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	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Age Manor	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interview, the facility did not store, prepare, distribute, serve food in accordance with professional standards for food service safety. This has the potential to affect all 62 residents. -Surveyor observed clean water pitchers not inverted on open shelf in kitchen. -Surveyor observed in the walk-in cooler an open bag of whipped topping, an open container of butter, and prepared cinnamon rolls in a baking pan without dates indicating when they were opened, prepared, or when they should be used by. -Surveyor observed in the walk-in freezer opened bags of potato wedges, vegetables, and berries all without dates of when they were opened. -Surveyor observed in the dry storage area opened packages of cookies, dried noodles, split peas, powdered pudding and gelatin mixes, all without dates indicating when they were opened or when they should be used by. Findings include: On 6/22/26 at 8:50 AM, during initial tour of the kitchen with Dietary Manager (DM) I, Surveyor observed clean pitchers on bottom shelf that were not inverted or covered. On a shelf below the serving area, a covered bowl of cereal was not labeled with contents or date. In the milk cooler, an open jug of milk did not have an opened on or use by date written on it. During tour of the walk-in cooler, Surveyor observed an open bag of whipped topping, an open container of butter, and prepared cinnamon rolls in a baking pan. All of these items did not have dates indicating when they were opened or prepared or when they should be used by. Surveyor and DM I then toured the walk-in freezer and observed opened bags of potato wedges, vegetables, and berries all without dates of when they were opened. Surveyor then toured dry storage area with DM I and found opened packages of cookies, dried noodles, split peas, powdered pudding and gelatin mixes, all without dates indicating when they were opened or when they should be used by. On 6/22/26 at 9:15 AM, Surveyor interviewed DM I, who stated the expectation would be that all clean dishes are to be inverted when stored to prevent contamination from debris and all opened food items should be labeled and dated with the opened-on date.

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 5 of 62 residents residing in the facility. Improper hand hygiene was observed during personal cares for R4, R6, R13, R40. Staff did not disinfect mechanical lifts after use for R4, R13, and R40 observed transferring with a mechanical lift. Staff did not wear proper personal protective equipment (PPE) when caring for R30 who is on Enhanced Barrier Precautions (EBP).Example1 The facility policy, titled Handwashing/Hand Hygiene, dated 2000, states: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.1. Hand Hygiene is indicated:a. immediately before touching a resident;b. before performing an aseptic ask (for example.);c. after contact with blood, body fluids, or contaminated surfaces;d. after touching the resident's environment;e. before moving from work on a soiled body site to a clean body site on the same resident; andg. immediately after glove removal.5. The use of gloves does not replace hand washing/hand hygiene. On 6/23/26 at 4:11 PM, Surveyor observed Certified Nursing Assistant (CNA) N enter R13's room, complete hand hygiene, and put on gloves. CNA O pushed the sit to stand in R13's room. CNA O did not complete hand hygiene upon entering room before putting on gloves. The sit to stand sling was applied to R13, and they were raised with the sit to stand to a standing position by CNA O. CNA N pulled down R13's pants to check their brief. CNA M and CNA N then looked and touched the brief and resident's thighs to see if R13 needed to be changed. CNA O stated no, it's dry. CNA N pulled up R13's pants. R13 was lowered back into their wheelchair. CNA N took off gloves, completed hand hygiene, and pushed R13 out to the dining room. CNA O took off gloves, no hand hygiene, and pushed the sit to stand lift out of R13's room. On 6/23/26 at 4:20 PM, Surveyor observed CNA N and CNA M enter R40's room to provide cares. CNA N completed hand hygiene prior to donning gloves. CNA M did not perform hand hygiene prior to entering room and donning gloves. CNA M stated they had already emptied R40's ostomy, and they needed to place the sling under R40 and transfer them to their chair. CNA N and CNA M rolled R40 and placed a Hoyer sling under them. Once in place CNA N took off their gloves, completed hand hygiene, and left the room. CNA M remained with same gloves standing by R40's chair. At 4:26 PM, CNA O came into R40's room pushing the Hoyer lift. CNA O did not perform hand hygiene upon entering room or donning gloves. CNA O put R40's shoes on them. Then both CNAs attached the Hoyer sling to the Hoyer lift. CNA O operated the lift while CNA M assisted with sitting R40 correctly in their wheelchair. When R40 was in wheelchair, CNA O doffed gloves, completed hand hygiene, and pushed R40 out to the dining area. CNA M took off gloves, pushed Hoyer out of room, and parked it out in the community area. CNA M did not perform hand hygiene after taking off gloves, prior to leaving the room, or before they went over and touched R42's shoulder and attempted to chat with R42, asking if they were hungry. On 6/23/26 at 4:34 PM, Surveyor observed CNA N assist R6 to the bathroom. CNA N entered R6's room and guided R6 to the bathroom. CNA N put on gloves. Of note: CNA N did not complete hand hygiene upon entering the room or prior to putting on gloves. CNA N proceeded to assist R6 with pulling their pants down and sitting on the toilet. When R6 was ready, CNA N assisted R6 with peri cares and pulled up their pants. Afterwards, CNA N took off their gloves, followed R6 out of their room and toward the dining area. Once in the dining room, CNA N washed their hands at kitchen sink, touching faucets with hands after just completing peri-care. On 6/23/26 at 6:32 PM, Surveyor observed CNA O and CNA M provide personal cares to R4. CNA O pushed R4 in the wheelchair into their room. CNA O completed hand hygiene upon entering R4's room and donned gloves. CNA O positioned themselves behind R4's wheelchair. CNA M entered R4's room, did not complete hand hygiene and moved Hoyer lift into place. Of note: CNA O had brought Hoyer into room at 6:08 PM. This is the same Hoyer used at 4:11 PM and still not wiped down. CNA M donned gloves without completing hand hygiene. CNA M and CNA O (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	between, but we do not have the time. We only have to do it at the end of the shift. On 6/23/26 at 5:53 PM, Surveyor interviewed CNA O who stated lifts should be wiped down after use whenever possible and at the end of your shift. On 6/23/26 at 6:28 PM, Surveyor interviewed MA L who stated lifts should be wiped down every day and after every person. We used to keep the wipes with the lifts, but residents would take them, and one resident would eat them, and one resident would put them down their pants. So, they are kept up on the counter. Because the wipes are not with the lifts, I think the CNAs sometimes forget to wipe down the lifts between residents. The lifts get wiped down at the end of every shift for sure. On 6/24/26 at 12:38 PM, Surveyor interviewed Director of Nursing (DON) B who stated DON B's expectation is that lifts are cleaned with wipes after every use. There are wipes kept with the lifts. Surveyor shared with DON B the observation of no wipes with lift or visible on the unit. DON B said oh you're talking about the Cottage (special unit), that's true. DON B stated in the Cottage they planned to keep them somewhere else. DON B stated maybe on the counter. Surveyor asked DON B if not having the wipes with the lifts would change the expectation for wiping down the lifts. DON B stated, no they should be wiped after every use. Example 3 The facility policy titled, Enhanced Barrier Precautions, dated 5/1/2024, states: 3. Implementation of Enhanced Barrier Precautions:b. PPE for enhanced barrier precautions is only necessary when performing high contact care activities (described below) and may not need to be donned prior to entering the resident's room.4. High-contact resident care activities include:a. Dressingc. Transferringd. Providing hygienef. Changing briefs or assisting with toileting. On 6/23/26 at 7:11 AM, Surveyor observed CNA J getting R30 up off the toilet. Surveyor entered R30's unit and checked on R30, finding cares were in progress. CNA J had gloves on, but no gown. R30 was sitting on the toilet. CNA J used EZ stand to assist resident to stand and help off toilet. CNA J completed peri care, took off gloves, and completed hand hygiene. R30 was on Enhance Barrier Precautions (EBP). CNA J did not have a gown on during these cares. On 6/23/26 at 7:15 AM, Surveyor interviewed CNA J regarding Enhanced Barrier Precautions (EBP). Surveyor asked CNA J what the PPE on the door is for. CNA J said, For in here. CNA J opened the door and looked. CNA J stated, It must be new, definitely new to me, must be from yesterday. CNA stated, It has to do with their wound I'm guessing. I'll be honest we didn't have that before. I am back here every day, and it was not there. Surveyor asked if CNA J is supposed to use EBP. CNA J stated, Yes, I will have to and should have used it. On 6/23/26 at 10:02 AM, Surveyor interviewed Licensed Practical Nurse (LPN) K who stated EBP means a resident usually has a wound or catheter. The EBP sign means we should wear gloves and gowns any time we are toileting, providing cares, or dealing with the wound or catheter. LPN K stated R30 was placed on EBP yesterday morning. LPN K indicates they were aware of R30 being placed on EBP because they were on shift yesterday. LPN K stated staff are told about changes in report and in a message on messaging system regarding precautions. LPN K didn't recall if it was brought up to the CNAs in report but there was a message. On 6/23/26 at 10:30 AM, Surveyor interviewed DON B and asked what the expectation is for EBP. DON B stated the expectation is staff follow the EBP whenever they are providing personal care to residents. Surveyor informed DON B of their observations with CNA J not wearing a gown and only gloves. DON B stated CNA J should have known. DON B said we sent a Teams message about it. Surveyor asked how CNAs and nurses learn when residents have changes in their cares. DON B said it should have been passed on in report but there is a Teams message in case it is missed. CNA J should have known, there was a Teams message about R30.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the Infection Preventionist (IP) is trained in the required specialized education for infection prevention and control. This has the potential to affect all 62 residents.-The facility failed to ensure Registered Nurse (RN) G, who is acting in the role of the facility's Infection Preventionist (IP), had completed specialized training in infection prevention and control.Findings include: On [DATE], Surveyor reviewed the documentation the facility had provided for proof of the IP's training and certification. Surveyor found a portion of the modules had certificates of completion from the Center for Disease Control (CDC) infection control program. The CDC training log stated expired for the certificate of IP final test indicating the test was not taken in the time allowed after completing the modules. The required IP course does not show the IP certification test was taken and passed. Surveyor requested missing documentation and proof of certification from RN G.On [DATE] at 1:24 PM, Surveyor interviewed RN G who reported they were not sure if they took a final test after completing the IP training modules. RN G stated they do not have a certificate which indicates passing the IP test. On [DATE] at 8:50 AM, Surveyor interviewed Nursing Home Administrator (NHA) A, who stated they had thought RN G had taken and completed the IP course and the expectation is the IP meets the qualifications as indicated by the federal regulations.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility did not maintain documentation of screening, education, offering, and current Coronavirus 19 (COVID) vaccination status to staff. This has the potential to affect all 62 residents.Findings include: The facility policy titled, Employee Infection and Vaccination Status, with a revised date of January 2024 states: 2. Employees are offered or provided with vaccinations per state or local agency policies/regulations. 3. Employees are provided with educational materials to make informed decisions for non-mandated vaccinations. If declined, a declination form is completed and placed in the employee's health record. 5. Documentation of vaccinations includes the signature of the licensed healthcare provider and the employee when being administered. Vaccinations that are declined by the employee are documented on the applicable declination form and placed in the employee's health record.On 06/23/26 at 10:10 AM, Surveyor asked RN G if the facility maintains staff documentation on screening, education, offering, and current vaccination status. RN G stated only when staff are hired. RN G stated COVID vaccination information is provided at staff meetings and is offered yearly; a sign-up sheet is then put up. RN G reported very few staff get the COVID vaccine. RN G stated they do not maintain any documentation on the education which was provided or the staff who received the information. RN G reported they do keep record of the current vaccination status of the employees. On 06/23/26 at 12:39 PM, Surveyor interviewed Certified Nursing Assistant (CNA) P, who reported they were offered the COVID vaccine and Influenza this past year. CNA P stated the offer to immunize comes through a chat platform used by staff. CNA P does not get the vaccination. CNA P believes they signed a form declining COVID when starting employment a couple of years ago.Surveyor requested and reviewed CNA P's employee vaccination record noting it had their vaccinations received at the time of hire on 10/12/22 and a signed declination of the COVID vaccination on that date. On 06/24/26 at 8:52 AM, Surveyor met with Nursing Home Administrator (NHA) A and Director of Nursing (DON) B. NHA A and DON B verbalized understanding of the regulation to maintain documentation of screening, education, offering, and current Coronavirus 19 (COVID) vaccination status of the staff.DON B stated they were unaware this was not being done, as the facility used to maintain this information. DON B reported the expectation would be the Infection Preventionist maintains the required documentation of the employees screening, education, offering, and the current Coronavirus 19 (COVID) vaccination status of all staff.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that the Advanced Directives information related to resuscitation status was clearly identified on residents' medical records to ensure their life-sustaining wishes would be honored. This occurred for 9 of 18 sampled residents (R) reviewed for Advanced Directives. (R31, R5, R9, R7, R2, R59, R4, R30, and R32) R31's physician order noted code status of Do Not Resuscitate (DNR)/Do Not Intubate (DNI). R31's advance directive did not include R31's wishes for resuscitation, no DNR/DNI form was signed by R31 or R31's representative, and no documentation in R31's medical record regarding conversation with R31 regarding code status. R5's physician order noted code status of Do Not Resuscitate (DNR)/Do Not Intubate (DNI). R5's advance directive did not include R5's wishes for resuscitation, no DNR/DNI form was signed by R5 or R5's representative, and R5's medical record did not document any conversation being held with R5 regarding code status. R9's physician order noted code status DNR/DNI. R9's medical record did not have documentation of the facility or provider discussing advanced directive with R9, an advance directive stated Full Code status, and social service assessment stated DNR/DNI. R7's physician order noted code status of Do Not Resuscitate (DNR)/Do Not Intubate (DNI). R7's medical record did not have a DNR/DNI signed by R7 or R7's representative, an inquiry report stated Full Code, and Resident Assessment stated Full Code. R2's physician order code status stated DNR/DNI. R2's advance directive did not include R2's wishes for resuscitation and no DNR/DNI form was signed by R2 or R2's representative. R59's physician order code status stated DNR/DNI. R59's medical record did not have documentation of the facility or provider discussing Advanced Directive with R59, an inquiry report noted Full Code status, and a Resident Assessment stated Full Code. R4's electronic medical record indicates that R4's code status is DNR, document titled Honoring Choices Wisconsin, checked the option I [R4] want CPR attempted unless my doctor determines: * I have a medical condition and no reasonable chance of survival of CPR, or* CPR would harm me more than help me, document titled Statement of Incapacity does not address code status, no evidence the facility provided education and discussed resuscitation changes from Full Code to DNR status, and no updated advance directive or DNR/DNI for signed by R4 or R4's representative. R30's physician orders stated DNR/DNI (do not intubate), R30's medical record does not address code status, R30's hospital transfer orders indicated Code Status: Full code. No evidence the facility provided education and discussed resuscitation changes from Full Code to DNR/DNI. No updated Advance Directive or DNR/DNI document was signed by R30 or R30's representative. R32's physician order states Code status: DNR/DNI, R32's medical record documents care conference with no change in code status, and no ave or DNR/DNI document signed by R32 or R32's representative. Findings include: Facility Policy titled, Advance Directives, states, in part: Definitions: b. Advance Directive-a written instruction, such as a living will or durable power of attorney (POA) for health care, recognizing by state law, relating to the provisions of health care when the individual is incapacitated. 1. Living Will. 2. A durable POA of healthcare, 3. Do Not Resuscitate (DNR)- indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used. 4. Do Not Hospitalize (DNH). Determining Existence of Advance Directive: 1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	representative, about the existence of any written advance directives. 3. Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advanced directive is provided in a manner that is easily understood by the resident or representative. If the resident does not have an Advance Directive: 1. If the resident or representative has not established advance directives, the facility staff will offer assistance in establishing advance directives. A. The resident or representative is given the option to accept or decline assistance, and care will not be contingent on either decision. B. Nursing staff will document in the medical record the order to assist and the resident's decision to accept or decline assistance. 2. Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff. 3. The attending physician provides information to the residents and legal representative regarding the residents' health status, treatment options and expected outcomes during the development of the initial comprehensive assessment and care plan. Example 1 R31 was admitted to the facility on [DATE]. R31's physician order, dated [DATE], noted code status of Do Not Resuscitate (DNR)/Do Not Intubate (DNI). Surveyor reviewed R31's Advanced Directive scanned on [DATE], dated [DATE], which did not include R31's wishes for resuscitation. No DNR/DNI form was signed by R31 or R31's representative. Surveyor reviewed R31's medical record and noted: -[DATE]: Social Service Assessment – under Finance/Legal section stated, 'DNR/DNI.' Of note: no documentation of provider documenting conversation of resuscitation wishes. On [DATE] at 9:08 AM, Surveyor interviewed R31's Family Member (FM) F and asked about R31's code status and if R31 was educated on risks and benefits of code status upon admission. FM F reported to Surveyor that FM F does not remember facility educating on advance directives and code status on admission. FM F reported facility should know R31's wishes. Surveyor reported to FM F upon review of advance directives it does not address code status. FM F reported to Surveyor FM F did not know code status was not on the advance directive, but the code status is in fact DNR/DNI. On [DATE] at 11:50 AM, Surveyor interviewed Registered Nurse (RN) D and asked if RN D processes new admissions. RN D reported to Surveyor they do assist with the admissions of new residents admitted to the facility. Surveyor asked RN D how they address code statuses with newly admitted residents. RN D reported they usually will review hospital discharge notes and use the order from the hospital for what the code status is while in hospital and then RN D places the order in the medical record. Surveyor asked RN D who discusses the risks and benefits of the residents' code status for being full code or DNR. RN D reported to Surveyor Social Services Aide C usually makes notes and educates on risks and benefits during the admission process. Surveyor asked RN D where this information is kept. RN D reported to Surveyor RN D is unsure but thinks it's in the medical record under advance directive tab in residents' scanned documents. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 2 R5 was admitted to the facility on [DATE]. R5's physician order, dated [DATE], noted code status of Do Not Resuscitate (DNR)/Do Not Intubate (DNI). Surveyor reviewed R5's Advanced Directive scanned on [DATE], dated [DATE], which did not include R5's wishes for resuscitation. No DNR/DNI form was signed by R5 or R5's representative. Surveyor reviewed R5's medical record and noted: -[DATE]: Social Service Assessment – under Finance/Legal section stated, 'DNR/DNI.' Of note: no documentation of provider documenting conversation of resuscitation wishes. On [DATE] at 11:50 AM, Surveyor interviewed Registered Nurse (RN) D and asked RN D to review R5's medical record and to look at advance directive together to see if it matches up with R5's code status. RN D reported that RN D does not do anything with the advance directive and with R5's admission, RN D just reviewed hospital discharge notes and noted R5 was a DNR/DNI status, so another RN placed the information in the medical record. RN D stated, I'm assuming it was from the form from the hospital discharge note as that is how we address code status from hospital admissions. Example 3 R9 was admitted to the facility on [DATE]. R9's physician order, dated [DATE], noted code status DNR/DNI. Surveyor was unable to locate any documentation of the facility or provider discussing Advanced Directive with R9. Surveyor reviewed R9's Advanced Directive scanned on [DATE], dated [DATE], which included R9's wishes for Full Code resuscitation (CPR). Surveyor reviewed R9's medical record and noted: -[DATE]: Social Service Assessment – under Finance/Legal section stated, 'DNR/DNI.' Of note: no documentation of provider documenting conversation of resuscitation wishes. On [DATE] at 8:23 AM, Surveyor interviewed Social Services Aide C and asked to explain process for new admissions into facility and address advance directives/code status for residents. Social Services Aide C reported to Surveyor they do not have anything to do with the code status of residents as Social Services Aide C is the assistant of Social Services. Social Services Aide C reported code statuses are addressed by Nurse Practitioners (NP) or Providers on all new admissions. Surveyor asked Social Services Aide C what time frame residents are seen by providers on admission. Social Services Aide C reported the NP or provider has up to 14 days to assess all new (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admissions and then they will review code status with residents at that point. Social Services Aide C reported to Surveyor they do not do anything with the code statuses and Surveyor would need to talk with nursing staff and providers. On [DATE] at 8:37 AM, Surveyor interviewed Director of Nursing (DON) B and asked process for residents newly admitted and addressing code status. DON B reported providers usually address all residents' code status upon admission. Surveyor asked DON B for the time frame for when provider visits new admissions in the facility to address code status. DON B reported provider has up to 14 days to see new admissions for assessments. DON B reported to Surveyor then the provider will address code status and write an order of DNR/DNI status, nursing changes in the medical record, and it is placed in the medical record via scanned in document. Surveyor asked DON B what the document looks like when scanned in. DON B reported the form is the advance directives scanned into resident documents and/or the provider will dictate a note explaining if the provider has addressed code status with set resident. Surveyor asked DON B what are the elements that make an Advance Directive. DON B reported to Surveyor the Advance Directive includes care planning for health care needs, code status that being DNR/DNI or Full Code, and Power of Attorney information. Surveyor asked DON B to review the medical records of R31, R5, R9, R7, R2, R59, R4, R30, and R32 and find the code status POST sheet scanned into their medical record for their current code status and advance directives. DON B could not find a POST form but stated, Maybe the provider documented a visit note explaining the code status. Surveyor asked DON B who reviews the provider's dictation from the initial admission visit. DON B reported RN G and RN D review and change code status of provider orders and admission assessments. Surveyor asked DON B if it was best practice for newly admitted residents to wait up to 14 days before code status is addressed. DON B reported expectation would be within 24 hours of being admitted the code status should be addressed. Surveyor asked DON B who is addressing residents' code status then until provider assesses residents about code status. DON B stated, That is a good question. DON B reported NP will assess residents' code status and dictate it to a note if code status was addressed. Surveyor asked DON B how a new nurse coming on shift to work knows the resident was educated about code status and risks/benefits were explained. DON B reported NP does this for newly admitted residents and is unsure if that is in paper form or just dictation note. Surveyor requested code status policy to review. DON B reported to Surveyor that they would gather code status policy. Surveyor asked DON B if the code status paperwork is supposed to be scanned into the medical record. DON B's expectation is code status be scanned into the medical record. DON B reported that Surveyor will need to request follow up documentation from Medical Records. On [DATE] at 8:52 AM, Surveyor interviewed Director of Medical Record E and requested any pertinent information in the medical records of R31, R5, R9, R7, R2, R59, R4, R30, and R32 that would show Surveyor code status was addressed with residents and their representatives. Surveyor provided Director of Medical Record E with a list of 15 residents' names and requested POLST information for all residents so Surveyor could understand how code status is being addressed. On [DATE] at 8:36 AM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked for expectation of advance directives and what the elements are in an advance directive. NHA A reported to Surveyor the expectations would be what DON B noted to Surveyor yesterday [DATE] but that code status is addressed at care conferences. Surveyor reported to NHA A, DON B's expectation that was explained would be code status is addressed in advance directives upon admission within 24 hours of being in the facility. NHA A reported to Surveyor code statuses should be addressed within 24 hours for new admissions and then staff can address quarterly at care conferences. Surveyor explained that R31, R5, R9, R7, R2, R59, R4, R30, and R32 were either missing advance directives, had (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conflicting code status that did not match advance directives, and/or advance directives that did not address code status at all. Surveyor reported to NHA A Surveyors could not find documentation of conversations and education relayed to R31, R5, R9, R7, R2, R59, R4, R30, and R32 regarding the code status in the medical record. NHA A reported to Surveyor NHA A will fix the code status and advance directive expectation in facility going forward. Example 4 R7 was admitted to the facility on [DATE]. R7's physician order, dated [DATE], noted code status of Do Not Resuscitate (DNR)/Do Not Intubate (DNI). Surveyor reviewed R7's Advanced Directive did not include R7's wishes for resuscitation. No DNR/DNI form was signed by R7 or R7's representative. Surveyor reviewed R7's medical record and noted: -[DATE]: Inquiry Report – under special needs section stated, 'Full Code.' -[DATE]: Resident Assessment – under Physical Condition section stated, 'Full Code.' Of note: no documentation of provider documenting conversation of resuscitation wishes changed from Full Code to DNR/DNI were noted. On [DATE] at 7:34 AM, Surveyor interviewed Registered Nurse (RN) D regarding Advanced Directives. Surveyor asked RN D where staff look to find a resident's code status. RN D stated the electronic medical record will have a banner at the top displaying the code status, the physician orders, and a copy of the Advanced Directive will be uploaded into the chart. Surveyor asked RN D if there was any other place staff would look to find the Advanced Directive. RN D stated a copy should also be in the paper chart for the resident. Surveyor asked if nursing ensures the Advanced Directive is in place for each resident. RN D stated, no, the Nursing Home Administrator (NHA) reviews each resident's code status weekly and updates the 'Full Code' list at the nursing station. Example 5 R2 was admitted to the facility on [DATE]. R2's physician order, dated [DATE], noted code status DNR/DNI. Surveyor reviewed R2's Advanced Directive did not include R2's wishes for resuscitation. No DNR/DNI form was signed by R2 or R2's representative. Example 6 R59 was admitted to the facility on [DATE]. R59's physician order, dated [DATE], noted code status DNR/DNI. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor was unable to locate any documentation of the facility or provider discussing Advanced Directive with R59. Surveyor reviewed 59's medical record and noted: -[DATE]: Inquiry Report – under special needs section stated, 'Full Code.' -Resident Assessment (with no date) – under Physical Condition section stated, 'Full Code.' Of note: no documentation of provider documenting conversation of resuscitation wishes changed from Full Code to DNR/DNI were noted. Example 7 R4 was admitted to the facility on [DATE]. Nurse Practitioner order dated [DATE] states, Change code status to DNR (do not resuscitate). Ok to hospitalize. Surveyor reviewed R4's electronic and paper medical record and noted: ~R4's electronic medical record indicates that R4's code status is DNR. ~Document titled Honoring Choices Wisconsin, dated and signed by R4 on [DATE] has checked the option I [R4] want CPR attempted unless my doctor determines: * I have a medical condition and no reasonable chance of survival of CPR, or * CPR would harm me more than help me. ~Document titled Statement of Incapacity, dated [DATE], does not address code status. Note: No evidence the facility provided education and discussed resuscitation changes from Full Code to DNR. No updated Advance Directive or DNR/DNI form was signed by R4 or R4's representative. Example 8 R30 was admitted to the facility on [DATE]. Physician orders dated [DATE] stated DNR/DNI (do not intubate), signed [DATE]. Surveyor reviewed R30's electronic and paper medical record and noted: ~Document titled Statement of Incapacity, dated [DATE], does not address Code status. ~R30's Hospital Transfer orders dated [DATE] indicated Code Status: Full code. Note: No evidence the facility provided education and discussed resuscitation changes from Full Code to DNR/DNI. No updated Advance Directive or DNR/DNI document was signed by R30 or R30's (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	representative. Example 9 R32 was admitted to the facility on [DATE]. R32's physician order, dated [DATE] states Code status: DNR/DNI. Surveyor reviewed R32's electronic and paper medical record and noted: ~Progress note dated [DATE] 10:41, states: Care Conference: Initial care conference was held today w/ family.No changes to code status. ~R32's electronic medical record indicates that R32's code status is DNR. Note: No Advance Directive or DNR/DNI document signed by R32 or R32's representative. On [DATE] at 9:10 AM, Surveyor interviewed CNA J who stated they cannot do CPR; CNA J does not know resident's code status. CNA J stated if there is an issue she radios for the nurse immediately. CNA J stated I think their code status is listed in their plans, but we can't do anything, so I've never really looked, I'm not sure. On [DATE] at 9:19 AM, Surveyor interviewed Licensed Practical Nurse (LPN) K who stated it says right by resident's name what code status they are, and we have a red sheet on the bulletin board that highlights those that are Full Codes. If a resident is not listed on the sheet, then they are a DNR. LPN K took Surveyor to the nurse's station and showed Surveyor the red sheet on the bulletin board. It was turned over, so names were not visible but said Code Status, and there were two listed for the special unit. LPN K stated there is one of these sheets on every unit and list all full code residents, so all nurses have access. Surveyor asked what role nurses play in setting up the Advance Directive. LPN K stated they were not sure how that all works. This is a social service thing. It is all legal stuff, if they can't do it then the county ends up taking over. On [DATE] at 1:02 PM, Surveyor interviewed DON B who stated they already gave the information to the Team Coordinator for R4, R6, R30 and R32. DON B stated they thought this was part of the admission process and is already putting plans in place to correct that. Surveyor informed DON B that R4, R30, and R32 are missing evidence of education and discussion related to going from full code to DNR and a resident or representative signed document of code status. DON B stated they would make sure it wasn't missed. On [DATE] at 1:53 PM, DON B stated there wasn't more information regarding Advance Directives.

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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 observation, interview, and record review, the facility did not provide pharmaceutical services, including procedures that ensure that accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident, for 1 of 1 resident (R32) reviewed. R32 did not receive prescribed eye drops per physician order. Findings include: The facility policies, titled Administering Medications and Instillation of Eye Drops, both dated 2001, do not address reordering of medication or what to do when medication is not available. Per CFR S483.70 (f) the facility must provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement as described. Per CFR S483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. R32 was admitted to the facility on [DATE] with a diagnosis of glaucoma. R32's Brief Interview of Mental Status (BIMS) of 04/15, dated 12/20/25, indicates that R32 is severely cognitively impaired. On 6/22/26 at 2:00 PM, Surveyor interviewed R32's Family Member (FM) R and asked if they were ever told why R32 is missing medications. FM R indicated they were told it was the pharmacy's fault but either way, sometimes R32 is without their medication over one week. R32's physician order states: Latanoprost drops; 0.005%; amt: 1 gtt both eyes; ophthalmic [Dx: Unspecified glaucoma] At bedtime; HS 1900-22:30. Start date: 12/12/2022- open ended. Per R32's electronic medication administration record (MAR),On 1/4/26, R32 did not receive eye drops. MAR documented Not Administered: Drug/Item Unavailable.On 2/12/26, R32 did not receive eye drops. MAR documented Not Administered: Drug/Item Unavailable.On 3/29/26, 3/30/26, and 3/31/26, R32 did not receive eye drops. MAR documented Not Administered: Drug/Item Unavailable.On 4/1/26, 4/2/26, 4/3/26, 4/4/26, 4/5/26, 4/6/26, and 4/7/26, R32 did not receive eye drops. MAR documented Not Administered: Drug/Item Unavailable.On 5/7/26, 5/9/26, 5/10/26, 5/11/26, 5/12/26, 5/15/26, 5/16/26, 5/17/26, 5/18/26, 5/19/26, 5/20/26, 5/21/26, 5/24/26, and 5/26/26, R32 did not receive eye drops. MAR documented Not Administered: Drug/Item Unavailable. On 6/23/26 at 5:18 PM, an email was sent from the facility's pharmacy to DON (Director of Nursing) B that states, in part Requested on 1/25/26. sent .1/25/25 for a 25-day supply.Requested on 2/5/26 but was refill to soon. 2/12/26 for a 25-day supply.We dispensed next 4/6/26. I do not see any refill request between 2/5 and 4/6. We sent a 25-day supply.Requested on 5/26/26 and we sent same day for a 25-day supply. Of note: This email from the facility pharmacy indicates there was no refill request from the facility between 2/5/26 and 4/6/26, indicating no order was present for the eye drops. On 6/23/26 at 4:35 PM, Surveyor interviewed Medical Assistant (MA) L regarding R32's eye drops having multiple missed administrations. MA L indicates staff had a hard time obtaining this medication. On 6/24/26 at 12:38 PM, Surveyor interviewed DON B regarding how the facility ensures medication is available to residents and refills are ordered. DON B indicated she believes Surveyor is asking about R32's eye drops. Surveyor noted to DON B there is a concern about R32's eye drops. DON B indicated she emailed the pharmacy yesterday. DON B indicated this has always been a concern for R32's family, even if it is only one day. Surveyor provided DON B with R32's MAR, the email of doses missed, when the medication was ordered, and the refill confirmations from the facility pharmacy. DON B indicated R32 has missed too many days of their medication. DON B also indicated Registered Nurse (RN) Q is very good about calling the pharmacy right away. Nurses are educated to keep calling to find out when the medication will be delivered. DON B indicated refills can be ordered by faxing, calling, or pushing a button in the electronic medical record. DON B indicated she will see if there is a report that can be run that shows evidence of the medication being ordered. On 6/24/26 at 1:53 PM, DON B brought medication related policies to Surveyor. DON B stated she was unable to print off a report (continued on next page)

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