STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525511	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheboygan Progressive Health Services	1902 Mead Ave Sheboygan, WI 53081

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility did not ensure their abuse policy was implemented for 1 (Registered Nurse (RN)-E) of 9 employees reviewed for caregiver background checks. The facility did not complete a thorough background check for RN-E. Findings include: The facility's Abuse, Neglect and Exploitation policy, revised 7/15/22, indicates: .Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property .Background, reference, and credentials checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. Background checks, including re-checks, will be completed consistent with applicable state law and regulation. Responsibility for performance of compliance checks on contracted temporary staff will be established via contractual agreement .Screenings may be conducted by the facility itself, a third-party agency, or academic institution .The facility will maintain documentation of proof that the screening occurred . On 6/16/26, Surveyor requested background check information, including Department of Justice (DOJ) and Governmental Findings reports for a sample of 9 staff. Surveyor reviewed background check information for RN-E who was hired by the facility on 6/24/25. Surveyor noted part of RN-E's background check was completed on 6/6/25, however, RN-E's DOJ and Governmental Findings reports were dated 6/16/26. On 6/16/26 at 3:32 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated they contacted the agency from which RN-E was hired, but the agency did not have DOJ or Governmental Findings reports for RN-E and stated RN-E's file had been deleted. NHA-A indicated the facility should have completed all background check and pre-employment screening prior to RN-E's employment and should retain copies of background check and pre-employment screening information for all employees.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 2 residents (R) (R1 and R2) of 7 sampled residents received care and treatment based upon comprehensive assessments and in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) after experiencing a change in condition.The day after an unwitnessed fall, R1 presented with a change of condition including increased pain, decreased appetite, reduced fluid intake, and decreased mobility. The facility did not ensure a nursing assessment was completed or notify R1's physician and Power of Attorney for Healthcare (POAHC) in a timely manner. R1's pain and decreased intake continued until they were transferred to the hospital 4 days after the fall. R1 was diagnosed with minimally displaced left lateral L2 and L3 transverse process fractures and a mild compression fracture of the T12 vertebral body. R1 was also diagnosed with sepsis secondary to urinary tract infection (UTI), toxic metabolic encephalopathy secondary to infection, concern for bilateral lobe infiltrates, acute kidney injury, cystitis, and severe protein-calorie malnutrition. R1 passed away at the hospital 13 days after the change of condition.R2 bumped their foot on a sit-to-stand lift and sustained a left great toe wound. Advance Practice Nurse Practitioner (APNP)-D ordered Betadine twice daily until healed and to monitor for signs and symptoms of infection. Staff did not consistently complete the Betadine treatment or monitor R2 for infection. The wound increased in size and R2's great toenail fell off. Betadine twice daily was ordered a second time but not consistentely completed by facility staff. Nineteen days later, R2 was admitted to the hospital with confusion, altered mental status, and an open wound on the left great toe. A magnetic resonance imaging (MRI) scan showed early osteomyelitis in the tip of the toe. R2 underwent a partial amputation of the left great toe. The facility's failure to address changes in condition by completing comprehensive nursing assessments, monitoring, providing treatment as ordered, and notifying the provider in a timely manner created a finding of immediate jeopardy that began on 5/2/26. Nursing Home Administrator (NHA)-A was informed of the immediate jeopardy on 6/16/26 at 5:20 PM. The immediate jeopardy was removed on 6/17/26, however, the deficient practice continues at a scope/severity level D (potential for harm/isolated) as the facility continues to implement its action plan. Findings include: The facility's Change in Condition of the Resident policy, dated 9/20/22, indicates the facility should immediately inform the resident, consult with the resident's physician, and notify the resident's representative when there is .a significant change in condition in the resident's physical, mental, or psychosocial status (that is, a deterioration in heath, mental, or psychosocial status in either life-threatening conditions or clinical complications) or a need to significantly alter treatment (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) .Immediate notification of the physician for any symptom, sign, or apparent discomfort that is .acute or sudden in onset, and a marked change in relation to usual symptoms and signs, or unrelieved by measures already prescribed requires a phone call to the provider. According to the Wisconsin Nurse Practice Act, N6.03(1): An RN (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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(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 LPNs (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. Example 1: R1 was admitted to the facility on [DATE] and had diagnoses including malignant lung cancer, dysphagia, anxiety, and difficulty walking. A Minimum Data Set (MDS) assessment, dated 2/16/26, stated R1's Brief Interview for Mental Status (BIMS) score was 11 out of 15, indicating moderate cognitive impairment. R1 had an activated POAHC (POAHC-C) to assist with healthcare decisions. A fall care plan, dated 2/11/26, indicated R1 was at risk for falls. A urinary incontinence care plan, dated 2/11/26, contained an intervention to report signs/symptoms of UTI such as flank pain and change in mental status. A risk for alteration in hydration care plan, dated 2/20/26, indicated R1 was at risk due to inadequate intake. The care plan contained an intervention to report changes related to signs of fluid deficit (dry skin and mucous membranes, cracked lips, poor skin turgor, thirst, fever, constipation, dizziness upon sitting/standing, confusion or change in mental status, decreased urinary output, abnormal labs, etc.) An MDS assessment, dated 5/5/26, indicated R1 was at risk for falls and had experienced 2 or more falls since admission. The assessment also indicted R1 was at risk for UTIs with frequent urinary incontinence. R1's medical record contained an order for oxycodone (an opioid medication) 5 milligrams (mg) every 6 hours as needed (PRN) for pain. On 6/15/26, Surveyor reviewed a grievance filed by POAHC-C on 5/5/26. The grievance stated the facility failed to recognize and notify the physician and POAHC-C of a change in condition for R1. The grievance indicated an investigation was initiated. On 6/15/26 at 10:36 AM, Surveyor interviewed POAHC-C who stated R1 fell on 5/1/26. POAHC-C stated they arrived at the facility on 5/5/26 after they were notified of R1's change in condition. POAHC-C stated R1 was in bed, was weak and lethargic, and POAHC-C had to wipe out R1's mouth which was full of junk. POAHC-C stated Director of Nursing (DON)-B acknowledged the facility failed to recognize the change in condition and update the physician and POAHC-C timely. DON-B indicated the facility woud do an investigation. POAHC-C indicated if the facility had updated them sooner, they would have asked that R1 be sent to the hospital since R1 had a history of mental status changes with UTIs. POAHC-C stated they did not receive information from the facility regarding the outcome of the investigation or corrective measures that were taken. POAHC-C stated R1 did not recover at the hospital and passed away on 5/15/26. A fall investigation, dated 5/5/26, indicated R1 had an unwitnessed fall in the bathroom at (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	approximately 1:40 PM while attempting to self-transfer from the toilet. A nursing assessment identified a 6.0 centimeter (cm) x 0.5 cm abrasion on the right scapula. R1 complained of back pain immediately following the fall and was assisted to bed via 2 staff and a Hoyer lift. R1's physician was notified at 2:04 PM. POAHC-C was notified at 2:03 PM. R1's Medication Administration Record (MAR) indicated they had a pain level of 5 out of 10 (with 10 being the worst pain) on 5/1/26 at 3:58 PM. Oxycodone was administered. A progress note, dated 5/1/26 at 5:31 PM, stated R1 reported oxycodone was ineffective; however, R1 was more relaxed and less vocal. Staff applied ice per R1's request. A progress note, dated 5/2/26 at 5:21 AM, stated R1 rested comfortably in bed during the shift and had no complaints of pain or discomfort. R1's MAR indicated they had a pain level of 7 out of 10 on 5/2/26 at 9:49 AM. Oxycodone was administered. A progress note at 10:10 AM indicated R1 seemed more relaxed. A progress note at 8:59 PM indicated R1 was alert but not talking, not eating, and not taking medication. Staff were unsure if this was R1's choice. R1 remained in bed but did not call out in pain when turned from side-to-side or boosted. R1's MAR indicated they had a pain level of 3 out of 10 on 5/3/27 at 11:47 AM. Oxycodone was administered. A progress note at 1:01 PM indicated R1 seemed more relaxed. A progress note at 9:01 PM indicated R1 complained of minimal pain. R1 had not urinated during the shift and accepted medication only when placed in their mouth. The note indicated R1 did not eat supper and may need to be fed. When staff attempted to obtain vital signs, R1 turned over and said leave me alone. A progress note, dated 5/4/26 at 9:51 AM, indicated R1 was sleeping and declined breakfast. A progress note at 1:59 PM indicated R1 declined to get up for a meal during the AM shift and was incontinent of a large amount of urine. A progress note at 9:14 PM indicated R1 remained in bed, refused to eat even after staff attempted to feed them, and hardly drank any water with medication. There were no signs of increased pain or discomfort to R1's back. A progress note, dated 5/5/26 at 12:43 AM, indicated R1 was resting comfortably in bed and had no complaints of pain or discomfort. A progress note at 2:40 PM indicated APNP-D was updated and ordered R1 be sent to the Emergency Department (ED). A progress note at 2:55 PM indicated R1 remained in bed, was quiet, and did not eat. R1 drank a bit of water and did not complain of pain when asked but was slow to respond. R1's skin was warm, dry, and pale. A progress note at 3:02 PM indicated POAHC-C was updated. On 6/15/26 at 1:16 PM, Surveyor interviewed APNP-D who confirmed staff updated them about R1's fall on 5/1/26. APNP-D indicated R1 was at baseline at the time. APNP-D stated staff did not provide additional updates until the afternoon of 5/5/26. APNP-D stated if staff had contacted them sooner, APNP-D would have sent R1 to the hospital sooner due to a critical status change. Surveyor reviewed statements from nursing staff who worked with R1 from 5/1/26 through 5/5/26. Of the 13 staff who provided statements, 10 staff indicated they were aware of R1's decreased intake, increased pain, and/or overall change in routine, abilities, and condition. A written statement by Licensed Practical Nurse (LPN)-F, dated 5/6/26, indicated LPN-F worked (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	with R1 on the 5/1/26, 5/2/26, 5/3/26, and 5/4/26 PM shifts. LPN-F was aware R1 was not getting out of bed or eating but questioned behavioral issues. LPN-F stated they told the Certified Nursing Assistants (CNAs) to assist R1 with eating, however, R1 refused. LPN-F also indicated R1 did not drink much water with medications. On 6/16/26 at 10:58 AM, Surveyor left a voicemail for LPN-F but did not receive a return call. A written statement by LPN-G, dated 5/6/26, indicated LPN-G worked with R1 at the time of the fall on 5/1/26 and again on 5/4/26. LPN-G stated the night nurse reported R1 had decreased output from 5/2/26 through 5/3/26, however, LPN-G noted R1 was incontinent of a large amount of urine on 5/3/26 into the morning of 5/4/26. LPN-G indicated during their shift on 5/4/26, R1 declined to get up for meals and had incontinent episodes. LPN-G indicated R1 did not complain of pain but was visibly agitated. On 6/16/26 at 9:36 AM, Surveyor left a voicemail for LPN-G but did not receive a return call. Surveyor reviewed R1's bowel and bladder elimination record for 5/1/26 through 5/5/26 and noted there was no urinary elimination recorded on all 5 days. On 6/16/26 at 9:40 AM, Surveyor interviewed NHA-A who stated R1's urinary output was not included in bowel and bladder elimination because R1 did not have a catheter and was incontinent of urine. Surveyor reviewed R1's fluid intake which indicated documentation is completed once per shift. R1's fluid intake for 2/11/26 through 4/30/26 indicated R1 refused fluids during 2 of 234 shifts and consumed less than 260 cubic centimeters (ccs) of fluid during 4 of 234 shifts. R1's fluid intake documentation for 5/1/26 through 5/5/26 (until R1 was transferred to the hospital) indicated: ~ 5/1/26: 360 ccs (AM shift); 360 ccs (PM shift); 240 ccs night (NOC) shift ~ 5/2/26: 0 ccs; R1 refused fluids on all three shifts. ~ 5/3/26: 200 ccs (AM shift); 240 ccs (PM shift); R1 refused fluids on the NOC shift. ~ 5/4/26: 300 ccs (AM shift); 320 CCs (PM shift); 200 ccs NOC shift ~ 5/5/26: 120 ccs (AM shift); R1 refused fluids on the PM shift. Surveyor reviewed R1's nutrition intake which indicated documentation is completed once per shift. R1's nutrition intake documentation for 2/11/26 through 4/30/26 indicated R1 refused meals on 14 of 234 shifts. R1's overall meal intake was greater than 25% for 226 of 234 shifts. R1's nutrition intake documentation for 5/1/26 through 5/5/26 (until R1 was transferred to the hospital) indicated: ~ 5/1/26: R1 consumed 76-100% for 2 of 3 meals. R1 refused dinner. ~ 5/2/26: R1 refused 2 of 3 meals. R1 consumed 0-25% of dinner. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~ 5/3/26: R1 consumed 0-25% of breakfast and 51-75% of lunch. R1 refused dinner. ~ 5/4/26: R1 consumed 0-25% of all three meals. ~ 5/5/26: R1 consumed 0-25% of breakfast. R1 refused lunch. R1's overal intake prior to 5/1/26 compared to after 5/1/26 revealed a decline in overall fluid and nutrition intake. A hospitalist note, dated 5/7/26, indicated R1 was diagnosed with sepsis secondary to UTI with known source, leukocytosis with white blood cell count 20,000, tachycardia with a heart rate of 114, UTI with hematuria and proteinuria, toxic metabolic encephalopathy secondary to infection, concern for bilateral lobe infiltrates, acute kidney injury, and severe protein-calorie malnutrition with low albumin. R1 was started on intravenous (IV) antibiotics. A hospitalist note, dated 5/12/26, indicated R1 was transitioned to Hospice care. R1 passed away on 5/15/26. R1's death certificate indicated the cause of death was urosepsis and acute cystitis. The facility's failure to identify a significant change in condition, complete ongoing assessments, and notify the provider and POAHC in a timely manner created a reasonable likelihood for serious harm thus leading to a finding of Immediate Jeopardy. On 6/16/26 at 9:40 AM, Surveyor interviewed NHA-A who provided documentation and indicated the facility completed a past non-compliance (PNC). NHA-A indicated the facility was aware of the non-compliance related to staff identifying R1's significant change in condition and timely notifying R1's physician and POAHC-C. On 6/16/26, Surveyor reviewed the facility's PNC documentation which included a Critical Event Analysis and Action Plan Worksheet, dated 5/7/26. The worksheet indicated the facility became aware of the non-compliance on 5/5/26. Systemic measures taken to prevent recurrence included re-education of nurses on proper notification of healthcare providers and resident representatives on changes in condition. The worksheet indicated audits would be completed weekly for 4 weeks on residents with changes in condition to ensure proper notification and assessments are completed. Training Log/In-Service sheets attached to the worksheet contained training dates of 4/30/26 which was 2 days prior to the onset of R1's change in condition. The list of trainings included 4 topics, including notification on change of condition. Surveyor noted 20 staff signatures were dated prior to 5/5/26 which indicated the training was provided prior to the facility identifying the non-compliance on 5/5/26. On 6/16/26 at 2:40 PM, Surveyor interviewed [NAME] President of Success (VPS)-H, NHA-A and DON-B about the education. NHA-A stated the facility educated staff on an unrelated topic and added the education about change of condition to the training. On 6/16/26 at 3:37 PM, Surveyor again interviewed NHA-A. Surveyor asked when the change of condition training was added and when staff received the education. NHA-A stated they were not certain. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility removed the jeopardy on 6/17/26, however, the deficient practice continues at a scope/severity level D (potential for harm/isolated) as the facility contiues to implement the following action plan as well as the action plan for Example 2: 1. Completed a review of residents who had a change of condition within the last 30 days to ensure notifiications were made in a timely manner. 2. Provided staff education on the facility's change in condition policy, including assessing/evaluating the resident and timely provider notification. Initiated re-education of the E-Interact change in condition tool of when to report to the MD/NP/PA. A print out of the tool was placed at each nursing station for staff reference. 3. Held an ad-hoc QAPI meeting to discuss survey findings and removal plan. Reviewed the facility's change in condition policy with the Medical Director to ensure the policy meets current standards of practice. 4. Initiated change in condition audits that include reviewing progress notes, validating completion of assessments, and notification of the MD. Audits will be completed daily for 7 days and then continue with weekday morning clinical meetings for 8 weeks. Example 2: The facility's Skin Integrity/Foot Care Policy, dated 12/15/23, indicates the facility will ensure residents receive proper treatment and care to maintain good foot health and maintain skin integrity of the foot .referrals to podiatrists or wound care physicians will be made when appropriate .RNs and LPNs will participate in the management of medical conditions by following physician orders, assessment/observation of residents, and reporting changes in condition to the resident's physician. R2 was admitted to the facility on [DATE] and had diagnoses including dementia, diabetes, chronic kidney disease, and congestive heart failure with lower extremity edema. An MDS assessment, dated 5/1/26, stated R2's BIMS score was 7 out of 15, indicating severe cognitive impairment. R2 had an activated POAHC (POAHC-M) and discharged from the facility on 5/25/26. A comprehensive care plan, revised 5/5/26, indicated R2 had an open area on the left great toe. The care plan contained interventions to administer treatment per MD orders and for podiatric care as needed. R2's care plan also had an endocrine focus area related to diabetes with interventions to inspect feet daily for open areas, sores, edema, or redness and to administer all medications/treatments per MD order. A progress note, dated 5/6/26 at 9:06 PM, indicated R2 had a bruise on the left great toe that measured 0.6 cm x 1.2 cm with a loosened toenail, erythema (redness) but blanchable, and scant blood. The injury was noted by an RN during bedtime cares. R2 indicated they bumped their toe on the sit-to-stand machine that morning. Betadine was applied to the site. The physician and POAHC-M were notified. R2's care plan was updated to ensure R2 wore proper footwear during transfers. A fax from APNP-D on 5/6/26 contained an order to apply Betadine twice daily until healed and monitor for signs/symptoms of infection. (Of note: The order was not transcribed in R2's medical record and was not on R2's Treatment Administration Record (TAR).) A progress note, dated 5/7/26 at 2:30 AM, indicated R2 had a bruise on the left great toe and the nail (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The wound bed was 40% slough and 60% granulation. No measurements were available.) An X-ray report, dated 5/25/26 at 2:29 AM, revealed soft tissue swelling on the left distal first digit (toe). An MRI report, dated 5/26/26 at 1:13 PM, indicated a concern for early osteomyelitis on the distal tuft of the first distal phalanx (toe). A surgical report, dated 5/29/26 at 1:10 PM, indicated R2 was diagnosed with gangrene with osteomyelitis of the left hallux (big toe). The digit was disarticulated (amputated) at the interphalangeal joint without incident. A portion of necrotic soft tissue was sent to microbiology for culture and sensitivities. Wound culture results, dated 5/29/26 at 1:28 PM, indicated many staphylococcus lugdunensis, corynebacterium striatum, and rare staphylococcus coagulase negative. On 6/16/26 at 3:14 PM, Surveyor interviewed DON-B who stated they were not informed wound care for R2's left toe was done incorrectly or not at all. DON-B was not sure when R2's toenail fell off but thought it was between 5/7/26 and 5/18/26 based on the limited documentation and was not sure if the physician was notified of the change in wound status. The failure to provide treatment in accordance with physician orders and failure to update the physician of a change in condition of a wound led to serious harm for R2 which created a finding of Immediate Jeopardy. The facility removed the jeopardy on 6/17/26, however, the deficient practice continues at a scope/severity level D (potential for harm/isolated) as the facility continues to implement the following following action plan as well as the action plan for Example 1: 1. Completed a skin sweep of all residents to identify any skin concerns. Assessments were completed for residents identified with skin impairments. Treatment orders and physician notification were reviewed. 2. Iniitiated re-education on the facility's pressure injuries and non-pressure injuries policy, including appropriately monitoring and assessing wounds and following treatment orders as indicated. Initiated re-education for nursing staff on accurately transcribing provider orders and using a double-check system requiring two nurses to validate transcribed orders. 3. Held an ad-hoc QAPI meeting to discuss survey findings and a removal plan. Reviewed the facility's pressure injuries and non-pressure injuries policy and change in condition policy with the Medical Director to ensure the policies meet current standards of practice. 4. Initiated weekly audits of newly identified and existing wounds to ensure assessments are completed thoroughly per policy and there is documentation of MD notification. Dressing change competencies will be initiated with licensed nurses at least 5 times per week for 3 weeks until completed. Weekly audits of no less than 5 new or changed orders will be completed to ensure the double check process is followed and orders are transcribed appropriately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525511	A. Building B. Wing	06/23/2026

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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 - 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 assistive devices to prevent accidents were implemented for 1 resident (R) (R1) of 3 residents from a total sample of 9 residents. R1 had an unwitnessed fall while self-transferring from wheelchair to toilet. Staff did not ensure R1's chair alarm was in place prior to the fall. R1 was transferred to the hospital and diagnosed with minimally displaced left lateral L2 and L3 (lumbar spine/lower back) transverse process fractures and a mild compression fracture of the T12 vertebral body (junction between the mid and lower back).Findings include:The facility's Fall Prevention and Management Guidelines policy, dated 7/18/24, indicates each resident will be assessed for fall risk and will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls or reduce the possibility/severity of injury.R1 was admitted to the facility on [DATE] and had diagnoses including malignant lung and brain cancer and difficulty walking. R1's Comprehensive Minimum Data Set (MDS) assessment, dated 2/16/26, stated R1's Brief Interview for Mental Status (BIMS) score was 11 out of 15, indicating moderate cognitive impairment. An admission Evaluation, dated 2/11/26, indicated R1 was at risk for falls. A fall care plan was initiated. The care plan contained an intervention, dated 4/14/26, for a chair alarm in wheelchair to be changed between surfaces. A fall incident report, dated 5/1/26, indicated R1 had an unwitnessed fall in the bathroom at approximately 1:40 PM while attempting to self-transfer from toilet to wheelchair. A nursing assessment identified a 6.0 centimeter (cm) x 0.5 cm abrasion on the right scapula. R1 complained of back pain immediately following the fall and was assisted to bed via 2 staff and a Hoyer lift. R1's physician and Power of Attorney for Healthcare (POAHC) were notified. A post fall assessment, dated 5/1/26, indicated R1's chair alarm was not in place. An immediate intervention indicated staff would be educated to transfer R1's bed alarm to the wheelchair. The assessment indicated education was provided to the Certified Nursing Assistant (CNA) (CNA-K) on 5/1/26 at 1:50 PM. On 6/16/26, Surveyor reviewed the nursing schedule for 5/1/26 which indicated Licensed Practical Nurse (LPN)-G and CNA-K were assigned to R1's unit at the time of the fall. On 6/16/26 at 10:43 AM, Surveyor interviewed CNA-K who stated they heard yelling after lunch on 5/1/26 and and went to check on R1. CNA-K and LPN-G found R1 on the floor in the bathroom. CNA-K stated R1 had attempted to self-transfer to the toilet and fell. CNA-K and LPN-G assisted R1 from bed to wheelchair earlier in the day and assisted R1 with toileting prior to lunch. CNA-K acknowledged that when assisting R1 from bed to wheelchair earlier in the day, CNA-K noticed R1 had a bed alarm and wondered if they also had a chair alarm. CNA-K did not see a chair alarm listed on R1's care plan. CNA-K confirmed they did not transfer the alarm to R1's wheelchair and the alarm was not on the wheelchair when they fell. CNA-K confirmed they were educated about ensuring the alarm is transferred from bed to chair. CNA-K stated when they next worked with R1 on 5/4/26, they noticed R1 was moving slower and did not get out of bed. CNA-K stated R1 was transferred to the hospital the following day. On 6/16/26 at 9:36 AM, Surveyor left a message for LPN-G. A return call was not received.A change in condition summary, dated 5/5/26, indicated R1 had altered consciousness, decreased mobility following the fall, a resting pulse of greater than 100, and indicators of pain. The physician was updated and ordered R1 be sent to the hospital for evaluation. A computed tomography (CT) scan of R1's lumbar spine on 5/5/26 revealed minimally displaced left lateral L2 and L3 (lumbar spine/lower back) transverse process fractures and a mild compression fracture of the T12 vertebral body (junction between the mid and lower back) with minimal height loss and no retropulsion (an involuntary tendency to lean or walk backward).Nursing Home Administrator (NHA)-A added an Interdisciplinary Team (IDT) note to R1's fall report on 5/5/26 that indicated R1 had a sensor pad in bed which was not moved to the wheelchair. Reeducation for direct care staff to ensure alarms are properly placed was initiated. On 6/16/26 at 2:40 PM, Surveyor interviewed NHA-A, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Director of Nursing (DON)-B, and [NAME] President of Success (VPS)-H. When asked about the chair alarm, DON-B and VPS-H indicated R1 most likely self-transferred from bed to chair which is why the alarm was not transferred. When Surveyor stated CNA-K said they transferred R1 from bed to chair but did not transfer the alarm, VPS-H stated even if the chair alarm was in place, it would not have changed the outcome and would only have notified staff that R1 was out of the chair. DON-B stated education was completed with all nursing staff to ensure alarms are transferred between surfaces. When Surveyor asked what prompted the education if management was not aware staff did not transfer the alarm, VPS-H, NHA-A, and DON-B could not recall. NHA-A stated they spoke with CNA-K via phone but did not record their statement or that NHA-A had done one-on-one education with them at that time. NHA-A and DON-B confirmed staff were not educated on following residents' care plans and other residents were not interviewed to ensure there were no other concerns with following care plans. On 6/16/26 at 3:14 PM, DON-B provided Surveyor with chair alarm education sign-in sheets and stated education was completed with all nursing staff. Surveyor reviewed the sign-in sheets which included CNA-K's signature dated 5/22/26.