with a blanket covering them. R33 was last checked and changed one hour prior to the fall. Neurological checks, skin assessment, pain assessment and vital signs were completed. R33's call light was noted to be within reach. Staff statement was documented as R33 was cleaned up at 8:30 PM. While staff provided cares, R33 kept trying to roll towards the window and would get upset when staff tried to reposition R33. When staff were leaving the room, R33 was noted to be moving around their bed. Root cause analysis documented, R33 was not centered properly in the bed. R33 rolled off the edge of (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the bed. New care plan intervention included position (R33) in the center of the bed and two staff members for all cares. Care plan was updated on 11/6/25. On 6/8/26, at 10:04 PM, Surveyor discussed with ADON-C the detail that R33 was noted by staff providing cares that R33 was upset and rolling within their bed on 11/4/25, at 8:30 PM, and R33 fell out of bed at 9:45 PM. Why did staff potentially leave R33 in an unsafe situation? ADON-C stated the big thing there (referring to R33's fall & the investigation details) is R33 was documented as moving a lot and R33 can't move a lot. ADON-C then stated I don't think R33 has the capability to move on their own and fall out of bed. R33 doesn't have the capability to reach over and turn and doesn't move a lot. There was a question of what really occurred. This was not further investigated by the facility. Surveyor reviewed R33's fall investigation dated 11/28/25, which documents the following: On 11/28/25, at 7:15 PM, R33 was found lying on the floor mat beside the bed. Neurological checks and Registered Nurse (RN) assessment were completed. Fall interventions were noted to be in place at the time of the fall. Surveyor noted the fall investigation does not include when R33 was last seen or toileted. Root cause analysis documented: (R33) is cognitively impaired and can't or won't call for assistance. Staff need to anticipate (R33's) needs. (R33's) family would like (R33) up as much as possible, but (R33) will normally go to bed between 6:00 PM and 7:00 PM. (R33) is still aroused at night. Further intervention is to put (R33) to bed later, to address the issue of (R33) still being aroused. R33's care plan was updated on 12/1/25 to include a new intervention to offer (R33) to l

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility did not ensure sufficient nursing staff was provided to all residents to maintain or attain their highest practicable physical, mental, and psychosocial well-being. Surveyor conducted a record review of the facility's nursing staff schedule and verified the facility is not providing staffing levels that meet the facility's identified staffing needs documented in the facility assessment for the night shift. The facility did not consistently designate a licensed nurse to serve as a charge nurse on each tour of duty. This deficient practice has the potential to affect all 83 residents residing at the facility. Findings include: The facility's policy titled, Nursing Services and Sufficient Staff and dated 4/21/25 under policy documents It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment. Under Policy Explanation and Compliance Guidelines include documentation of 2. The facility must designate a licensed nurse to serve as a charge nurse on each tour of duty (except when waived). On 6/8/26, at 11:24 a.m., surveyor reviewed the facility assessment last updated 5/30/26. Surveyor noted under the section staffing plan for direct care staff documents 1:9 to 16 ratio days, 1:9 to 16 ratio evenings and 1:8 to 10 ratio nights. Below the staffing ratio is documented Depends on the acute (sic) may be 3-4 Certified Nursing Assistants (CNAs) assigned to 1st and 2nd floor for days and PMs (evenings) and nights will have 2-3. Subacute will have 2 CNAs on all three shifts. Assistance with activities daily living (ADL) section in the facility assessment documented the number of residents who are independent for dressing is 2, require an assist of 1-2 staff is 39, and dependent upon staff is 38. For bathing 5 residents are independent, 53 require assistance of 1-2 staff and dependent is 31. For transfer 7 residents are independent, 58 require assistance of 1-2 staff, and 40 are dependent. For eating 31 residents are independent, 39 require assistance of 1-2 staff, and 11 are dependent. For toileting 4 residents are independent, 39 residents require assistance of 1-2 staff, and 11 are dependent. Surveyor reviewed the daily nursing schedules from 5/3/26 to 6/6/26 and noted the following: On 5/3/26 the census was 88. According to the facility assessment on the night shift there should be 8.8 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/4/26 the census was 88. According to the facility assessment on the night shift there should be (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8.8 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs and 1 med tech working as a CNA on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/5/26 the census was 91. According to the facility assessment on the night shift there should be 9.1 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs and 1 med tech working as a CNA on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/6/26 the census was 91. According to the facility assessment on the night shift there should be 9.1 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/7/26 the census was 93. According to the facility assessment on the night shift there should be 9.3 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 8 CNAs, including 2 CNAs who were on orientation working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/8/26 the census was 93. According to the facility assessment on the night shift there should be 9.3 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 7 CNAs, including 2 CNAs who were on orientation working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/9/26 the census was 91. According to the facility assessment on the night shift there should be 9.1 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 7 CNAs, including 1 CNAs who were on orientation and one med tech working as a CNA for a total of 8 on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/10/26 the census was 89. According to the facility assessment on the night shift there should be 8.9 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/12/26 the census was 87. According to the facility assessment on the night shift there should be 8.7 CNAs. Surveyor reviewed the nursing schedule and noted there were 8 CNAs, including 2 CNAs who were on orientation working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/13/26 the census was 88. According to the facility assessment on the night shift there should be 8.8 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 7 CNAs, including 2 CNAs who were on orientation working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/14/26 the census was 86. According to the facility assessment on the night shift there should be 8.6 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 8 CNAs, including 2 CNAs who were on orientation working on the night shift. The facility did not meet their staffing level identified in the facility assessment. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Greenfield	5790 S 27th St Milwaukee, WI 53221

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/15/26 the census was 86. According to the facility assessment on the night shift there should be 8.6 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 8 CNAs, including 1 CNA who was on orientation working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/16/26 the census was 86. According to the facility assessment on the night shift there should be 8.6 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/17/26 the census was 82. According to the facility assessment on the night shift there should be 8.2 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/18/26 the census was 83. According to the facility assessment on the night shift there should be 8.3 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 7 CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/19/26 the census was 83. According to the facility assessment on the night shift there should be 8.3 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs and 1 med tech working as a CNA who are on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/20/26 the census was 84. According to the facility assessment on the night shift there should be 8.4 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/21/26 the census was 85. According to the facility assessment on the night shift there should be 8.5 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/22/26 the census was 84. According to the facility assessment on the night shift there should be 8.4 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/23/26 the census was 87. According to the facility assessment on the night shift there should be 8.7 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 4 CNAs and 1 med tech working as a CNA on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/24/26 the census was 85. According to the facility assessment on the night shift there should be 8.5 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/25/26 the census was 85. According to the facility assessment on the night shift there should be 8.5 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs and 1 med tech working as a CNA on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/26/26 the census was 85. According to the facility assessment on the night shift there should be 8.5 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 5 CNAs and 2 med techs working as a CNA on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/27/26 the census was 86. According to the facility assessment on the night shift there should be 8.6 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 5 CNAs and 2 med tech who are working as CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/28/26 the census was 86. According to the facility assessment on the night shift there should be 8.6 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 5 CNAs and 2 med tech who are working as CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/29/26 the census was 86. According to the facility assessment on the night shift there should be 8.6 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/30/26 the census was 86. According to the facility assessment on the night shift there should be 8.6 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs and 1 med tech who was working as a CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 5/31/26 the census was 83. According to the facility assessment on the night shift there should be 8.3 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 6/1/26 the census was 83. According to the facility assessment on the night shift there should be 8.3 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 5 CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 6/2/26 the census was 84. According to the facility assessment, on the night shift there should be 8.4 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs, 1 orientee, and 1 med tech working as a CNA on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 6/3/26 the census was 83. According to the facility assessment on the night shift there should be 8.3 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs and 1 CNA orientee working on the night shift. The facility did not meet their staffing level identified in the facility assessment. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/5/26 the census was 83. According to the facility assessment on the night shift there should be 8.3 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs and 1 CNA orientee working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 6/6/26 the census was 84. According to the facility assessment on the night shift there should be 8.4 (Certified Nursing Assistant) CNAs. Surveyor reviewed the nursing schedule and noted there were 6 CNAs working on the night shift. The facility did not meet their staffing level identified in the facility assessment. On 6/9/26, at 11:02 a.m., Director of Nursing (DON)-B provided Surveyor the transfer assistance residents for the 83 residents who resided at the facility when the survey team entered on 6/1/26. Surveyor noted 44 residents required either contact guard or assistance of one staff member and 39 residents required assistance of 2 staff with a mechanical lift. For continence status 15 residents were identified as being continent and 68 residents were identified as being incontinent. Surveyor reviewed the daily nursing schedules from 5/3/26 to 6/6/26 and noted the following: On 5/3/26 there was not a designated charge nurse on the day, evening, & night shifts. On 5/4/26, 5/5/26, 5/6/26, & 5/7/26 there was not a designated charge nurse on the evening & night shifts. On 5/8/26, 5/9/26, 5/10/26, 5/11/26 there was not a designated charge nurse on the day, evening & night shifts. On 5/12/26 there was not a designated charge nurse on the evening shift. On 5/13/26 there was not a designated charge nurse on the day, evening, & night shifts. On 5/14/26 there was not a designated charge nurse on the day & evening shifts. On 5/15/26 there was not a designated charge nurse on the day, evening, & night shifts. On 5/16/26 there was not a designated charge nurse on the evening & night shifts. On 5/17/26 there was not a designated charge nurse on the day & evening shifts. On 5/18/26 there was not a designated charge nurse on the day, evening, & night shifts. On 5/19/26 there was not a designated charge nurse on the day & evening shifts. On 5/20/26, 5/21/26, 5/22/26, 5/23/26, 5/24/26, & 5/25/26 there was not a designated charge nurse on the day, evening, & night shifts. On 5/26/26 there was not a designated charge nurse on the day and evening shifts. On 5/27/26, 5/28/26, & 5/29/26 there was not a designated charge nurse on the day, evening and night shifts. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/30/26 & 5/31/26 there was not a designated charge nurse on the evening shifts. On 6/1/26 there was not a designated charge nurse on the day and evening shifts. On 6/2/26 there was not a designated charge nurse on the day, evening, and night shifts. On 6/3/26 there was not a designated charge nurse on the day shift. On 6/4/26 there was not a designated charge nurse on the day, evening, and night shifts. On 6/5/26 there was not a designated charge nurse on the day shift. On 6/6/26 there was not a designated charge nurse on the day, evening, and night shifts. On 6/9/26, at 8:12 a.m., Surveyor interviewed Scheduler-J to inquire how she determines to staff the facility. Scheduler-J informed surveyor it's based on acuity of the residents in the facility. Surveyor asked if there is a minimum number of Certified Nursing Assistants (CNAs) required. Scheduler-J informed surveyor she usually gets the number from Nursing Home Administrator (NHA)-A which fluctuates based on census. Surveyor asked Scheduler-J if she reviews the facility assessment to ensure they have the required number of staff based on the facility assessment. Scheduler-J informed surveyor that would be NHA-A. Surveyor informed Scheduler-J surveyor had reviewed the daily nursing schedule from 5/3/26 to 6/6/26 and didn't note where the facility designated a charge nurse each shift. Scheduler-J informed surveyor the charge nurse is their unit manager. Surveyor informed Scheduler-J there are days on the day shift when there are two-unit managers listed but there isn't a charge nurse designated. Scheduler-J informed surveyor there are shifts they don't have a charge nurse because they are constantly going through staff. On 6/9/26, at 9:12 a.m., Surveyor asked NHA-A how the facility determines the number of nursing staff required each shift. NHA-A replied how many residents we have and the acuity on that unit. Surveyor informed NHA-A surveyor noted based on the facility's assessment they meet their staff ratios for day and evening shift but not for the night shift. Surveyor informed NHA-A that the facility assessment indicates a ratio of one staff to eight to ten residents. Surveyor informed NHA-A surveyor had required the facility's staffing from 5/3/26 to 6/6/26 and noted on nights many days reviewed there are only six CNAs on the schedule for nights. NHA-A informed surveyor she thought the scheduler increased this referring to the number of CNAs on the night shift. On 6/4/26, Surveyor reviewed the facility's nursing staff daily schedules from September 2025 to November 2025. Surveyor noted the Facility was short-staffed on the following dates: On 9/15/25, the census was 82. On night shift the total CNAs working was 5. Based on the census and facility assessment, the lowest total number of CNAs required that shift would be 8. This shift only had 1 CNA staffed for the rehab unit, and the assessment stated the rehab unit should have 2 CNAs on all 3 shifts. On 9/20/25, the census was 84. On night shift there was not a nurse scheduled on the 1st floor, 5 CNAs scheduled total, and only 1 CNA working on the rehab unit. According to the census and facility assessment there should be at least 1 Nurse working night shift on the 1st floor, 8 CNAs total, and the rehab unit should have 2 CNAs scheduled. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/29/25, the census was 89. On night shift there were 6 CNAs scheduled total and on AM shift there were 3 Nurse and 1 orientee scheduled, with only 1 Nurse on the rehab unit. According to the census and facility assessment there should be at least 8 CNAs total. On AM shift there should be at least 4 Nurses scheduled. On 6/9/26, at 11:12 AM, Surveyor interviewed Scheduler-J regarding low staffing. Surveyor asked Scheduler-J about the staffing numbers for the dates 9/15/25, 9/20/25, and 9/29/25. Surveyor asked Scheduler-J if the facility was short staffed for the shifts on those dates. Scheduler-J reviewed the schedule and agreed the listed days were short staffed and the facility units did not have full coverage. Surveyor asked Scheduler-J if they knew why the facility was short staffed on those dates and if Scheduler-J knew if they attempted to cover the shifts with different staff. Scheduler-J indicated they did not know why they were short staffed and whether there was an attempt to cover the missing staff on those dates. On 6/9/26 at 11:45 AM, Surveyor shared the concern of short staffing on 9/15/25, 9/20/25, and 9/29/25 with Nursing Home Administrator (NHA)-A.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review, the facility did not ensure nurse staff posting information was accurate.Review of nursing schedules and the nurse staff posting from 5/3/26 through 6/6/26 revealed 17 of 35 days had discrepancies between the documents. This resulted in inaccuracies with the total number and actual hours worked for Certified Nursing Assistant (CNA) directly responsible for resident care each shift.This has the potential to affect 83 of 83 residents residing at the facility.Findings include:On 6/8/26 Surveyor reviewed the nursing schedules and staff posting from 5/3/26 through 6/6/26. Surveyor compared the actual nursing schedule with the nursing staff posting and noted the following discrepancies:On 5/3/26 the evening shift nursing schedule has 8 CNAs and the nursing staff posting documented 9 CNAs.On 5/7/26 the evening shift nursing schedule has 8 CNAs and the nurse staff posting documented 9 CNAs.On 5/9/26 the evening shift nursing schedule has 9 CNAs and the nurse staff posting documents 8 CNAs. The night shift nursing schedule has 6 CNAs and the nurse staff posting documented 5 CNAs.On 5/10/26 the evening shift nursing schedule has 7 CNAs and the nurse staff posting documented 9 CNAs. The night shift nursing schedule has 6 CNAs and the nurse staff posting documented 8 CNAs.On 5/11/26 the day shift nursing schedule has 10 CNAs and the nurse staff posting documented 9 CNAs.On 5/18/26 the day shift nursing schedule has 12 CNAs and the nurse staff posting documented 11 CNAs. The night shift nursing schedule has 7 CNAs and the nurse staff posting documented 8 CNAs.On 5/19/26 the night shift nursing schedule has 6 CNAs and the nurse staff posting documented 7 CNAs.On 5/22/26 the evening shift nursing schedule has 7 CNAs and the nurse staff posting documented 8 CNAs.On 5/23/26 the evening shift nursing schedule has 7 CNAs and the nurse staff posting documented 9 CNAs. The night shift nursing schedule has 4 CNAs and the nurse staff posting documents 5 CNAs.On 5/24/26 the evening shift nursing schedule has 7 CNAs and the nurse staff posting documented 10 CNAs.On 5/25/26 the day shift nursing schedule has 9 CNAs and the nurse staff posting documented 11 CNAs. The evening shift nursing schedule has 7 CNAs and the nurse staff posting documented 9 CNAs.On 5/26/26 the day shift nursing schedule has 9 CNAs and the nurse staff posting documented 8 CNAs. On 5/27/26 the evening shift nursing schedule has 9 CNAs and the nurse staff posting documented 8 CNAs.On 5/28/26 the evening shift nursing schedule has 9 CNAs and the nurse staff posting documented 8 CNAs.On 5/30/26 the night shift nursing schedule has 6 CNAs and the nurse staff posting documented 7 CNAs.On 5/31/26 the day shift nursing schedule has 8 CNAs and the nurse staff posting documented 10 CNAs. The evening shift nursing schedule has 7 CNAs and the nurse staff posting documented 8 CNAs.On 6/6/26 the day shift nursing schedule has 8 CNAs and the nurse staff posting documented 9 CNAs.On 6/9/26 at 8:20 a.m. surveyor asked Receptionist-J who is responsible for completing the nurse staff posting. Receptionist-J informed Surveyor Lead Receptionist (LR)-TT does this based on their schedules.On 6/9/26, at 8:27 a.m., surveyor asked Lead Receptionist (LR)-TT if she was responsible for completing the nurse staff postings. LR-TT informed Surveyor she was. LR-TT informed surveyor she already did today's and showed surveyor the nurse staff posting which is located to the right of the elevators opposite the receptionist area. LR-TT explained to surveyor she receives the schedule from the scheduler and whatever she sees on the schedule she writes on the nursing staffing hours form. If someone calls in, she does the changes the next day to correct the nursing staffing hour form. Surveyor inquired if CNAs who are on orientation are included in the staffing totals. LR-TT replied we do not count them explaining she writes them on the bottom of the form. Surveyor informed LR-TT surveyor compared the facility's daily nursing schedule with the nurse staff posting (nursing staffing hour) form and noted discrepancies on multiple days. LR-TT informed Surveyor she may not have been notified when something changed. As an example, surveyor showed LR-TT the discrepancy on 5/3/26. The evening shift nursing schedule has 8 CNAs and the nurse staff posting documented 9 CNAs. LR-TT reviewed the scheduling sheets she was provided for 5/3/26 and informed surveyor she wasn't given the right schedule and goes by what she is given.On (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	6/9/26, at 9:21 a.m., Surveyor informed Nursing Home Administrator (NHA)-A surveyor compared the daily nursing schedule with the nurse staff posting. Surveyor noted multiple days where there is a discrepancy between the two documents. NHA-A informed Surveyor LR-TT spoke to her and LR-TT thought she was doing it correctly.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 3 (R108, R4, and R31) out of 19 sampled residents were provided and administered medications based upon physician orders and standards of practice for ensuring accurate administration of ordered medications. * R108 had multiple medications that were not administered from September to November of 2025 with notations that indicated the medications were not available to administer as ordered. * R4 had tooth pain and facial swelling. Chlorhexidine Gluconate solution was not administered as ordered by the physician. * R31 had multiple medications and treatments that were not documented as being administered or completed as ordered. Findings Include: The facility's policy titled, Medication Administration, dated 2/15/2026, documented Medications are administered by licensed nurses, or other staff who are legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination more infection. Ensure that there are 6 rights of medication administration are followed: right resident, write drug, write dosage, right route, right time, and write documentation. Sign MAR after administered. correct any discrepancies and report to nurse manager. 1.) R108 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R108's 5 day admission Minimum Data Set (MDS) completed on 9/29/25 documented R108 had a Brief Interview for Mental Status (BIMS) score of 11 (1-15), indicating that R108 had moderate cognitive impairment. On 6/2/26, Surveyor reviewed R108's Medication Administration Record (MAR) from September to November 2025. Surveyor noted the following missing medication administration notes in September 2025: * Loratadine 10 mg daily, ordered 2/26/25 – 11/21/25 was not administered on 9/28/25 and 9/30/25 and documented as 9 which means Other/See nurses notes. Surveyor reviewed R108's progress notes and both dates note Loratadine 10 mg to be on order. * Temazepam 22.5 mg given at bedtime, ordered 9/22/25 – 11/21/25 was not administered for the first 4 days the medication was ordered from 9/22/25 – 9/25/25. Surveyor reviewed R108's progress notes and the notes stated, med not yet delivered and awaiting pharmacy delivery. * Clonazepam 0.5 mg given 2 times a day, ordered 9/22/25 – 11/21/25 was not administered on 9/22/25-9/25/25 and the PM administration on 9/27/25. Surveyor reviewed R108's progress notes on those dates documented: med not yet delivered and med not available. Surveyor noted the following missing medication administration notes in October 2025: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Lidocaine cream 4% apply 4 times a day, ordered 9/22/25 – 11/26/25. Lidocaine was not administered: 10/1/25 at 12:00 AM and 6:00 AM; 10/2/25 at 12:00 AM, 12:00 PM, and 6:00 PM; 10/3/25 at 12:00 AM and 6:00 AM; 10/4/25 at 12:00 AM and 6:00 AM; 10/5/25 at 12:00 AM and 6:00 AM; 10/6/25 at 12:00 AM and 6:00 AM; and 10/7/25 at 12:00 AM and 6:00 AM. Surveyor reviewed R108's progress notes on those dates that documented na, on order, med not yet delivered, awaiting pharmacy delivery, or no note at all. * Clonazepam 0.5 mg given 2 times a day, ordered 9/22/25 – 11/21/25 was not administered 10/26/25 at 8:00 AM and 6:00 PM, 10/29/25 at 8:00 AM and 6:00 PM, 10/30/25 at 8:00 AM, and 10/31/25 at 8:00 AM and 6:00 PM. Surveyor reviewed R108's progress notes on those dates that documented waiting for pharmacy to send, medication not available, or no note at all. Surveyor noted the following missing medication administration notes in November 2025: * Temazepam 22.5 mg given at bedtime, ordered 9/22/25 – 11/21/25. This medication was not given 11/1/25, 11/3/25, 11/5/25, 11/6/25, and 11/9/25. Surveyor reviewed R108's progress notes on those dates that documented medication not in facility, reorder, pharmacy notified, med not available, missing medication, or no note at all. On 6/9/26, at 8:01 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-CC regarding medication availability and the process of ordering medications. LPN-CC stated when a resident is admitted , the medications are put into the system; they are automatically ordered, and pharmacy begins to process them. LPN-CC stated medications will arrive the next shift or the next morning. LPN-CC stated if a medication is needed sooner the nurse can either pull the medication from contingency if available, call pharmacy and have the medications sent STAT (immediately), or call the Physician and notify them of the medication unavailability and possibly have another medication ordered in its place. On 6/9/26, at 11:03 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-C regarding medication availability. ADON-C stated medications are to be reordered before running out, if the medication is not available staff are to pull the medication from contingency, and as a last resort the nurse is expected to call the pharmacy to get the medication STAT or document why the medication is not being sent. Surveyor questioned ADON-C why there were missing medication administrations for R108 from September 2025 – November 2025. ADON-C reviewed the dates in question and was unable to provide why the medications were not given. ADON-C stated the Nurses were not checking the manifest when medications would arrive to ensure the pharmacy delivery was complete and around that time a new pharmacy was being used and switching pharmacy providers caused issues with the reordering process. On 6/9/26 at 11:45 AM, Surveyor shared the concern of R108 not receiving medications on select dates from September 2025 to November 2025 with Nursing Home Administrator (NHA)-A. 2.) The facility policy titled Dental Services dated 12/1/25 documents (in part) . . It is the policy of this facility to assist residents in obtaining routine (to the extent covered under the state plan) and emergency dental care. Emergency dental services includes services needed to treat an episode of acute pain in teeth, gums, or palate; broken or otherwise damaged teeth, or any other problem of the oral cavity that required (continued on next page)

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	525504	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Greenfield	5790 S 27th St Milwaukee, WI 53221

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediate attention by a dentist. The facility policy titled Pharmacy Services dated 2/15/26 documents (in part) . . It is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. 6. The facility will maintain a limited supply of medications for emergency or after hours situations in accordance with facility policy and applicable state laws. 8. The pharmacist, in collaboration with the facility and medical director, should include within its services to: f. Strive to assure that medications are requested, received, and administered in a timely manner as ordered by the authorized prescriber. R4 was admitted to the facility on [DATE] and had diagnoses of major depressive disorder, hypertension, paroxysmal atrial fibrillation, heart failure, cerebral infarction, type 2 diabetes mellitus, chronic kidney disease, myocardial infarction peripheral vascular disease and dementia. On 6/1/26 at 9:55 AM, Surveyor spoke with R4 in her room. Surveyor obserbed R4 had several missing and jagged teeth. R4 reported no concern with eating or chewing food but told Surveyor her teeth hurt sometimes. Facility progress notes documented: 12/3/25 at 10:50 AM, general nurses note: Resident has facial swelling that started last night, no symptoms or pain, vitals normal, Np (Nurse Practitioner) notified, told to hold Amlodipine x 2 days and to monitor swelling. Resident denies pain, trouble swallowing or SOB (shortness of breath). No swelling or redness in mouth or throat. 12/4/25 at 6:20 PM, general nurses note: Resident complained of left sided face pain and stated it was her tooth that's hurting. Left side of face appears swollen and third eye notified. New order received for Tramadol 50 mg (milligrams) q (every) 8 hours prn (as needed) for tooth pain and for PCP (primary care provider) to be contacted in am for possible CT (computerized tomography) scan. Will continue to monitor. 12/4/25 at 6:34 PM, third eye health note: Primary Chief Complaint: Oral Pain/SwellingHistory Present Illness: The patient is having pain in her mouth. This has been going on for several days and the PCP is aware. She has swelling on the left side of her face she only has Tylenol for pain. I cannot appreciate any cellulitis. Review of Systems Notes: Tooth pain. Condition is stable. Will order tramadol. Will need an outpatient CT. Surveyor noted a physician's order for Chlorhexidine Gluconate Solution 20%, place and dissolve 20 milliliters buccally three times a day for tooth pain for 7 Days oral rinse and spit start date 12/5/25. Surveyor review of facility progress notes documented: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/5/25 at 10:38 PM, (L) (left) side facial swelling remains. Writer asked the resident was she in any pain and she stated no. Resident ate and drink without issue this shift. Awaiting swish and spit to arrive from the pharmacy. 12/6/25 at 2:21 PM, facial swelling has gone down, no complaints of any pain, prescribed mouthwash has not come in from pharmacy yet. 12/7/25 at 8:44 PM, facial swelling diminished. Resident eating and drinking without difficulty. Resident denies any pain at this x (time). Currently awaiting swish and spit to arrive from the pharmacy. 12/9/25 at 2:59 PM, facial swelling is down, medicated mouthwash should be coming tonight told to me by pharmacy. 12/10/25 at 1:59 PM, resident has no pain or facial swelling, I contacted pharmacy again about the medicated mouth wash. Pharmacy stated it will for sure be sent out tonight and that they are not sure why it was not sent out last night. 12/10/25 at 9:09 PM, minimal (L) and (R) (right) side facial swelling observed this shift. Patient denies pain. Patient eating and drinking without difficulty. T (temperature) 97.7. 12/12/25 9:57 AM, Chlorhexidine Gluconate Solution 20 % did not come from pharmacy. 12/13/25 at 8:20 PM, denies oral discomfort, no swelling to face noted. Denies any difficulty chewing or swallowing. Surveyor noted the last documentation regarding R4's tooth pain or facial swelling was on 12/13/25. Surveyor noted R4's facial swelling started on 12/3/25 accompanied by tooth pain that started on 12/4/25. Physician's orders for Chlorhexidine Gluconate Solution 20% three times a day for tooth pain for 7 Days starting 12/5/25 was not administered as ordered. On 6/8/26 at 11:37 AM, Surveyor told NHA-A of concern R4 had documented tooth pain and facial swelling and an order for Chlorhexidine solution, which was never administered. She reported she was not sure why the Chlorhexidine solution was not given because it is in contingency. NHA-A stated, I bet they didn't know that, and were just waiting for pharmacy to deliver it. No additional information was provided. (Cross reference F791). 3.) R31 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction, and chronic pain syndrome. R31's Quarterly Minimum Data Set (MDS) assessment, dated 4/2/26, indicated that R31's Brief Interview for Mental Status (BIMS) score was documented as 15, which indicated R31 did not have cognitive concerns. R31's MDS also assessed R31 had range of motion (ROM) impairment to both upper and lower extremity on one side and dependent for showers, dressing, mobility, and transfers. R31's MDS also documented R31 was receiving pain management. R31's current physician orders documented: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Monitor/document/report to MD signs/symptoms of Opioid complications: Constipation, Delirium, Over-sedation, Change in mental status, and reduced respirationsevery shift for Opioid MonitoringActive 4/21/2026 2. Tramadol HCl Oral Tablet 50 MG Give 50 mg by mouth two times a day for Pain ManagementActive 1/6/2026 3. Diclofenac Sodium External Gel 1 % 9 (Voltaren)Apply to Bilateral Knees/Shoulders topically two times a day for Pain Management: Arthralgia Upper Extremity: Apply 2g to each affected area. (Max Dose per joint is 8g/day). Lower Extremity: Apply 4g to each affected area. (Max dose per joint is 16g/day) MAX DAILY DOSE (ALL JOINTS): 32g/dayActive 12/16/2025 4. Apap (Acetaminophen) Oral Tablet 325 MG Give 2 tablet orally three times a day for painActive 4/20/2024 5. High Calorie Nutritional Supplement three times a day for weight loss Ensure Plus 1 bottle three times a day-nursing to provide Active 8/24/25 Surveyor reviewed R31s Medication Administration Records (MARS) for December 2025-June 2026 and noted multiple days with shifts that were blank. Surveyor noted there are days that R31 did not receive R31's medications as prescribed for the months of February-June 2026. February 2026 High Calorie Nutritional Supplement 3x a day 2/14/26, 2/28/26-missed administration at 6:00 AM Tramadol 50 mg 2/14/26, 2/15/26, 2/16/26, 2/28/26 missed administration at 6:00 AM 2/19/26 missed administration at 10:00 PM Acetaminophen Oral Tablet 325 mg 2/14/26, 2/28/26 missed administration at 6:00 AM Assessment of pain level 2/27/26 missed night assessment April 2026 High Calorie Nutritional Supplement 3 times a day 4/27/26 missed administration at 2:00 PM Acetaminophen Oral Tablet 325 mg 4/27/26 missed administration at 2:00 PM May 2026 High Calorie Nutritional Supplement 3 times a day 5/5/26 missed administration at 2:00 PM and 5/11/26, 5/23/26 missed administration at 6:00 AM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tramadol HCl 50 mg 5/1/26, 5/23/261 missed administration at 6:00 AM Acetaminophen Oral Tablet 325 mg 5/11/26, 5/23/26 missed administration at 6:00 AM Pain Level once a Shift 5/9/26, 5/10/26, 5/22/26 missed night assessments Surveyor noted there is no documentation as to why R31 had not received the medications. On 6/8/2026, at 10:46 AM, Surveyor interviewed Unit Manager (UM)-BB. UM-BB informed Surveyor that agency staff were a problem with medication administration. UM-BB was unaware there were shifts that R31 had not received physician ordered medications and R31's pain was not assessed. On 6/9/2026, at 8:18 AM, Surveyor interviewed R31 regarding R31's medications. Surveyor asked R31 if there was ever a time that R31 had not received medications. R31stated R31 had not received tramadol multiple times and did not know why. R31 informed Surveyor that tramadol was effective in managing R31's pain. On 6/9/2026, at 9:27 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-Z. Surveyor asked LPN-Z why R31 would have gone without prescribed medications. LPN-Z stated the reason would most likely be because R31 ran out. LPN-Z stated there was an instance where the contingency drawer would not open. LPN-Z stated there should never be an instance when R31 should go without medications. Just being honest, there has to be accountability. I am Monday-Friday on day shift; there needs to be accountability on other shifts. I heard R31 recently ran out of Tramadol. On 6/9/2026, at 10:21 AM, Surveyor interviewed Director of Nursing (DON)-B. DON-B stated DON-B was not aware of any days when R31 would have gone without medications. Surveyor shared the times when R31 had not been administered physician ordered medications. DON-B informed Surveyor there had been a period of time when medications were not being administrated to residents because of agency nursing staff. DON-B stated that ordered medications must be administered as prescribed and there was no exception. DON-B stated that the process would be to check the dashboard and for instance if there is 80% administration, it would need to be reviewed to see who did not get medications that day and it must not have been checked with (R31). On 6/9/2026, at 11:24 AM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that R31's MARS contained documented days with shifts that were blank with no documentation as to why R31did not receive physician prescribed medications.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review the facility did not ensure that 4 out of 5 Certified Nursing Assistants (CNAs) completed required dementia training annually. This has the potential to affect a pattern of the 83 residents residing in the facility who receive care from the 4 staff members.*CNA-Q, CNA-R, CNA-S, and CNA-V did not have documentation they had completed required dementia training.Findings include:The facility's policy titled, competency evaluation, dated 3/15/2026, documented it is the policy of this facility to evaluate each employee to assure they meet appropriate competencies and skills for performing their job. the knowledge and skills required among staff to meet residences needs are determined through the facility assessment process. Checklists are used to document training and competency evaluations. employee competency forms are maintained in the staff development coordinators office for current training year, then forwarded to the human resources director for placing into the employees personal file.The facility's Assessment, dated 5/30/26, in part 3 under staff training/education and competencies documented: .required in-service training for nurse aids in service training must: be sufficient to ensure the continuing competence of nurse aids, but must be no less than 12 hours per year.include dementia management training and resident abuse trainings.On 6/3/26, Surveyor requested and reviewed annual employee training for CNA-Q, CNA-R, CNA-S, and CNA-V. Surveyor noted the CNAs had not received the required annual training on dementia.On 6/3/26 at 8:19 AM, Surveyor interviewed Human Resources (HR) -D regarding staff training. HR-D stated they will do the initial orientation training courses that cover everything and to ensure staff have the required training courses yearly. HR-D stated they do not pick which trainings are done. HR-D stated Nursing Home Administrator (NHA) - A chooses the trainings based off the needs of the facility. HR-D was unable to locate training was completed by CNA-Q, CNA-R, CNA-S, and CNA-V. HR-D was not aware dementia training was required and stated the training will be implemented going forward.On 6/4/26, at 1:03 PM, Surveyor interviewed NHA-A regarding staff training. NHA-A stated there are mandatory training courses to be completed that NHA-A keeps a list of. NHA-A stated the Director of Nursing (DON)-B and Assistant Director of Nursing (ADON)-C will come up with a list of training based on weak areas in the facility. NHA-A will take the mandatory training and weak areas and make a training course to be completed for that year. Surveyor shared the concern of CNA-Q, CNA-R, CNA-S, and CNA-V not receiving annual dementia training. NHA-A stated they were unable to locate additional training records for those staff. NHA-A stated the facility plans to implement an in-depth dementia training going forward.