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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525507	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Age Manor	220 Scholl CT Amery, WI 54001

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not complete a Minimum Data Set (MDS) assessment for significant change in a timely manner.-R1 was admitted to hospice. The MDS assessment for significant change was not completed within 14 days.Findings include:Facility Policy titled, Comprehensive Assessments, last revised [DATE], states: Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual.The RAI User Manual states the Significant Change in Status Assessment (SCSA) must be completed by the end of the 14th calendar day following determination that a significant change has occurred.Surveyor reviewed R1's electronic health record. Last completed MDS assessment was completed on [DATE].R1 was admitted to hospice on [DATE]. A SCSA was started on [DATE] but was incomplete and never submitted. R1 expired on [DATE].On [DATE] at 2:50 PM, Surveyor interviewed Director of Nursing (DON) B. DON B stated the MDS assessments are completed upon admission, annually, quarterly, with a significant change, and as needed. DON B stated the facility follows the guidelines in the RAI. DON B stated a significant change would be a decline or improvement of 2 or more areas of care, or when a resident admits to or is removed from hospice. DON B stated the timeframe was 14 or 15 days after recognizing the change for completion of the assessment. DON B acknowledged R1's significant change MDS had not been completed and was past the 14 days.

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

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

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NAME OF PROVIDER OR SUPPLIER Golden Age Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 220 Scholl CT Amery, WI 54001	

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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 0689 Level of Harm - Minimal harm or potential for 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 interview and record review, the facility did not ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 3 residents reviewed (R4).R4 had a fall during a 1-staff transfer with mechanical lift. Per care plan, R4 required 2-assist. Findings include:Facility policy titled, Falls and Fall Risk, Managing, last revised March 2018, reads in part: Unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force.The staff, with the input of the attending physician will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls.Facility policy titled, Care Plans, Comprehensive-Centered, last revised March 2022, reads in part: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.Each resident's comprehensive person-centered care plan is consistent with the resident's rights to.receive the services and/or items included in the plan of care.Example 1R4 was admitted to the facility on [DATE], with diagnoses including abnormal posture, weakness, type 2 diabetes with polyneuropathy, and morbid obesity.On 02/01/26, R4's MDS assessment showed a BIMS score of 13/15 indicating no cognitive impairment.R4's care plan includes problem of self-care deficits related to type 2 diabetes and obesity with an approach of all transfers are now sit-to-stand mechanical lift with assist of 2 (01/20/26).Progress notes on 01/24/26 states Certified Nursing Assistant (CNA) H called nurse to R4's room. R4 was lying on the floor with R4's feet on the sit-to-stand, R4's butt on the floor and R4's back against the bed, holding onto the trapeze on R4's bed. CNA H states CNA H was assisting resident to bed and trying to unhook the sling when R4 told CNA H to get R4's feet up on the bed. CNA H had 1 side unhooked and was attempting to unhook the other side, CNA H had a hard time reaching so CNA H unlocked the sit-to-stand lift and because R4 was pushing with R4's legs it started to move forward and R4 slowly slid to the floor. R4 was assisted back up to his bed using the Hoyer lift.On 01/26/26, RN M interviewed CNA H. CNA H stated CNA H knew to use 2 assist for R4's transfer and always does but this time chose not to. CNA H did not give reasoning for the choice not to get another staff member. CNA H was reminded to use the walkie talkie to get help if needed. CNA H was told this was unacceptable due to safety, and this would be documented as verbal counseling in CNA H's file and there is no tolerance for any further issues following this or any other safety policy. RN M stated education was completed with 3 staff on each shift, spot checked 3 mechanical lift transfers, verified for several days that staff had walkie talkies, and were communicating if help was needed.On 03/30/26 at 2:05 PM, Surveyor interviewed R4 about R4's recollection of R4's most recent fall. R4 stated R4 was partially on the bed with feet on the mechanical lift and R4 was hanging onto the trapeze on R4's bed. R4 stated the lift moved and R4 slid off the bed onto the floor. R4 stated there was only one CNA present and usually there are 2 because of R4's size. R4 stated R4 feels safe at the facility but knows to have the staff come in pairs from now on.On 03/30/26 at 2:26 PM, Surveyor interviewed RN E (Registered Nurse) in regard to what RN E would do if a resident had a fall. RN E stated RN E would make sure the resident is safe after a fall, complete assessments, use a lift or gait belt to assist the resident from the floor, and call an ambulance if there is a serious injury. RN E stated RN E would interview the resident if able, and/or the staff present if any to find out what happened and why. RN E stated RN E would speak with the supervisor. RN E stated all Hoyer lifts require 2 staff and the sit-to-stand require 1-2 assist depending on the resident's care plan.On 03/30/26 at 2:32 PM, Surveyor interviewed CNA C about how CNA knows what care each resident requires. CNA C stated the care plan/Kardex in the computer lets staff know what care residents need for transfers and other activities of daily living (ADLs). CNA C stated sit-to-stand lifts require 1-2 assist depending on the resident. CNA C stated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA C has never had to use a lift alone when the care plan stated 2 staff were required. CNA C stated R4 uses a sit-to-stand lift and requires 2 staff for transfers.On 03/30/26 at 2:37 PM, Surveyor interviewed CNA D in regard to how CNA D knows how a resident transfers. CNA D stated the transfer status for each resident would be located in the computer in their care plan. CNA D stated all Hoyer lifts require 2 staff assist and sit-to-stand lifts can be 1 or 2 depending on what the care plan says. CNA D stated CNA D has never had to use a lift alone when it required 2 staff but has had to wait a while at times for someone to assist. CNA D stated R4 uses a sit-to-stand lift and requires 2 staff for transfers.On 03/30/26 at 2:41 PM, Surveyor interviewed RN F in relation to what RN F would do if a resident had a fall. RN F stated in the event of a fall, RN F would assess immediately, obtain vitals, and call 911 if needed. RN F stated RN F would start an event assessment and try to find out what happened. RN F stated if the fall is unwitnessed or if the resident hits their head, RN F would initiate neurological checks. RN F stated RN F would initially talk to the CNAs and give re-education.On 03/30/26 at 2:50 PM, Surveyor interviewed DON B about what DON B's expectations of the nurse would be in the event of a fall. DON B stated DON B's expectation in the event of a fall is for the nurse on duty to assess resident for injury. DON B stated the nurse should then start an event assessment and find out the cause of the fall. DON B stated interviews should be done with resident and staff as able. DON B stated the nurse should implement immediate intervention until the Interdisciplinary Team (IDT) can further investigate. DON B stated if a fall occurs as a result of staff not following a care plan re-education should be completed. If there is severe injury, DON B stated the staff member may get sent home or the workload would be adjusted if it would cause a staffing concern and would have the staff in question work with a partner. DON B acknowledged CNA H was working alone when R4's fall occurred, and CNA H was not following the care plan.