STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525519	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Care Age	1755 N. Barker Rd. Brookfield, WI 53045

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that all residents are clinically appropriate to self-administer medications for 2 of 2 sampled residents (R36, 31) and 1 of 1 supplemental resident's (R24) reviewed for self- administration of medications. R36 was observed to have a cup of medications left on his bedside table for him to take independently. R36 does not have an assessment for self-administration of medications indicating that he is safe to administer medications independently. R31 had containers of medication at bedside and had scheduled medications left on her bedside table for longer than 1 hour. R31's self-administration assessment only allows Lactaid at bedside and requires nurses to follow up with R31 after 1 hour. R24 had an inhaler at his bedside. R24 does not have an assessment for self-administration of medications indicating that he is safe to administer medications independently. Evidenced by: The facility's policy titled Resident Self- Administration of Medication dated 5/28/25 states in part, .3. When determining if self- administration is clinically appropriate for a resident, the interdisciplinary team should, at a minimum consider the following: a. The medications appropriate and safe for self- administration; b. The resident's physical capacity to open medication bottles, administer injections. c. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for. d. The resident's capability to follow directions and tell time to know when medications need to be taken. e. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff . Example 1 R36 was admitted to the facility on [DATE] with diagnoses that include generalized anxiety disorder, polyosteoarthritis (a diagnosis that indicates that arthritis is present in 5 or more joints simultaneously), and congestive heart failure (the heart cannot pump enough blood to meet the body's needs). R36's most recent Minimum Data Set (MDS) dated [DATE] states that R36 has a Brief Interview of Mental Status (BIMS) of 14 out of 15, indicating that R36 is cognitively intact. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/9/25 at 10:45 AM, Surveyor interviewed R36. Surveyor noted that there was a medication cup with medications in it, sitting on R36's bedside table. Surveyor asked R36 if those were his morning medications, R36 stated yes, and reported to Surveyor that he always takes them. Surveyor reviewed R36's physician's orders. There was no order for R36 to self- administer medications. Surveyor reviewed R36's care plan. There was no care plan for self- administration of medications. Surveyor reviewed R36's assessments. There was no assessment completed indicating that R36 was safe to self- administer medications. On 6/10/25 at 2:29 PM, Surveyor interviewed LPN F (Licensed Practical Nurse). Surveyor asked LPN F if she had administered R36's morning medications on 6/9/25, LPN F stated yes. Surveyor asked LPN F if R36 is able to take medications independently, LPN F stated yes. Surveyor asked LPN F if R36 has an order to self- administer medications, LPN F stated no. Surveyor asked LPN F if R36 has a completed self-administration assessment, LPN F stated that she was not sure. On 6/11/25 at 11:23 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what the facility's process is for determining that a resident is safe to self- administer medications, DON B reported that they would complete an assessment and based on the results of the assessment, they would get an order for the resident to self- administer medications. Surveyor asked DON B if R36 has an assessment to self- administer medication, DON B stated that R36 has never indicated that he was interested in self-administration, so there is not an assessment. Surveyor shared observation with DON B. Surveyor asked DON B if R36 should have an assessment and a physician's order to self- administer medications if the nurses are going to leave the medications in the room, DON B stated yes. Example 2 R31's self-administration assessment dated [DATE] includes the following: Lactaid at bedside with resident. All other meds must be administered by nurse but may be left at bedside for up to 1 hour. 1. The resident can correctly read label and/or identify each medication. Requires assistance. 2. The resident can correctly state what each medication is for. Requires assistance. 3. The resident can correctly state the time/frequency medications are to be taken. Requires assistance. 4. The resident can correctly state the correct dosage/quantity for each administration. Requires assistance. 6. The resident can appropriately document self-administration of the medications listed. Requires assistance. 7. The resident can demonstrate secure storage of medications kept in room. Requires assistance. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11. The resident can correctly administer eye drops or eye ointments correctly. Not Applicable. C. Approvals IDTC (Interdisciplinary Team) 1a. IDTC Review Summary: Medications will be administered by Nurse but may be left at bedside for up to 1 hour. 1b. IDTC fees resident is safe to self-administer listed medications? No. R31's physician orders, printed 6/11/25, include: NURSE to administer all meds to resident - can leave at bedside for up to 1 hour after dispensing but must follow up and document. On 6/9/25 at 3:00 PM, Surveyor observed containers of Lactaid, artificial tears, Imodium and Tums in a basket on R31's bedside table. On 6/10/25 at 11:51 AM, Surveyor entered R31's room. CNA Z (Certified Nursing Assistant) was finishing getting R31 up for the day. Prior to CNA Z leaving the room, CNA Z reminded R31 to take her medications. Surveyor observed 3 pills on R31's bedside table and a pill on R31's floor. On 6/10/25 at 12:10 PM, Surveyor interviewed LPN F (Licensed Practical Nurse) regarding R31's medications. LPN F indicated she had given R31 her morning medication between 9:45 - 10:00 AM. LPN F indicated R31 had taken all her medication at that time. LPN F indicated R31 may have medications at bedside for up to 1 hour. LPN F picked up the pill off the floor and removed the pills from R31's bedside table. LPN F indicated those medications were left from the evening shift yesterday. LPN F removed the Imodium and Tums from R31's room and informed R31 that DON B (Director of Nursing) would come talk with R31 regarding the medications. On 6/10/25 at 12:10 PM, Surveyor interviewed R31 regarding her medications. R31 indicated the medications were from last night. R31 indicated she was too tired and forgot to take them. On 6/11/25 at 1:47 PM, Surveyor was walking past R31's room. R31's door was open. Surveyor observed R31 was not in her room. Surveyor observed 8 pills in a medication cup on R31's lunch tray. On 6/11/25 at 1:52 PM, Surveyor interviewed LPN J regarding noon medication pass. LPN J indicated the noon medication pass takes about 30 minutes. LPN J indicated she completed her noon medication pass before 1:00 PM. LPN J indicated R31 is allowed to have her medications at bedside after administration for up to 1 hour then the nurse must ensure R31 took her medications. On 6/11/25 at 2:06 PM, Surveyor observed R31 coming down the hallway. R31 indicated she had been in the rehabilitation room to meet with visitors. R31 indicated she left her room at 1:00 PM. On 6/11/25 at 2:36 PM, Surveyor observed R31 had taken her noon medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 8:44 AM, Surveyor interviewed DON B (Director of Nursing) regarding R31's medications. DON B indicated R31 was assessed to have medications left at bedside for up to 1 hour and the nurses must follow up with R31 to ensure the medications were taken. DON B indicated the artificial tears, Imodium, and Tums should not be at R31's bedside and the nurse should have followed up within an hour to ensure R31 took her medications but did not. Example 3 On 6/9/25 at 10:30 AM, Surveyor observed R24's room. R24 had a Combivent inhaler on his bedside table. On 6/11/25 at 2:17 PM, Surveyor observed R24's room. R24 had a Combivent inhaler on the stand next to his bed. On 6/11/25 at 1:52 PM, Surveyor interviewed LPN J regarding self-administration of medications. LPN J indicated R24 was not assessed to safely self-administer medications. On 6/10/25 at 2:47 PM, Surveyor interviewed DON B (Director of Nursing) regarding R24's self-administration of medication assessment. DON B indicated R24 does not have a self-administration of medication assessment. DON B indicated medications should not be left at their bedside if a resident is not assessed to be safe to take medications independently.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure that a comprehensive person-centered care plan included a sleep assessment and sleep tracking for 3 of 5 residents (R6, R18, and R43) reviewed for unnecessary medications. R6 is prescribed melatonin and does not have a sleep assessment or sleep tracking. R18 is prescribed melatonin and does not have a sleep assessment or sleep tracking. R43 is prescribed melatonin and does not have a sleep assessment or sleep tracking. This is evidenced by: The facility's policy titled Use of Psychotropic Medication(s), dated 5/28/25, includes: Adequate indications for use refers to the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and after any other treatments have been deemed clinically contraindicated. 5. The indications for initiating, maintaining, or discontinuing medications(s), [sic] as well as the use of non-pharmacological approaches, will be determined by evaluating the resident's physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment. 7. The resident's medical record shall include documentation of this evaluation and the rationale for chosen treatment options. 15. The resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the residence medical record. Example 1 R6's physician orders, printed on 6/12/25, include melatonin 3 mg at bedtime for difficulty sleeping. R6 does not have a sleep assessment completed. R6 does not have sleep monitoring documented. Example 2 R18's physician orders, printed on 6/12/25, include melatonin 3 mg at bedtime for sleep hygiene. R18 does not have a sleep assessment completed. R18 does not have sleep monitoring documented. Example 3 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R43's physician orders, printed on 6/12/25, include melatonin 3 mg at bedtime for insomnia. R43 does not have a sleep assessment completed. R43 does not have sleep monitoring documented. On 6/11/25 at 4:27 PM, Surveyor interviewed DON B (Director of Nursing) regarding sleep assessment and sleep monitoring for residents taking a sleep aid. DON B indicated the facility does not complete sleep assessments and sleep monitoring as part of their routine practice for sleep aids. DON B indicated R6, R18, and R43 do not have sleep assessments or sleep monitoring.

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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 did not ensure each resident receives the necessary care and services in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) after experiencing a change of condition for 1 of 11 residents reviewed (R20). R20 had an unintended sudden change of plane while being transferred by a sit to stand lift by a lone Certified Nursing Assistant (CNA). While in the lift sling, the lift's battery died, and resident ended up in a squatting position with her buttocks touching the foot pads of the lift. This sudden change of plane resulted in a hip fracture. Staff did not follow R20's plan of care which included using 2 staff for transfers with a sit to stand lift, and staff moved resident twice without a Registered Nurse (RN) assessment after the change of plane. The facility failed to report R20 having a change of plane to the oncoming shift, failed to give details regarding R20's incident to R20's provider delaying medical treatment, failed to complete a thorough assessment including vital signs at the time of the incident, failed to provide continued monitoring with change in condition including completion of a thorough RN assessment when R20 reported 8 out of 10 pain and 9 out of 10 pain, failed to complete an RN assessment when CNA K reported changes to the appearance of R20's leg and that something was wrong, and failed to document known changes in condition in R20's medical record, including internal rotation of lower right extremity. The facility's failure to ensure each resident received the necessary care and services in accordance with professional standards of practice after experiencing a change of condition led to a finding of immediate jeopardy that began on [DATE]. Surveyor notified NHA A (Nursing Home Administrator) and DON B (Director of Nursing) of the immediate jeopardy on [DATE] at 11:35 AM. The immediate jeopardy was removed on [DATE]; however, the deficient practice continues at a severity/scope of D (potential for no more than minimal harm/isolated) as the facility continues to implement its action plan. Evidenced by: Facility policy, titled Notification of Changes, implemented [DATE], includes: The purpose of this policy is to ensure the facility promptly informs resident, consults with the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification . Definitions . Need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences (such as adverse drug reaction), or commence a new form of treatment to deal with a problem; for example the use of any medical procedure, or therapy that has not been used on that resident before . Clinical complications: examples- development of stage 2 pressure injury, recurrent episodes of delirium, recurrent UTIs or onset of depression . Guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Accidents- Resulting in injury. Potential to require physician intervention. Significant change in the resident's physical, mental, or psychosocial condition such as deterioration. This may include: Life threatening conditions, or Clinical complications. Circumstances that require a need to alter treatment. This may include: New treatment. Discontinuation of current treatment due to: adverse consequences, acute condition, exacerbation of a chronic condition . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An article from the Nation Library of Medicine, titled, Risk Factors for Preoperative Deep Venous Thrombosis in hip fracture patients: a meta-analysis, by J Orthop Traumatol. 2022, includes: . Hip fracture (HF), including intertrochanteric fracture, femur neck fracture, and subtrochanteric fracture, as one of the most geriatric fractures associated with osteoporosis, is expected to affect about 6 million people by the year 2050 worldwide. Previous studies have demonstrated a close relationship between geriatric hip fractures and perioperative morbidity and mortality at 1 year. The treatment of geriatric hip fracture patients is a great challenge due to multiple medical comorbidities and serious perioperative complications. Obtaining stable reduction and fixation to permit early mobilization is critical to decreasing the development of perioperative complications. Early surgery is thought to be the best option for HF patients to reduce the risk of perioperative complications and death . Preoperative DVT, which affects 8-34.9% of hip fracture patients and may be as high as 62% in those with delayed operations, plays a critical role in HF patients' preoperative waiting time. [NAME] reported that delayed surgery, hypoproteinemia, three or more comorbidities, and a d-dimer level?>?1.59 mg/l were predictors of preoperative DVT . Preoperative DVT is one of the most common complications after hip fractures because of immobilization and medical problems of patients. Early prevention of preoperative DVT was beneficial in shortening the time from injury to surgery and lowering the incidence of postoperative complications. Medical problems and prolonged time from injury to admission have recently been linked to an increased risk of preoperative DVT . Patients over the age of 90 had a significantly higher rate of preoperative DVT than any other age group, which was linked to a prothrombotic state and decreased vascular function due to aging . In the present study, the mean time from injury to admission and surgery was significantly longer in the DVT group than in the non-DVT group. Three possible reasons may explain this. First, prolonged immobilization could result in venous congestion; second, vascular injury caused by fracture activated the coagulation system; third, the fracture was frequently coupled with dominant and hidden blood loss, especially hidden blood loss for intertrochanteric fractures. Therefore, earlier admission was necessary for intertrochanteric fractures . 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R20 admitted to the facility on [DATE]. Her diagnoses include rheumatoid arthritis, atrial fibrillation, atherosclerotic heart disease, joint disorder, history of falling, weakness, hypertension, sensorineural hearing loss bilaterally, pulmonary hypertension, and age-related osteoporosis. R20's Minimum Data Set (MDS), with Assessment Reference Date (ARD) of [DATE], indicates R20 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15. R20's Comprehensive Care Plan, initiated on [DATE], indicates R20 required assistance of 1 for the following: dressing, bathing, bed mobility, and assist of 2 with sit to stand lift for transfers and needs one staff member to propel her in the wheelchair for long distances. R20's Comprehensive Care Plan indicates R20's medications are administered by the nurse. Facility Self Report, dated [DATE], includes: Investigation Summary: . On [DATE], R20 put on her call light because she wanted to be toileted. The assigned CNA (Certified Nursing Assistant) . was in the lunchroom, and CNA L was covering the floor. CNA L transferred R20 with sit to stand lift and took her to the toilet. Shortly thereafter, R20 put on the call light to get off the toilet and go back to bed. CNA L once again used the sit to stand lift without assistance of another staff member and upon raising her up the battery died. R20 was complaining that under her arms (where sling was) was hurting her, so CNA L used the emergency button to lower the lift arm. Apparently, that did not lower initially so CNA L tried to start pushing lift toward R20's bed and after going from the tile bathroom floor to the carpeted bedroom, the lift started to lower with resident still in sling. As the lift arm lowered the resident ended up in a squatting position with her buttocks touching the foot pad of the lift. CNA L decided to try to help the resident by pushing her buttocks and got her high enough to sit in her wheelchair. Shortly after that, CNA M arrived at the unit. CNA L told her she needed help with the transfer from the wheelchair to the bed. After the resident was settled, CNA L told the nurse that the resident was complaining of pain in her leg and that during the transfer with the sit to stand the battery died. She did not mention that this transfer was completed by only herself. LPN G (Licensed Practical Nurse) asked CNA L to write a statement and then she was going to see the resident. CNA L wrote an initial statement on [DATE] that was left for the nurse and not read until after end of day shift. CNA L statement left at nurse station, includes: [DATE] While transfer with the sit to stand. The sit to stand went dead in mid-air. She complained about her arms hurts [sic] so did the force thing to force the sit stand while that was going. [sic] It end sitting her down on the floor. I held her back with my legs so she wouldn't fall back. With her help I was able to get her back in her chair. Then a new sit to stand was used to get her in bed. Nurse was told. Statement was wrote [sic]. UM/RN Q (Unit Manager/Registered Nurse) statement, dated [DATE], includes: R20 had complained of right knee pain after being in the sit to stand. Resident was assessed in bed. Pain to right knee was stated at a 4 out of 10. Floor nurse gave scheduled Tylenol for pain. Resident's right knee was parallel to left knee. Right leg did not have internal rotation when assessed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA L second statement, dated [DATE], includes: I answered R20's call light. She was in the bathroom, [sic] as I am lift her up with sit to stand, she complains of pain in her arm pits as I go to lower her the machine died in mid-air, so I press the release button so it can be lower. [sic] wasn't aware that it was going so I tried to get her to her bed as quick as possible but on the way, she had been lower to the ground, so I made sure she didn't hit head and made sure she was sitting upright. With her help, I was able to get her off the floor into her wheelchair, then I use a charged sit to stand to put her in her bed. (Handwritten on the interview is a statement that states per interview did a squat on lift and was able to push up enough to get into wheelchair.) DON B (Director of Nursing) statement, dated [DATE], includes: On [DATE] at around 2:30 PM LPN G reported to me that R20 said she had an issue with an earlier transfer in the sit to stand lift and that her leg was sore. I instructed her to get Unit Manager/RN Q and look at R20 and prepare an incident report. LPN G did complete incident report as other incident. On [DATE] R20 was seen by Nurse Practitioner (NP O and NP P) and she noted there was a leg discrepancy and ordered an x-ray. R20 also had denied any fall at that time and told NP O that she thought it was from being up in the sit to stand too long. I was made aware of the possible change just around 9:00 AM. CNA L was in the facility with a resident . completing one-on-one observation. Around 10:30 AM, I interviewed CNA L and had her complete a new written statement. During that interview I found out that the sit to stand transfer was not completed per policy initially and that only CNA L was in the room. CNA L witnessed the issue with the lift and resident. I felt at that point that the potential injury could be the result of a witnessed fall due to change of plane for the resident. I then went into risk management and changed the reason for the incident report from other to witnessed fall and completed the corresponding assessments for the incident. At about 1:00 PM, the X-ray did reveal a fracture of the right hip, and the resident was being transferred to the emergency room for evaluation. The incident was then reported to the state as an injury of unknown origin because I could not definitively determine cause and investigation was initiated. Facility 24 Hour Communication Board, dated [DATE], includes: R20- Day shift- right knee pain, up long in sit to stand, complained of right knee/leg pain . PM shift- extra strength Tylenol as needed given for 9 out of 10 pain, new order for Flexeril 10mg (milligrams) 1 dose . (It is important to note there is no mention of R20 sitting down on the floor during a sit to stand transfer.) R20 Nurse Notes, Medication Administration Record (MAR), and text messages exchanges with R20's provider include: Nurse Note, Late entry added on [DATE] for [DATE] at 2:00 PM . Writer was notified by LPN G that resident had complaints of pain to her right knee after being in the sit to stand too long. Writer assessed the resident. Right knee appeared equal to left knee. No rotation, redness, or swelling noted. Resident stated she has arthritis in that knee and has pain from time to time. Had pain 4 out of 10 at that time. (It is important to note this is the documentation in R20's medical record of an assessment being completed, but this note was not added to R20's medical record until [DATE], 9 days later. It is also important to note there is no evidence in R20's medical record of vital signs being gathered, including heart rate, blood pressure, or respirations per minute.) (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Text message, date and time unknown, from facility to provider, includes: resident complained of knee and leg pain after being in sit to stand too long. No injury noted. Will continue to monitor for pain and update with any changes. (It is important to note the facility did not report R20's change of plane, fall, or sudden drop from lift to R20's medical doctor.) Text message dated [DATE] at 2:59 PM, from provider to facility, includes: noted no new orders. Thank you. MAR Note dated [DATE] at 7:33 PM Tylenol Extra Strength Tablet 500 MG. Give 1000 mg by mouth as needed for pain every evening. Text message dated [DATE] at 8:04 PM, from facility to provider, included: R20 is now complaining of 9 out of 10 pain with movement. I did give her as needed Tylenol. Nurse Note, [DATE] at 8:06 PM: Resident is rating hip pain a 9 out of 10, no swelling or discoloration to hip, Pain is with movement. Message sent . to on call Nurse Practitioner. As needed Tylenol given to resident. Will monitor. (It is important to note there is no evidence in R20's medical record of an RN assessment being completed with this new onset of 9 out of 10 pain.) Text message, dated [DATE] at 8:07 PM, from provider to facility, includes: Is there any visible change? (It is important to note R20's medical provider still is unaware of R20's change of plane or that a transfer ended sitting her on the floor.) Text message dated [DATE] at 8:09 PM, from facility to provider, includes: No swelling or skin discoloration but she said it hurt during cares with movement. (It is important to note R20's medical record did not contain evidence of a thorough RN assessment being performed. The above data of no swelling and no discoloration was gathered by an LPN.) Text message, dated [DATE] at 8:10 PM, from provider to facility, includes: It was just from being in the sit to stand? Text message, dated [DATE] at 8:13 PM, from facility to provider, includes: Are you able to see the incident report in point click care? Text message dated [DATE] at 8:16 PM, from facility to provider, includes: Apparently she was in the sit to stand for a while according to her and now is having the right hip pain. She says it feels like she pulled a muscle. MAR Note dated [DATE] at 8:30 PM, includes: Tylenol Extra Strength Tablet 500 MG. Give 1000 mg by mouth as needed for pain every evening. Administration was ineffective . Follow up pain scale: 8. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Care Age	1755 N. Barker Rd. Brookfield, WI 53045

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Text message, dated [DATE] at 8:35 PM, from facility to provider, includes: any new orders? Text message dated [DATE] at 8:41 PM, from facility to provider, includes: She now rates the hip pain 8 out of 10, this is one hour after taking the extra strength Tylenol. Text message dated [DATE] at 8:49 PM, from provider to facility, includes: We can try a one time dose of Flexeril 10 milligrams to see if it helps. Text message dated [DATE] at 9:15 PM, from facility to provider, includes: Thank you. Noted. Will continue to monitor for pain and update with any changes. Nurse Note dated [DATE] at 9:29 PM, includes: Physician Assistant from . aware and new order for one time dose of Flexeril 10mg muscle relaxer. Resident aware. Will monitor. Nurse Note, [DATE] at 10:13 PM, includes: One time dose of Flexeril given and effective. Resident reports less pain to right hip, 2 out of 10. Facility 24 Hour Communication Board, dated [DATE], includes: Night Shift- R20- complained of pain to right knee/leg . Day Shift- New order stat x-ray related to right hip, right knee, Flexeril 5mg as needed three times a day for pain . Advanced Practice Nurse Practitioner (APNP) Note, dated [DATE] at 10:30 AM, includes: Chief complaint- right knee and leg pain . Patient was an acute add on today presenting today with right knee and leg pain after being transferred via sit to stand overnight last night per RN report . vital signs- [DATE]: blood pressure- 122/64, oxygen saturation- 96%, pain- 0, temperature- 97.6 degrees, respirations-18, heart rate 74, weight 140 . vitals [DATE] blood pressure- 110/62, oxygen saturation- 95%, pain-0, temperature 97.3 degrees, respirations-17, heart rate- 65 . vitals [DATE] pain 8 . vitals [DATE] pain-0 .Muscoskeletal- no joint tenderness or deformity. Right lower extremity with minimal range of motion. Unable to flex, extend, abduct, adduct, or externally rotate hip without extreme pain. Right lower extremity internally rotated while resting in bed and unable to straighten. Pedal pulses plus 2 bilaterally, warm to touch, and sensation intact. No bruising or swelling noted. (It is important to note the incident took place on [DATE] between 1:00 PM and 2:30 PM according to the resident's statement, CNA L's statement, CNA M's statement, LPN G's statement, and UM/RN Q's statement and this APNP's note reflects the most recent vitals recorded in R20's medical record. These vitals are from [DATE] and [DATE]. The facility did not record R20's blood pressure, heart rate, respiratory rate, or temperature on [DATE] or after the change in condition was noted.) R20's Radiology Report, dated [DATE] at 12:25 PM, includes: . Hip . Right . Results: Intertrochanteric right femoral fracture with mild angulation. Mild soft tissue swelling . Conclusion: Acute Intertrochanteric right femoral fracture as noted . Knee . Right . No acute fracture or dislocation. The osseous structures appear intact. Modest joint space narrowing. Soft tissues are unremarkable. Conclusion: No acute osseous findings. Recommend a repeat multi-view imaging in 1 week or sooner if clinically warranted especially if symptoms continue or persist or progress. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R20's SBAR Communication Form, dated [DATE], includes: this started on [DATE] . Since it started it has stayed the same. The condition, symptom, sign has occurred before: No . Medication Changes in the last week: Flexeril . Vital Signs: 139/79, Pulse: 81, Respirations: 18, Temperature: 97.8 . Functional Status: No changes observed. Skin Evaluation: not clinically applicable to the change in condition being reported . Pain: New Intensity of pain: 9 . Appearance- Summarize your observations and evaluations: (blank) . Review and Notify: Primary Care Clinician Notified: Yes- date and time: [DATE] at 1:00 PM. Recommendations of Primary Clinicians: Send to emergency room for evaluation and treatment of right hip fracture. Check all that apply: X-ray . Nursing Note for additional information on change in condition: (blank) . Signed by RN/UM Q . R20's Emergency Department Note, dated [DATE], includes: X-ray today shows a broken hip. Given that you are not ambulatory, there is no clear indication for surgery and based on your wishes and discussion with family, it is safe to go back to your facility. You will need care with movement to try to avoid significant displacement of the right leg especially. You should at least take Tylenol, up to 1 gram, every 6 hours, as needed; if you have stronger pain, it is reasonable to try hydrocodone. The medication prescribed for pain today will make you sleepy; . X-ray pelvis AP and hip right final results: Impression: Impacted and displaced intertrochanteric right femur fracture . Reason for exam: fall, deformity . additional relevant history: fall, deformity . Findings: The osseous structures appear demineralized. There is a mildly impacted and displaced fracture of the proximal right femur involving the base of the femoral neck extending into the intertrochanteric region. Increased varus angulation. The femoral head remains normally aligned with the acetabulum. The pelvic ring appears intact. Left hip alignment is normal . On [DATE] at 10:42 AM during a phone interview, CNA M indicated when she entered the room R20 was in her wheelchair and CNA L told her the sit to stand lift malfunctioned and R20 was on the floor. CNA M indicated she did not report this change of plane to the nurse on the floor or to the oncoming shift, because she figured CNA L would report it. CNA M indicated when a resident has a change of plane, is on the floor, or has a sudden fall from a lift she goes to get the nurse immediately and does not move the resident until the nurse is done with an assessment and tells her it is ok to move the resident. CNA M indicated 2 staff are to be present when staff use any mechanical lift per facility policy. On [DATE] at 11:24 AM during interview, LPN G stated, Originally I was told by CNA L that R20 was complaining of pain to her leg and there was an issue with the sit to stand. I had asked her to write a statement. I ended up finding the statement later on. It was very unclear, and I was looking for clarification. LPN G indicated she did not see any changes in R20 when she looked but asked UM/RN Q to assess her. LPN G indicated she did not remember gathering a set of vitals on R20. LPN G stated, I would like to have had more accurate information and more information by the CNA L. She should not have picked R20 up off of the floor. She should have grabbed a nurse. LPN G indicated education was given after the incident to be sure staff are using sit to stand lifts with two staff. LPN G indicated education that was given did not include what to do post fall or reporting accurate information. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:47 AM during a phone interview, CNA K indicated he came in on [DATE] at 2:30 PM and in report they said there was an incident with R20 and the sit to stand lift. CNA K stated, During first rounds, I could tell something was wrong with R20. I said to LPN N I think you need to get an x-ray, her leg does not look quite right. The position of her leg was not right. She was laying in the bed. Didn't look normal. CNA K indicated if a resident has a fall, he is to report the fall immediately and he does not move resident until after an RN has completed an assessment. CNA K indicated staff are to have two staff present when running any mechanical lifts in house per facility policy and he received education on this. CNA K indicated the typed summary of his interview in the Facility Self Report does not reflect what he reported to the facility. On [DATE] at 1:54 PM during interview, DON B indicated CNA L reported to LPN G that the lift battery died during transfer and now R20 is complaining of pain. Then CNA L slipped a written statement containing more information on the nurses' desk before exiting the building for the day. LPN G found the statement around 2:30 PM and brought it to DON B. DON B told LPN G to start an incident report, grab UM/RN Q for an assessment, and to report incident and findings to R20's provider. DON B and Surveyor reviewed CNA L's first statement. DON B and Surveyor reviewed contact with R20's provider. DON B indicated the provider was not made aware R20 was sitting on the ground. DON B stated, I was going to get a second statement from her to make sure there was a fall. DON B indicated CNAs are to report falls immediately to the floor nurse and give as many details as possible. Surveyor asked DON B what the process is for witnessed falls and unwitnessed falls. DON B indicated the process is for an RN to complete an assessment and notify the resident's provider. DON B indicated a thorough assessment contains a full set of vitals, a description of the affected area including any deformities, any discoloration, any changes in temperature, any shortening, or any rotation. DON B indicated she does not see any vitals recorded for [DATE] in R20's medical record. DON B indicated a fall is an unintended change of plane. DON B indicated staff are to have two staff present for all mechanical lift transfers per facility policy and CNA L transferred R20 two times alone, once to the toilet and once out of the bathroom. DON B indicated LPN N called her on [DATE] around 8:15 PM to let her know R20 was experiencing 9 out of 10 pain. DON B indicated she planned to assess R20 when she came in on [DATE] in the morning. Surveyor asked DON B if she would be willing to do an enactment of a staff member using the mechanical lift. DON B indicated she and Corporate Consultant EE would volunteer to demonstrate how to activate the emergency button so Surveyor could see how long it takes to lower a resident completely using the emergency button. (It is important to note R20's medical record does not contain a thorough assessment by DON B.) On [DATE] at 2:18 PM, Surveyor observed DON B and CNA FF maneuvering the lift while Corporate Consultant EE was seated with the sling in place around her. DON B, CNA FF, and Corporate Consultant EE could not get the emergency button to engage and lower the lift all at once. Surveyor observed a turn button on the hydraulic boom of the shift and when DON B turned that button it would only go one turn at a time. When the button made one full turn, the lift would lower a little bit and stop. Then DON B or CNA FF would turn button another full turn and lift would lower a small amount and stop. Surveyor observed staff were unable to drop the lift in one smooth motion using the red emergency buttons. DON B indicated she did not perform any re-enactments with CNA L or other staff after the incident, but she wished she would have. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:36 PM during interview, LPN N stated, When I got here for second shift, I was told R20 was on the sit -to - stand lift too long and now her knee hurts. R20 told me she pulled a muscle. I did look at her before dinner time and gave her a Tylenol at 8:30 PM. She said the pain was in her knee. Her leg goes in a little at baseline. I didn't think too much about it. CNA K thought it was an issue. I wasn't so sure. I had R20 move her leg, and it was her knee that she reported hurt. LPN N indicated R20 reported her pain was 9 out of 10 at one point, but she thought it was a strained muscle. LPN N indicated after Tylenol, R20 rated pain 8 out of 10 so she sent another message to R20's provider and eventually she was given a new order for a muscle relaxer. LPN N indicated she did not report R20 had a change of plane, a sudden drop from the lift, a witnessed fall, or ended up sitting on the ground during a transfer to R20's medical provider. LPN N stated, I was not given correct information in report. I would have monitored her differently through my shift if I knew she fell. CNA K and I looked at her leg and it was turned in a little. I thought that was normal. LPN N indicated her and CNA K thought an x-ray would have been ordered. LPN N indicated she did not remember gathering vitals and did not record information about R20's leg being internally rotated in R20's medical record. LPN N indicated she called DON B to report the resident's pain levels 9 out of 10 and 8 out of 10 and DON B indicated she would be in to look at her in the morning. On [DATE] at 3:46 PM, CNA K was interviewed in person this time and stated, I noticed before I did any cares on her (R20) that something was wrong. Her foot did not sit correctly. It was rotated in. I thought there was swelling above her knee. CNA K demonstrated for Surveyor by pointing the toes of his right foot towards his left foot. CNA K stated, I told the nurse. She contacted the doctor, and I was surprised she (the doctor) did not order an x-ray. I reported the pain and the leg to LPN N. I don't know what LPN N reported to the doctor. Surveyor and CNA K reviewed the facility's summary of CNA K's interview of the incident. CNA K indicated the typed statement from the Facility Self Report does not reflect the interview he gave to the facility. CNA K indicated again he knew something was wrong before he performed any cares with R20 and he was unsure if he should even move R20. On [DATE] at 4:33 PM, NP P (Nurse Practitioner) and Surveyor reviewed communication between the facility and the clinic. NP P indicated the clinic was not made aware that R20 had a change of plane, ended up sitting on the ground during a transfer with a mechanical lift, or was dropped suddenly from the lift. NP P stated, If I knew there was a fall I would have probably ordered x-ray then and there, on [DATE] at 8:04 PM. NP P indicated she was present in the facility on [DATE] in the morning and she did the exam in R20's appointment with NP O. NP P stated, R20 had severe bony tenderness and her foot looked like it had inward rotation. I could barely touch her. She was unable to flex, extend, abduct, or adduct. We did not know of a fall. X-ray was ordered stat because when I saw her it was internally rotated, and she was in so much pain. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 7:46 AM during interview, RN/UM Q (Registered Nurse/Unit Manager) indicated she never saw CNA L's first written statement and what she was told was the lift's battery died and the lift dropped her suddenly. RN/UM Q stated CNA L did not know how to activate the emergency button. CNA L pushed it and it didn't work. Then it did. CNA L tried to move R20 in the lift quickly so she wouldn't be on the floor. I did not see the note. I was told about it. Surveyor asked what the definition of fall is. RN/OM Q indicated a fall is a change of plane. Surveyor asked if dropped her suddenly was a fall? RN/UM stated, I don't know if it was a fall. RN/UM Q indicated she does not remember taking a set of vitals on R20 and if she did it would be recorded in R20's medical record. UM/RN Q indicated she did not report R20 had a fall to R20's provider. Surveyor asked, Are aides observed using lifts before they are using them with residents and does the facility perform competency checks? RN/UM Q stated, No they are not part of a skills checklist before they start. That is a good idea. UM/RN Q stated, She (CNA L)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Example 2 R35 was admitted to the facility 4/24/23 with diagnoses including, but not limited to, the following: Dementia (a group of thinking and social symptoms that interferes with daily functioning), diabetes mellitus type 2 (a long-term condition in which the body has trouble controlling blood sugar), abnormal gait (walking different than normal), chronic kidney disease (disease of the kidneys that will eventually lead to kidney failure), and hypertension (high blood pressure). On 4/24/23, the facility's Treatment Administration Record (TAR) documents the following: Monitor feet to ensure skin is intact and free from s/sx (signs/symptoms) of developing skin alterations. Notify MD (Medical Doctor) with any change in skin integrity. Every evening shift for prevention of skin impairment. R35's Braden's are as follows: 4/24/24: 19 (Not At Risk) 7/24/24: 20 (Not at Risk) 10/25/24: 18 (Mild Risk) 11/8/24: 15 (Mild Risk) 1/21/25: 14 (Moderate Risk) 2/13/25: 11 (High Risk) 5/3/25: 16 (Mild Risk) On 7/5/24, the facility's Skin and Wound Evaluation documents R35 developed an In-house acquired Stage II PI (Partial-thickness skin loss with exposed dermis) to her right heel that resolved on 8/20/24. The document notes, area resolved will continue prevalon boot x7 days. On 2/12/25, R35 enrolled in hospice services. R35's Significant Change Minimum Data Set (MDS) dated [DATE] indicates R35 has a Brief Interview of Mental Status (BIMS) of 2 out of 15, indicating she is severely cognitively impaired. Section M (Skin Conditions) indicates R35 is at risk of PI's. R35 has an Activated Power of Attorney for Health Care (APOAHC). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R35's comprehensive care plan documents, in part, as follows: (Date Initiated: 5/5/25) The resident has pressure ulcer (injury) right heel r/t (related to) tight shoes, DM (diabetes mellitus), and generalized weakness, on hospice care; also history of similar wound in 7/2024; Goal: Wound will heal within the limits of the disease process. (Target Date: 8/7/25); *Interventions: (Date Initiated: 5/5/25) Bilateral heel boots at all times; (Date Initiated: 5/5/25) *The resident needs monitoring/reminding/assistance to turn/reposition at least every 2-3 hours, more often as needed or requested. R35's comprehensive care plan for Restorative Program, documents, in part, as follows: (Date Initiated 1/20/25; Date Resolved: 5/13/25) Roll left and right: The resident requires supervision or touching assistance to complete task. (Date Initiated: 5/13/25) The resident requires partial/moderate assistance on [sic] 1 staff to complete task R35's Certified Nursing Assistant (CNA) Kardex, dated 5/27/25, documents, in part, as follows: *Prevalon boot on right foot AAT (at all times) except for transfers; no shoes; and Alternate Device(s): Offloading boots on bilateral feet when in bed. It is important to note, the comprehensive care plan indicates Bilateral heel boots at all times. On 4/29/25, R35's Physician visit documents, in part, as follows: 30 day compliance visit SKIN- no masses, no rashes, no lesion on exposed skin Unspecified protein-calorie malnutrition: Patient continues on Boost (supplement). Ongoing weight loss noted and not unexpected due to terminal disease. Weight has decreased by 3 pounds in the last week. On 5/3/25 at 11:33 AM, R35's Progress Notes documents as follows: Body check completed after shower. Resident c/o (complained of) pain to right heel when touched. Noted dark purple area to right heel. Skin is intact. Wound care nurse notified and new orders received. Hospice updated, family updated and provider updated. Will continue to monitor. On 5/4/25 at 10:49 AM, R35's Progress Note documents as follows: Heel boot on while in bed. Pressure injury remains to right heel. Skin remains intact. Area dark purple in color. No c/o (complaints of) pain noted at this time. Betadine applied as ordered. Will continue to monitor. On 5/6/25, NP C (Nurse Practitioner) assessed R35 indicating, in part, as follows: Diagnosis that could affect wound healing: diabetes, dementia, history of falls, abnormal gait, Vitamin D deficiency, CKD, HTN Interventions in Place: Offloading measures per facility protocol, nutrition support, topical wound care Physical Examination Right posterior heel (unstageable pressure ulcer) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*100% adherent eschar measuring 1 x 1 x UTD (Unstageable Tissue Depth) cm. No fluctuance or drainage noted. Peri wound is intact, no signs of infection. *Status: reoccurrence Plan: Apply betadine daily, leave open to air. Continue use of Prevalon boot whenever in bed Assessment *Unstageable pressure ulcer of right heel Discussed with nurse Medical records reviewed Wound care re-evaluation in 1 week On 5/13/25 at 8:30 AM, NP C documented the following note: Type: Wound Care Follow Up Chief Complaint: wound to right heel Subjective: Patient seen today sitting up in her wheelchair. Subjective is limited due to dementia however appears comfortable. Per staff no recent fever, chills, nausea or vomiting. Diagnosis that could affect wound healing: diabetes, dementia, history of falls, abnormal gait, Vitamin D deficiency, CKD, HTN Interventions in Place: Offloading measures per facility protocol, nutrition support, topical wound care Physical Examination: Right posterior heel (unstageable pressure ulcer) 100% adherent eschar measuring 1 x 1 x UTD (Unstageable Tissue Depth) cm. No fluctuance or drainage noted. Peri wound is intact, no signs of infection. Status: stable Plan: Apply betadine daily, leave open to air. Continue use of Prevalon boot whenever in bed Assessment: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*Unstageable pressure ulcer of right heel Discussed with nurse Medical records reviewed Wound care re-evaluation in 1 week On 5/19/25 at 10:05 AM, a Nutrition Note documents as follows: Most recent weight of 98.8# on 5/17 triggered for a significant weight loss 7.5% x 30d. Resident refused breakfast this morning & per nsg spit out meds. Continued weight loss anticipated as overall status declines. Will continue to offer foods as tolerated and follow hospice plan of care. R35 remains on hospice services, gradual weight loss is expected. Resident is triggering for 8# over 30 days. Resident intake varies and receives Boost supplement 3x (three times) daily. Will continue current POC (Plan of Care) . On 5/20/25 at 8:30 AM, NP C documented the following note: Type: Wound Care Follow Up Chief Complaint: wound to right heel Subjective: Patient seen today sitting up in her Broda chair. Subjective is limited due to dementia however appears comfortable. Per staff no recent fever, chills, nausea or vomiting. Diagnosis that could affect wound healing: diabetes, dementia, history of falls, abnormal gait, Vitamin D deficiency, CKD, HTN Interventions in Place: Offloading measures per facility protocol, nutrition support, topical wound care Physical Examination: Right posterior heel (unstageable pressure ulcer) 100% adherent eschar measuring 1 x 1 x UTD (Unstageable Tissue Depth) cm. No fluctuance or drainage noted. Peri wound is intact, no signs of infection. Status: stable Plan: Apply betadine daily, leave open to air. Continue use of Prevalon boot whenever in bed Assessment: *Unstageable pressure ulcer of right heel Discussed with nurse (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 0686 Level of Harm - Actual harm Residents Affected - Few	Medical records reviewed Wound care re-evaluation in 1 week 5/27/25 at 8:15 AM, NP C documented the following note: Type: Wound Care Follow Up Chief Complain: wound to right heel Subjective: Patient seen today sitting on the side of bed getting dressed. Subjective is limited due to dementia however appears comfortable. Per staff no recent fever, chills, nausea or vomiting. Diagnosis that could affect wound healing: diabetes, dementia, history of falls, abnormal gait, Vitamin D deficiency, CKD, HTN Interventions in Place: Offloading measures per facility protocol, nutrition support, topical wound care Physical Examination: Right posterior heel (unstageable pressure ulcer) 100% adherent eschar measuring 1 x 1 x UTD (Unstageable Tissue Depth) cm. No fluctuance or drainage noted. Peri wound is intact, no signs of infection. Status: stable Plan: Apply betadine daily, leave open to air. Continue use of Prevalon boot whenever in bed Assessment: *Unstageable pressure ulcer of right heel Discussed with nurse Medical records reviewed Wound care re-evaluation in 1 week On 5/27/25 at 11:39 AM, the facility documents the following note: Skin/Wound Note: Seen by wound team today. Wound on right heel measuring 1.0 x 1.0 x UNS (Unstageable); wound is now a hard eschar cap that the orders read skin prep and offloading; care plan reviewed and remains appropriate On 5/28/25 the facility changed ownership. (continued on next page)

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	525519	A. Building B. Wing	06/25/2025

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Complete Care at Care Age	1755 N. Barker Rd. Brookfield, WI 53045

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/1/25 the facility added the following documentation: Turned and repositioned for each shift (AM: 6:30 AM-2:30 PM, PM: 2:30 PM-10:30 PM, NOC: 10:30 PM-6:30 AM) It is important to note, turning and repositioning is not documented for the following dates/shifts: 6/1 AM 6/3 AM and NOC 6/5 NOC 6/6 PM, NOC 6/7 NOC 6/10 NOC 6/11 AM On 6/3/25 at 4:02 PM, the facility documents the following note: Skin/Wound Note: Seen by wound team today for wound on the right heel which is a UNS (Unstageable) pressure injury. The wound measures: 1.0x1.0xUTD (Unstageable Tissue Depth) (Unstageable Tissue Depth) (Unstageable Tissue Depth). The wound base has full eschar with no drainage. The current order is Iodine and OTA (open to air) twice daily with offloading boots on. All orders approved by NP C (Nurse Practitioner). Care plan in place and remains appropriate. On 6/10/25 at 7:45 AM, Surveyor observed R35 up in her broda chair in the dining room wearing gripper socks. Surveyor observed R35 was not wearing prevalon boots. On 6/10/25 at 8:10 AM, Surveyor spoke with LPN Y (Licensed Practical Nurse). Surveyor asked LPN Y, should R35 be wearing Prevalon boots. Surveyor showed LPN Y R35's care plan. LPN Y stated, R35 should have a prevalon boot on her right foot and is not wearing a prevalon boot. LPN Y stated, she will notify CNA HH (Certified Nursing Assistant). On 6/10/25 at 8:20 AM, Surveyor observed NP C measure and assess R35's PI to her right heel. DON B (Director of Nursing) and Unit Manager/RN Q (Unit Manager/Registered Nurse) were also present in R35's room. NP C stated, the PI measures 1.0 cm x 1.0 cm and is the same and stable. Surveyor observed NP C apply betadine to R35's right heel PI. DON B voiced the start date of the PI as 5/3/25. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/10/25 at 8:26 AM, Surveyor spoke with NP C (Nurse Practitioner). Surveyor asked NP C, what caused the PI to R35's right heel. NP C stated, not walking at all, has boots on her, previous PI to the same area, and overall health declining. NP C stated, the PI is unavoidable, she's at risk, she sits in broda or bed; NP C stated, I feel it's going to heal but going to be slow. NP C added, she does feel it's absorbing. NP C stated, it's important for R35 to have boots on. NP C added, R35 does not refuse the prevalon boots. NP C stated, she will always recommend prevalon boots first and if a resident refuses prevalon boots she will try a HeelzUp (an offloading device for heels/feet). NP C stated, R35 has not needed a HeelzUp as she is agreeable to wearing the prevalon boots and does not refuse them. Surveyor shared observation of R35 up in the broda chair in the dining room with no prevalon boots on. Surveyor asked NP C, would you expect R35 to be wearing bilateral prevalon boots per her care plan. NP stated, yes, this is important to offload pressure so the PI can heal. 6/10/25 at 12:15 PM, NP C (Nurse Practitioner) documented the following note: Type: Wound Care Follow Up Chief Complain: wound to right heel Diagnosis that could affect wound healing: diabetes, dementia, history of falls, abnormal gait, Vitamin D deficiency, CKD, HTN Interventions in Place: Offloading measures per facility protocol, nutrition support, topical wound care Physical Examination: Right posterior heel (unstageable pressure ulcer) 100% adherent eschar measuring 1 x 1 x UTD (Unstageable Tissue Depth) cm. No fluctuance or drainage noted. Peri wound is intact, no signs of infection. Status: stable Plan: Apply betadine daily, leave open to air. Continue use of Prevalon boot whenever in bed and in Broda chair Assessment: *Unstageable pressure ulcer of right heel Discussed with nurse General wound care instructions: Keep the wound clean and dry, Monitor for signs of infection (increased redness, warmth, swelling, drainage, odor, or pain), Elevate affected extremity when possible. Wound care re-evaluation in 1 week (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/10/25 at approximately 9:30 AM, Surveyor spoke to DON B (Director of Nursing) Surveyor asked DON B, if the facility has documentation from R35's provider indicating if the PI is avoidable or unavoidable. DON B stated, the facility does not have this documentation and has requested it from NP C (Nurse Practitioner). On 6/10/25 at 8:52 PM, NP C (Nurse Practitioner) appended the 6/10/25 note to include the following: The following unavoidable statement should be included: Patient with multiple comorbidities and multiple risk factors for developing and worsening of pressure injuries. Interventions consistent with individual needs, goals and standards of care have been implemented. Revisions to intervention were made as appropriate. Wound is considered unavoidable and patient is at risk for further worsening or development of additional areas. On 6/10/25 at 1:45 PM, Surveyor spoke with CNA HH (Certified Nursing Assistant). Surveyor asked CNA HH, how long she has worked at the facility. CNA HH stated, she has worked at the facility since January. Surveyor asked CNA HH, how do you know how to care for R35 and other residents. CNA HH stated, there's a CNA Kardex in each resident's bathroom. Surveyor asked CNA HH, what are R35's skin interventions. CNA HH stated, R35 is supposed to have heel boots in bed. Surveyor and CNA HH walked to R35's room and reviewed the CNA Kardex, dated 5/27/25, in R35's bathroom. Surveyor asked CNA HH, should you have put the prevalon boots on R35's bilateral feet when you got her up, dressed, and in her broda chair. CNA HH stated, Yes. Surveyor asked CNA HH, does R35 refuse the prevalon boot. CNA HH stated, No. Surveyor asked CNA HH, how does R35 transfer. CNA HH stated, she used to transfer with the stand lift but she is declining and now uses a Hoyer (full body) lift. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/12/25 at 8:25 AM and 11:00 AM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B to tell me about R35's current and previous PI to her right heel. DON B stated, R35 has diabetes, wears shoes and was wearing shoes after the PI healed the first time (in August 2024). DON B stated, R35's family member got what he believed were diabetic shoes. R35 with her dementia preferred the clunky shoes. DON B stated, she believes the clunky shoes were the cause of the previous PI to R35's right heel. DON B stated, R35 was walking at that time and still mobile. DON B stated, R35 has dementia, diabetes, peripheral vascular disease and started to decline. DON B stated, R35 was enrolled in hospice services in February 2025 before the PI re-developed. Surveyor asked DON B, what is the cause of R35's current PI to her right heel. DON B stated, digging her heels into the bed (note, care plan documents it was her same shoes that caused her first PI to her right heel), not on an air mattress, a lot of back pain, she lays on her back in bed with her arms crossed over her chest. Surveyor asked DON B, is R35 on an air mattress. DON B stated, she believes so. DON B stated, she asked hospice to get her an air mattress as the facility's standard mattress is pressure redistribution. DON B provided documentation that the facility's standard mattress is the Medline Advantage Select SE. R35's mattress is a the Medline Advantage Select SE which is indicated up to a Stage III PI (pressure injury). DON B added, sometimes she is at the mercy of hospice. DON B stated, she has paid for air mattresses in the past before the company changed ownership on 5/28/25. Surveyor asked DON B, how soon should a PI be measured and assessed when it's initially discovered. DON B stated, it should be completed upon discovery. Surveyor asked DON B, is it acceptable for the PI to not be measured and assessed for three (3) days. DON B stated, no. DON B stated, she has residents that have healed PI's that are on air mattresses because they need it. Surveyor requested documentation of DON B's request for an air mattress and hospice correspondence. Of note, no further information was provided to Surveyor. Surveyor asked DON B, was R35 on a turning and repositioning schedule prior to the Unstageable PI developing for the second time to R35's right heel. DON B stated, the facility did not document turning and repositioning prior to the development of the PI. DON B stated, the new company does have staff documenting turning and reposition every 2 hours for the shift. Of note, currently staff are not documenting that turning is repositioning is being done every 2 hours, per standard of practice. DON B stated, unfortunately prior to discovery of R35's PI, the facility's was turning and repositioning residents every 2-3 hours. DON B stated, going forward the facility will be turning and repositioning R35 (and other residents) every 1-2 hours. DON B stated, she learned turning and repositioning a resident a resident with a PI should be occurring every 1-2 hours. DON B added, initially NP C (Nurse Practitioner) instructed staff that R35 is to have prevalon boots on while in bed. DON B added, we did change it to at all times. Based on interview and record review, the facility did not ensure each resident receives necessary treatment and services, consistent with professional standards of practice, to prevent pressure injuries (PIs) from developing and/or worsening and promote healing of PIs for 3 of 5 residents (R35, R34, R28) reviewed for PIs out of a sample of 16 residents. R28 and R35 are being cited at Actual Harm/Isolated; R34 is being cited at Potential for Harm/Isolated. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R28 admitted with a pressure injury on his coccyx and was identified to be at risk for pressure injury development. R28 had an intervention in place to wear Prevalon boots at all times except for when in therapy. R28 developed an unstageable pressure injury on his left heel. Surveyor observed R28 to be without his Prevalon boots on, was wearing black shoes, and had his heels directly on the mattress. R28's Medication Administration Record/Treatment Administration Record (MAR/TAR) did not contain an order for Prevalon boots. R28's Kardex did not have an intervention for Prevalon boots. Staff interviewed were not aware R28 had orders for Prevalon boots to be worn at all times and did know that he was care planned to have Prevalon boots on at all times except for when working with therapy for standing/walking. R35 had a previous history of a PI to her right heel. On 5/3/25 the facility discovered a Deep Tissue Injury (DTI) to R35's right heel. The facility did not measure or assess the DTI prior to NP C (Nurse Practitioner) assessing the PI on 5/6/25. On 5/6/25, NP C classified the PI as Unstageable measuring 1.0 x 1.0 cm (centimeter) with 100% eschar. The facility did not notify NP C of any changes to the PI. The facility was turning and repositioning R35 every 2-3 hours versus every 1-2 hours. In addition, the facility is not documenting that turning and repositioning is being completed. R35's care plan documents a PI intervention of Bilateral heel boots at all times. Surveyor observed R35 up in her broda chair without bilateral heel boots with R35's heel in direct contact with the broda chair. R34 did not have an assessment of her pressure injury until 5 days after discovering the wound. Evidenced by: The facility policy, Pressure Injury Prevention Guidelines, dated 5/28/25, documents, in part, as follows: To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present. Support surfaces do not eliminate the need for turning and repositioning. The standard mattress for all facility beds are pressure redistribution mattresses (i.e. high specification reactive foam). Provide alternative support surfaces as needed. Considerations for utilizing specialized support surfaces: .Stage 3,4, unstageable, or deep tissue injury on trunk (lower body) The facility does not have a policy for turning and repositioning. The National Pressure Injury Advisory Panel (NPIAP) classifies a PI as follows: Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink, or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon, or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration, or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. Unstageable: Obscured full-thickness skin and tissue loss full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. The facility policy, Completing an Accurate Assessment Regarding Pressure Injuries, dated 5/28/25, includes: The purpose of this policy is to assure that all residents receive an accurate assessment of pressure injuries, including risk, presence, appearance, and change of pressure injuries. 1. Accurate assessments addressing each resident's skin status will be conducted by qualified staff and correctly documented in the medical record. 3. A qualified health professional will document the presence, number, stage, and pertinent characteristics of any pressure injury on the wound documentation form in the medical record. The facility policy, Documentation of Wound Treatments, dated 5/28/25, includes: 2. The following elements are documented as part of a complete wound assessment: a. Type of wound (pressure injury, surgical, etc.) and anatomical location b. Stage of the wound, if pressure injury (stage 1, 2, 3, 4, deep tissue pressure injury, unstageable pressure injury) or the degree of skin loss if non-pressure (partial or full thickness) c. Measurements: height, width, depth, undermining, tunneling d. Description of wound characteristics: i. Color of the wound bed ii. Type of tissue in the wound bed . iii. Condition of the peri-wound skin . iv. Presence, amount, and characteristics of wound drainage/exudate v. Presence or absence of odor vi. Presence or absence of pain. Example 1 R28 admitted to the facility on [DATE] with the following diagnoses: hemiplegia and hemiparesis, chronic atrial fibrillation, type 2 diabetes mellitus, cognitive communication deficit, abnormal gait and mobility, arthropathy, cerebral infarction, and need for assistance with personal cares. R28 admitted with a pressure injury on his coccyx area. R28's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/18/25, indicates R28's cognition is moderately impaired with a Brief Interview for Mental Status (BIMS) score of 12 out of 15. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R28's Comprehensive Care Plan, initiated Includes: The resident has pressure ulcer left heel, and sacrum-closed 5/27/25- related to immobility, prolonged hospitalization, some ascites and lymphedema with history of PVD, revision 6/2/25 . Goal: the resident's pressure ulcer will show signs of healing and remain free from infection through review date of 8/25/25 . Interventions: Heel lift boots on at all times except when working with therapy for standing/walking, revision date 2/26/25 . heel lift boots on at all times except when working with therapy for standing/walking date, initiated 3/11/25, revision 5/29/25 . the resident needs monitoring/reminding/assisting to turn/reposition at least every 2 to 3 hours, more often as needed or requested, initiated 3/11/25, revision 5/29/25 . R28's Braden Scale for Predicting Pressure Injuries, dated 3/4/25, indicates R28 is at risk for pressure injury development with a score of 15. R28's Nurse Note, dated 3/10/25, includes: Writer called to room by assigned CNA (Certified Nursing Assistant) concerning open area to left heel. Upon entering room resident had bilateral heel boots in place. Small amount of dried blood was seen on bed sheets near foot of bed. Open area observed to left heel and purple discoloration also observed to left heel. Open area to left heel measures 3.0 cm (centimeters) x 1.5 cm x 0.0 cm. Area cleansed and foam dressing applied to area. Heel boot in place. As needed Tylenol given for pain. Skin prep applied to purple discoloration on heel. (It is important to note R28 has a new open area to his left heel.) R28's Wound Care Initial Evaluation, dated 3/11/25, includes: Left posterior heel DTI (deep tissue injury) . Full thickness wound with mix of granular tissue and purple devitalized tissue at the base. Wound measuring 2.0cm x 2.0cm x unable to determine. Moderate serous drainage noted, no purulence or odor noted. Peri wound without redness or warmth to indicate infection . Plan: Cleanse with normal saline or wound cleanser then apply Silver Alginate to the wound base and cover with ABD pad, secure with kerlix. Change 3 times a week and as needed . Pressure ulcer of unspecified site, unstageable . Pressure-induced deep tissue damage of left heel . Discussed with wound care team . Continue aggressive offloading measures . R28's Nurse Practitioner Note, dated 3/12/25, includes: Pressure-induced deep tissue damage of left heel . Deep tissue injury to left posterior heel with mix of granular tissue and purple devitalized tissue at the base, measuring 2.0cm x 2.0cm x unable to determine. Moderate serous drainage noted, no purulence odor. Peri wound without redness or warmth. Evaluated by wound care team yesterday. Continue current wound care protocol and offloading measures. R28's Nurse Note , dated 3/17/25, includes: Pt (patient) has Left heel DTI, boot in place at all times. R28's Wound Care Follow Up Note, date: 3/18/2025, includes: Left posterior heel (deep tissue injury) . Full thickness wound with 80% Eschar and 20% granular tissue at the base. Wound measuring 2.0cm x 2.0cm x unable to determine . Small amount of serous drainage noted, no purulence or odor noted. Peri wound without redness or warmth to indicate infection. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Status: improving . Plan: Cleanse with normal saline or wound cleanser, then apply Silver Alginate to the wound base, and cover with ABD pad, secure with kerlix. Change 3 times a week and as needed . Assessment .Pressure ulcer of unspecified site, unstageable . Pressure-induced deep tissue damage of left heel . Deep tissue injury to left posterior heel with mix of granular tissue and purple devitalized tissue at the base, measuring 2.0cm x 2.0cm x unable to determine . Moderate serous drainage noted, no purulence or odor. Peri wound without redness or warmth. Evaluated by wound care team yesterday. Continue current wound care protocol and offloading measures. Discussed with wound care team . Continue aggressive offloading measures . R28's Wound Care Follow Up, dated 3/25/25, includes: . Left posterior heel (deep tissue injury) . Full thickness wound with 100% Eschar, measuring 2.0cm x 2.2cm x unable to determine. No drainage noted, no purulence or odor noted. Peri wound without redness or warmth to indicate infection . Plan: apply betadine daily, leave open to air . Pressure ulcer of unspecified site, unstageable . Pressure-induced deep tissue damage of left heel . Deep tissue injury to left posterior heel with mix of granular tissue and purple devitalized tissue at the base, measuring 2.0 x 2.0 x unable to determine. Moderate serous drainage noted, no purulence or odor. Peri wound without redness or warmth. Evaluated by wound care team yesterday. Continue current wound care protocol and offloading measures . Discussed with wound care team . Continue aggressive offloading measures . Medical records reviewed . Wound care re-evaluation in 1 week . R28's Wound Care Follow Up, dated 4/1/2025, includes: . Left posterior heel (deep tissue injury) Full thickness wound with 100% Eschar, measuring 2.0cm x 2.0cm x unable to determine. No fluctuance or drainage noted, no purulence or odor noted. Peri wound without redness or warmth to indicate infection . Plan: apply betadine daily, leave open to air . Pressure ulcer of unspecified site, unstageable . Pressure-induced deep tissue damage of left heel . Deep tissue injury to left posterior heel with mix of granular tissue and purple devitalized tissue at the base, measuring 2.0 x 2.0 x unable to determine. Moderate serous drainage noted, no purulence or odor. Peri wound without redness or warmth. Evaluated by wound care team yesterday. Continue current wound care protocol and offloading measures . Discussed with wound care team . Continue aggressive offloading measures . R28's Wound Care Follow Up, dated 4/8/2025, includes: . Left posterior heel (deep tissue injury) . Full thickness wound with 100% Eschar, measuring 2.0cm x 2.0cm x unable to determine. No fluctuance or drainage noted, no purulence or odor noted. Peri wound without redness or warmth to indicate infection . Plan: apply betadine daily, leave open to air . Pressure ulcer of unspecified site, unstageable . Pressure-induced deep tissue damage of left heel . Deep tissue injury to left posterior heel with mix of granular tissue and purple devitalized tissue at the base, measuring 2.0cm x 2.0cm x unable to determine. Moderate serous drainage noted, no purulence or odor. Peri wound without redness or warmth. Evaluated by wound care team yesterday. Continue current wound care protocol and offloading measures . Discussed with wound care team . Continue aggressive offloading measures . R28's Wound Care Follow Up, dated 4/15/25, includes: Left posterior heel (deep tissue injury) Full thickness wound with 100% Eschar, measuring 1.5cm x 1.5cm x unable to determine. No fluctuance or drainage noted, no purulence or odor noted. Peri wound without redness [TRUNCATED]

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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 interview and record review, the facility did not ensure that each resident receives adequate supervision and assistance devices to prevent accidents in 1 of 2 residents (R20) reviewed for falls resulting in actual harm, 1 of 1 resident (R31) reviewed for motorized wheelchair charging, and 2 of 4 units reviewed for lithium battery charging. R20 is being cited at Actual Harm/Isolated. R31 and 2 of 4 units is being cited at Potential for Harm/Isolated. R20 was care planned to be a two person assist with a sit to stand transfer. CNA L transferred R20 alone when the lift lost battery power. R20 ended up sitting on the ground, had a sudden drop from the lift, and a change of plane/fall. CNA L assisted R20 off the floor and did not report R20 ended up sitting on the ground, had a sudden drop from a lift, and a change of plane/fall immediately to the floor nurse or to the oncoming shift. CNA L reported that R20 was on the ground to CNA M. CNA M did not report R20 had a fall to the floor nurse. R20 was found to have an intertrochanteric right femoral fracture. R31's motorized wheelchair is charged in her room. The facility charges electric patient lifts in the hallways. This is evidenced by: Facility policy, titled Hoyer Lift and Sit to Stand, undated, states in part; it is important to use all lifts safely . All CNAs should have the proper training before using the lift . Each lift has a safety feature in case of battery malfunction, please be aware how to utilize that feature and potential obstacles that could happen . Per facility policy, all lifts require 2 staff members in the room for transfers for the resident's safety. It is NOT OPTIONAL. (It is important to note in this policy there are no further instructions on how to identify or activate the lifts safety feature.) Facility policy, titled Fall Prevention Program, reviewed and revised on [DATE], states in part; 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. A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not because of an overwhelming external force. The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere . When any resident experiences a fall, the facility will assess the resident, complete post fall assessment, complete an incident report, notify physician and family, review resident's care plan and update as indicated, document all assessments and actions, obtain witness statements in case of injury. Manufacturer's recommendations for use of battery-operated patient lift, states in part; the emergency lowering device is intended for use during lift failure. This device will allow lowering of patients only . Turn clockwise to lower. Emergency Lowering Mechanism: In case of lift failure, please follow the procedures below to safely lower the user. The emergency lowering device is located at the top of the actuator shaft. It is intended for use if the actuator fail to operate while a patient is suspended. The device consisting of a plastic collar ring that should be turned clockwise continually until the patient has been lowered. (continued on next page)

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	525519	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Care Age	1755 N. Barker Rd. Brookfield, WI 53045

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's policy titled Motorized Wheelchairs, dated [DATE], includes: 4. Charging of a motorized wheelchair will take place in an approved area, which is ventilated. At no time is a motorized wheelchair to be charged in a resident room. The facility's policy titled Safe Resident Handling/Transfers, dated [DATE], includes: it is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risk for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. R20 admitted to the facility on [DATE]. Her diagnoses include rheumatoid arthritis, atrial fibrillation, atherosclerotic heart disease, joint disorder, history of falling, weakness, hypertension, sensorineural hearing loss bilaterally, pulmonary hypertension, and age-related osteoporosis. R20's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of [DATE], indicates R20 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15. R20's Comprehensive Care Plan, initiated on [DATE], indicates R1 requires assistance of 1 for the following: dressing, bathing, bed mobility, and assist of 2 with sit to stand lift for transfers and needs one staff member to propel her in the wheelchair for long distances. R20's Comprehensive Care Plan indicates R1's medications are administered by the nurse. Facility Self Report, dated [DATE], includes the following: Date and time occurred-[DATE] at 1:35 PM . Date discovered-[DATE] . Date and time reported-[DATE] 12:46 PM Initial Report-Summary of incident: Patient had reported increased pain in her hip related to a transfer from bathroom to wheelchair where the sit to stand lost power and started to lower while resident was up in lift. The resident ended up in a squatting position with her buttocks touching bottom of the lift and staff were able with the resident's help to get her in an upright seated position and into her wheelchair. A new lift was used to transfer to the resident's bed. Resident is complaining of increased pain since incident and X-rays were ordered by primary nurse practitioner which indicates possible dislocation of right hip and resident will be transferred to hospital for further evaluation and treatment. An investigation initiated. CNA (Certified Nursing Assistant) who completed the transfers was suspended today. Investigation to follow . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Follow-up Report and Investigation-Investigation Summary: . On [DATE], R20 put on her call light because she wanted to be toileted. The assigned CNA (Certified Nursing Assistant) . was in the lunchroom, and CNA L was covering the floor. CNA L transferred R20 with sit to stand lift and took her to the toilet. Shortly thereafter, R20 put on the call light to get off the toilet and go back to bed. CNA L once again used the sit to stand lift without assistance of another staff member and upon raising her up the battery died. R20 was complaining that under her arms (where sling was) was hurting her, so CNA L used the emergency button to lower the lift arm. Apparently, that did not lower initially so CNA L tried to start pushing lift toward R20's bed and after going from the tile bathroom floor to the carpeted bedroom, the lift started to lower with resident still in sling. As the lift arm lowered the resident ended up in a squatting position with her buttocks touching the foot pad of the lift. CNA L decided to try to help the resident by pushing her buttocks and got her high enough to sit in her wheelchair. Shortly after that, CNA M arrived at the unit. CNA L told her she needed help with the transfer from the wheelchair to the bed. After the resident was settled, CNA L told the nurse that the resident was complaining of pain in her leg and that during the transfer with the sit to stand the battery died. She did not mention that this transfer was completed by only herself. LPN G (Licensed Practical Nurse) asked CNA L to write a statement and then she was going to see the resident. CNA L wrote an initial statement on [DATE] that was left for the nurse and not read until after end of day shift. CNA L statement left at nurse station, includes [DATE] While transfer with the sit to stand. The sit to stand went dead in mid-air. She complained about her arms hurts [sic] so did the force thing to force the sit stand while that was going. [sic] It end sitting her down on the floor. I held her back with my legs so she wouldn't fall back. With her help I was able to get her back in her chair. Then a new sit to stand was used to get her in bed. Nurse was told. Statement was written. (It is important to note R20's Care Plan indicates she requires the assistance of 2 staff members and a mechanical lift to meet her transfer needs and CNA L indicates in her interview that she used a sit to stand lift to transfer resident without another staff member present. It is also important to note CNA L indicates R20 ended up sitting on the floor experiencing a change in plane. Also important to note CNA L assisted R20 off of the floor and into her wheelchair without an RN assessing R20 per facility policy and current standards of practice for post fall care.) R20 statement, dated [DATE], includes I wanted to go get on the machine because I wanted to go to the bathroom, like I always do after lunch. It was around 1:00 PM and I put my call light on. It took a little time and then someone came in to take care of me. I had CNA M that day, but she was busy, so this other one came to help. I don't remember her name. She put me on the sit to stand. Then I went to the bathroom and then I was brought back by my bed. Then CNA M came in. She came to help this girl. They put me in bed. I don't think I fell or anything. I don't remember my butt hitting the ground. CNA M statement, dated [DATE], includes I wasn't present when the incident happened yesterday. I only came when I seen [sic] her on the chair and the aide together. The aide told me that R20 was on the floor and that the sit to stand wasn't working, but R20 stated she was never on the floor but that her legs started hurting after being up on the machine for a while. I then helped the CNA L put R20 on the bed. (It is important to note CNA M stated she was aware R20 was on the floor.) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	LPN G statement, dated [DATE], includes as the day shift was ending on [DATE], CNA L told me there was an issue with the sit to stand lift during the transfer prior to the end of shift and that R20 had said her leg hurt. I told CNA L to write a statement before she left about the transfer. I noticed a statement by my computer about R20 from CNA L. The statement was unclear, and I did not see it until after 2:30 PM. I went looking for CNA L off the unit and found out she had already left the building. I notified DON B (Director of Nursing) why I was looking for the CNA and she directed me to put in an incident report and notify NP O (Nurse Practitioner). I notified Unit Manager/Registered Nurse Q about the statement, and we went in to look at R20 and try to identify what had happened earlier to her. R20 reported she was hurting on her right side from being up in the sit to stand lift for too long and maybe she had pulled a muscle. The statement stated that R20 was on the floor at some point and R20 vehemently denied that. R20 was able to lift her knee and leg on the right side while lying in bed and LPN G had not noticed any change in her pain levels at that time or any leg discrepancy in length. R20 rated her pain as a six on a scale of one to ten. LPN G then completed a risk management report of other incident and passed on in report to LPN N what she knew of the incident. LPN G also did report to NP O (Nurse Practitioner) . of the incident . No new orders given at this time. (It is important to note LPN G did not follow facility fall protocol for a witnessed fall, a reported fall, or presumed fall.) DON B (Director of Nursing) statement, dated [DATE], includes on [DATE] at around 2:30 PM LPN G reported to me that R20 said she had an issue with an earlier transfer in the sit to stand lift and that her leg was sore. I instructed her to get Unit Manager/RN Q and look at R20 and prepare an incident report. LPN G did complete incident report as other incident. On [DATE] R20 was seen by Nurse Practitioner (NP O and NP P) and she noted there was a leg discrepancy and ordered an x-ray. R20 also had denied any fall at that time and told NP O that she thought it was from being up in the sit to stand too long. I was made aware of the possible change just around 9:00 AM. CNA L was in the facility with a resident . completing one-on-one observation. Around 10:30 AM, I interviewed CNA L and had her complete a new written statement. During that interview I found out that the sit to stand transfer was not completed per policy initially and that only CNA L was in the room. CNA L witnessed the issue with the lift and resident. I felt at that point that the potential injury could be the result of a witnessed fall due to change of plane for the resident. I then went into risk management and changed the reason for the incident report from other to witnessed fall and completed the corresponding assessments for the incident. At about 1:00 PM, the X-ray did reveal a fracture of the right hip, and the resident was being transferred to the emergency room for evaluation. The incident was then reported to the State as an injury of unknown origin because I could not definitively determine cause and investigation was initiated. CNA L second statement, dated [DATE], includes I answered R20's call light. She was in the bathroom, [sic] as I am lift her up with sit to stand, she complains of pain in her arm pits as I go to lower her the machine died in mid-air, so I press the release button so it can be lower. [sic] wasn't aware that it was going so I tried to get her to her bed as quick as possible but on the way, she had been lower to the ground, so I made sure she didn't hit head and made sure she was sitting upright. With her help, I was able to get her off the floor into her wheelchair, then I use a charged sit to stand to put her in her bed. Handwritten on the interview is a statement that states per interview did a squat on lift and was able to push up enough to get into wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(It is important to note CNA L reports a second time that R20 was on the ground and had a change of plane. It is also important to note CNA L reports she assisted R20 off the floor and transferred her 2 times without an RN assessing R20.) UM/RN Q (Unit Manager/Registered Nurse) statement, dated [DATE], includes R20 had complained of right knee pain after being in the sit to stand. Resident was assessed in bed. Pain to right knee was stated at a 4 out of 10. Floor nurse gave scheduled Tylenol for pain. Resident's right knee was parallel to left knee. Right leg did not have internal rotation when assessed. UM/RN Q second statement, dated [DATE], includes as we further investigated events from [DATE], I was made aware by CNA L, that only one person was used to transfer the resident with the sit to stand lift. I had previously been under the impression that 2 staff were used for the transfer as this is facility policy. R20's Nurse Note, dated [DATE], includes late entry for [DATE] at 2:00 PM: Writer was notified by LPN G that resident had complaints of pain to her right knee after being in the sit to stand too long. Writer assessed the resident. Right knee appeared equal to left knee. No rotation, redness, or swelling noted. Resident stated she has arthritis in that knee and has pain from time to time. Had pain 4 out of 10 at that time. (It is important to note UM/RN Q did not treat R20 as if she just had a fall, a change of plane, a sudden drop from a lift, and she did not record an RN assessment in R20's medical record until [DATE] when she added a late entry.) Advanced Practice Nurse Practitioner (APNP) Note, dated [DATE] at 10:30 AM, includes chief complaint- right knee and leg pain . Patient was an acute add on today presenting today with right knee and leg pain after being transferred via sit to stand overnight last night per RN report . vital signs- [DATE]: blood pressure- 122/64, oxygen saturation- 96%, pain- 0, temperature- 97.6 degrees, respirations-18, heart rate 74, weight 140 . vitals [DATE] blood pressure- 110/62, oxygen saturation- 95%, pain-0, temperature 97.3 degrees, respirations-17, heart rate- 65 . vitals [DATE] pain 8 . vitals [DATE] pain-0 .Muscoskeletal- no joint tenderness or deformity. Right lower extremity with minimal range of motion. Unable to flex, extend, abduct, adduct, or externally rotate hip without extreme pain. Right lower extremity internally rotated while resting in bed and unable to straighten. Pedal pulses plus 2 bilaterally, warm to touch, and sensation intact. No bruising or swelling noted. R20's Radiology Report, dated [DATE] at 12:25 PM, includes . Hip . Right . Results: Intertrochanteric right femoral fracture with mild angulation. Mild soft tissue swelling . Conclusion: Acute Intertrochanteric right femoral fracture as noted . Knee . Right . No acute fracture or dislocation. The osseous structures appear intact. Modest joint space narrowing. Soft tissues are unremarkable. Conclusion: No acute osseous findings. Recommend a repeat multi-view imaging in 1 week or sooner if clinically warranted especially if symptoms continue or persist or progress. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R20's Emergency Department Note, dated [DATE], includes x-ray today shows a broken hip. Given that you are not ambulatory, there is no clear indication for surgery and based on your wishes and discussion with family, it is safe to go back to your facility. You will need care with movement to try to avoid significant displacement of the right leg especially. You should at least take Tylenol, up to 1 gram, every 6 hours, as needed; if you have stronger pain, it is reasonable to try hydrocodone. The medication prescribed for pain today will make you sleepy; . X-ray pelvis AP and hip right final results: Impression: Impacted and displaced intertrochanteric right femur fracture . Reason for exam: fall, deformity . additional relevant history: fall, deformity . Findings: The osseous structures appear demineralized. There is a mildly impacted and displaced fracture of the proximal right femur involving the base of the femoral neck extending into the intertrochanteric region. Increased varus angulation. The femoral head remains normally aligned with the acetabulum. The pelvic ring appears intact. Left hip alignment is normal . On [DATE] at 10:42 AM, during a phone interview, CNA M indicated when she entered the room R20 was in her wheelchair and CNA L told her the sit to stand lift malfunctioned and R20 was on the floor. CNA M indicated she did not report this change of plane to the nurse on the floor or the oncoming shift, because she figured CNA L would report it. CNA M indicated when a resident has a change of plane, is on the floor, or had a sudden fall from a lift she goes to get the nurse immediately and does not move the resident until the nurse is done with an assessment and tells her it is ok to move the resident. CNA M indicated 2 staff are to be present when staff use any mechanical lift per facility policy. (It is important to note CNA M was aware R20 was on the floor and did not report this to the floor nurse.) On [DATE] at 11:24 AM, LPN G stated, Originally, I was told by CNA L that R20 was complaining of pain to her leg and there was an issue with the sit to stand. I had asked her to write a statement. I ended up finding the statement later. It was very unclear, and I was looking for clarification. LPN G indicated she did not see any changes in R20 when she looked but asked UM/RN Q to assess her. LPN G stated, I would like to have had more accurate information and more information by the CNA L. She should not have picked R20 up off of the floor. She should have grabbed a nurse. LPN G indicated education was given after the incident to be sure staff are using sit to stand with two staff. Surveyor asked if education was provided regarding the fall and post fall policy and protocol. LPN G indicated she was unsure. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 1:54 PM, DON B (Director of Nursing) indicated CNA L reported to LPN G that the lift battery died during transfer and now R20 is complaining of pain. Then CNA L slipped a written statement containing more information on the nurse' desk before exiting the building for the day. LPN G found the statement around 2:30 PM and brought it to DON B. DON B told LPN G to start an incident report, grab UM/RN Q for an assessment, and to report incident and findings to R20's provider. DON B and Surveyor reviewed CNA L's first statement. DON B and Surveyor reviewed contact with R20's provider. DON B indicated the provider was not made aware R20 was sitting on the ground. DON B stated, I was going to get a second statement from her to make sure there was a fall. DON B indicated the facility did not follow the Fall policy and procedure for witnessed falls, reported falls, or presumed falls. DON B indicated CNAs are to report falls immediately to the floor nurse and give as many details as possible. DON B indicated a fall is an unintended change of plane. DON B indicated staff are to have two staff present for all mechanical lift transfers per facility policy and CNA L transferred R20 two times alone, once to the toilet and once out of the bathroom. Surveyor asked DON B if she would be willing to do an enactment of a staff member using the mechanical lift. DON B indicated she and Corporate Consultant EE would volunteer to demonstrate how to activate the emergency button so Surveyor could see how long it takes to lower a resident completely using the emergency button. DON B indicated staff education was provided regarding always using 2 staff with mechanical lifts. DON B indicated education was not provided on the facility fall policy and post fall protocol. On [DATE] at 2:18 PM, Surveyor observed DON B and CNA FF maneuvering the lift while Corporate Consultant EE was seated with the sling in place around her. DON B, CNA FF, and Corporate Consultant EE could not get the emergency button to engage and lower the lift all at once. Surveyor observed a turn button on the hydraulic boom of the shift and when DON B turned that button it would only go one turn at a time. When the button made one full turn, the lift would lower a little bit and stop. Then DON B or CNA FF would turn button another full turn and lift would lower a small amount and stop. Surveyor observed staff were unable to drop the lift in one smooth motion using the red emergency buttons. DON B indicated she did not perform any re-enactments with CNA L or other staff after the incident, but she wished she would have. It should be noted there is a second emergency button that lowers the lift in one motion. On [DATE] at 7:46 AM Surveyor asked RN/UM Q,Are aides observed using lifts before they are using them with residents, does the facility perform competency checks? RN/UM Q stated, No they are not part of a skills checklist before they start. That is a good idea. UM/RN Q stated, She (CNA L) should have come and got LPN G right away. She shouldn't have led us to believe there was a second CNA in the room. Example 2 On [DATE] at 10:14 AM, Surveyor observed R31's motorized wheelchair in R31's room along with the charging cords for the motorized wheelchair. On [DATE] at 3:14 PM, Surveyor interviewed R31 regarding charging of her motorized wheelchair. R31 stated staff charge her wheelchair in her room. On [DATE] at 3:27 PM, Surveyor interviewed CNA CC (Certified Nursing Assistant) regarding charging R31's motorized wheelchair. CNA CC indicated staff charge R31's motorized wheelchair in her room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 3:31 PM, Surveyor interviewed DON B (Director of Nursing) regarding the charging of R31's motorized wheelchair. DON B indicated staff charge R31's motorized wheelchair in her room. DON B stated she was not certain of the facility's policy on charging motorized wheelchairs. VPOC DD (Vice President of Clinical Operations) was present during the interview with DON B. VPOC DD informed Surveyor and DON B that motorized wheelchairs are not allowed to be charged in a resident's room. Example 3 The facility utilizes Medline electric patient lifts. The battery used in these lifts are sealed lead acid batteries. The Safety Data Sheet (SDS) for sealed lead acid batteries, dated 6/23, includes: Battery posts, terminals, and related accessories contain lead and lead compounds, chemicals known to cause cancer and reproductive harm, and during charging, strong inorganic acid mists containing sulfuric acid are evolved. Use adequate ventilation. The acid mist and vapors generated by heat or fire are corrosive. Store batteries in cool, dry, well-ventilated areas. Avoid overcharging and smoking, or sparks near battery. On [DATE] at 10:15 AM, Surveyor observed a Hoyer (electric patient lift) plugged into the wall and charging on the 400-hallway. On [DATE] at 10:16 AM, Surveyor observed a stand lift (electronic patient lift) plugged into the wall and charging on the 300-hallway. On [DATE] at 10:16 AM, Surveyor interviewed CNA FF (Certified Nursing Assistant) regarding the charging of electronic patient lifts. CNA FF indicated staff charge the electronic patient lifts in the hallway. On [DATE] at 10:18 AM, Surveyor interviewed CNA GG regarding the charging of electronic patient lifts. CNA GG indicated staff charge the electronic patient lifts in the hallway. On [DATE] at 10:52 AM, Surveyor interviewed CNA M regarding the charging of electronic patient lifts. CNA M indicated staff charge the electronic patient lifts in the hallway. On [DATE] at 10:03 AM, Surveyor interviewed NC EE (Nurse Consultant) regarding the charging of electronic patient lifts. NC EE indicated typically electronic patient lifts are not charged in the hallways but the facility does not use wall battery charging stations, so they plug them into the wall on the hallways to charge. On [DATE] at 8:18 AM, Surveyor interviewed DON B (Director of Nursing) regarding where staff charge the electric patient lifts. DON B indicated the lifts are charged in the hallways. DON B indicated they have always charged the lifts in the hallway and the facility has no concerns regarding safety with the batteries charging in the hallways.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Example 2 R28 admitted to the facility on [DATE] with diagnoses including urinary tract infection (2/25/25) , urine retention, and neuromuscular dysfunction of bladder. On 6/10/25 at 10:56 AM Surveyor observed R28 being pushed in his wheelchair down the hallway. Surveyor heard something rubbing as R28 passed. Surveyor observed R28's catheter bag dragging on the floor. On 6/10/25 at 10:59 AM LPN Y (Licensed Practical Nurse) indicated R28's catheter bag should not be in contact with the floor. LPN Y stated, I will fix this. On 6/10/25 12:03 PM NHA A (Nursing Home Administrator) indicated residents' catheters should not be touching the floor. On 6/10/25 at 1:53 PM DON B (Director of Nursing) indicated R28's catheter should not be in contact with floor. On 6/11/25 at 1:26 PM during wound care observation, Surveyor observed R28's catheter bag to be resting in contact with the floor. On 6/11/25 at 1:27 PM LPN G indicated R28's catheter bag should not be in direct contact with the facility's floor. Based on observation, interview and record review, the facility did not ensure that residents with an indwelling catheter received the appropriate care and services to prevent a urinary tract infection (UTI) for 2 of 2 residents (R49 & R28) reviewed for catheters. *Certified Nursing Assistant (CNA) did not perform proper hand hygiene during catheter/peri care on R49. *R28's catheter bag was dragging on the floor under wheelchair. Evidenced by: The facility policy, dated 5/28/25, states, in part: . Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Policy Explanation: 1. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Care Age	1755 N. Barker Rd. Brookfield, WI 53045

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Catheter care will be performed every shift and as needed by nursing personnel . Compliance Guidelines: . 7. Perform hand hygiene . The facility policy entitled Hand Hygiene, dated 5/28/25, states, in part: . Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Policy Explanation and Compliance Guidelines: . 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table . 5. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . Hand Hygiene Table: . Before applying and after removing personal protective equipment (PPE), including gloves . Before and after handling clean or soiled dressings, linens, etc. After handling items potentially contaminated with blood, body fluids, secretions, or excretions. When, during resident care, moving from a contaminated body site to a clean body site . Example 1 R49 admitted to the facility on [DATE] and has diagnoses that include pressure ulcer of sacral region, unstageable and Type 2 diabetes mellitus with diabetic chronic kidney disease (a long-term condition in which the body has trouble controlling blood sugar and using it for energy and develops kidney disease). R49's Quarterly Minimum Data Set (MDS) Assessment, dated 5/21/25 shows R49 has a Brief Interview of Mental Status (BIMS) score of 13 indicating R49 is cognitively intact. R49's Care Plan dated 5/22/25, states, in part: . Focus: The resident has a urinary catheter. Date Initiated: 5/20/25. Revision on: 5/05/25 . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: *Catheter: care and treatment per current MD (Medical Doctor) orders. Date Initiated: 5/20/25. Revision on: 5/20/25 . R49's Physician Orders as of 6/11/25, states, in part: . Catheter care every shift for catheter hygiene . On 6/11/25 at 7:37AM, Surveyor observed CNA D (Certified Nursing Assistant) perform catheter care on R49. CNA D gathered supplies to include two garbage bags, one with 4 soapy washcloths in and the other garbage bag with rinse washcloths in. CNA D set both bags onto bed. CNA D grabbed a soapy washcloth and performed catheter care and then put soiled wash cloth back into the garbage bag with the clean soapy wash clothes. CNA D then reached into the garbage bag with the rinse washcloths in and retrieved a rinse washcloth and rinsed R49's peri area and catheter and put the used rinse washcloth back into garbage bag with the clean rinse wash clothes. CNA D then dried the peri area with a clean towel. CNA D removed gloves and performed hand hygiene with soap and water and applied new gloves. CNA D rolled R49 onto right side and reached into the garbage bag with soapy washcloths and grabbed the used washcloth with a spot of blood on it from previous catheter care. CNA D put the washcloth back into the garbage bag and retrieved a new washcloth and proceeded to perform cares on R49's bottom. CNA D placed used washcloths back into the garbage bag and grabbed a rinse washcloth out of the other garbage bag with the rinse washcloths in. CNA D rinsed and dried R49's bottom and then removed gloves and applied new gloves without hand hygiene. On 6/11/25 at 7:57AM, Surveyor interviewed CNA D and asked when hand hygiene should be performed during catheter/peri care. CNA D indicated before and after and if gloves become soiled. Surveyor asked if hand hygiene should be performed between removing gloves and applying new gloves. CNA D indicated yes. Surveyor asked CNA D if hand hygiene should have been completed after care was provided on R49's bottom, new gloves were applied, and a new brief placed under R49. CNA D indicated yes, I should have washed my hands. Surveyor asked if soiled washcloths should be in same garbage bag as the clean washcloths and CNA D indicated she keeps the dirty and clean separated in the garbage bags by keeping the dirty ones in one corner and clean ones in another corner. Surveyor asked CNA D if that could be a risk of cross contamination and CNA D indicated yes. On 6/11/25 at 8:20 AM, Surveyor interviewed DON B (Director of Nursing) and asked when hand hygiene should be performed during wound care and peri/catheter care. DON B indicated you would perform hand hygiene and change gloves in between cleansing the areas and rinsing the areas. DON B indicated hand hygiene should be performed after doffing and donning gloves. Surveyor informed DON B of observation of CNA D placing soiled washcloths and clean washcloths in the same garbage bags during catheter care. DON B indicated she would have expected separate garbage bags for the clean and dirty washcloths to avoid a risk of cross contamination.

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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 residents are free of any significant medication errors for 2 of 2 residents (R31 and R41) reviewed for medications. The facility did not ensure R31 took her evening medications as prescribed. R41 did not receive one dose of the intravenous (IV) antibiotic ordered for wound infection. This is evidenced by: The facility's policy titled Medication Errors, dated 5/28/25, includes: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services. Significant medication error means one which causes the resident discomfort or jeopardizes his/her health and safety. The facility shall ensure medications will be administered as follows: a. According to physician's orders. b. Per manufacturer's specifications regarding the preparation, and administration of the drug or biological. c. In accordance with accepted standards and principles which apply to professionals providing services. 3. Medication errors, once identified, will be evaluated to determine if considered significant or not by utilizing the following three general guidelines: a. Resident's condition: If the resident's condition requires rigid control . 4. The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: . Medication omission; The facility's Medication Administration policy, dated 5/28/25, states, in part: .20. Sign MAR (medication administration record) after administered. According to the National Institutes of Health National Library of Medicine (www.nih.gov), patients with Parkinson's disease require strict adherence to an individualized, timed medication regimen . Dosing intervals are specific to each individual patient because of the complexity of the disease. When medications are not administered on time and according to the patient's unique schedule, patients may experience an immediate increase in symptoms. Delaying medications by more than one hour, for example, can cause patients with Parkinson's disease to experience worsening tremors, increased rigidity, loss of balance, confusion, agitation, and difficulty communicating. Example 1 R31 admitted to the facility on [DATE] with diagnoses that include Parkinson's Disease (A disorder of the central nervous system that affects movement, often including tremors). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R31's physician orders, printed 6/11/25, include Carbidopa-Levodopa 25-100 mg tablet give 2.5 tablets by mouth six times a day for Parkinson's Disease 5:30 AM, 9:30 AM, 1:30 PM, 5:30 PM, 8:30 PM and 11:30 PM. On 6/10/25 at 11:51 AM, Surveyor entered R31's room. CNA Z (Certified Nursing Assistant) was finishing getting R31 up for the day. Prior to CNA Z leaving the room, CNA Z reminded R31 to take her medications. Surveyor observed medications on R31's bedside table and on R31's floor under R31's electric wheelchair. On 6/10/25 at 12:10 PM, Surveyor interviewed LPN F (Licensed Practical Nurse) regarding R31's medications. LPN F indicated she had given R31 her morning medication between 9:45 - 10:00 AM. LPN F indicated R31 had taken all her medication at that time. LPN F picked up the pill off the floor and removed the pills from R31's bedside table. LPN F identified the medications as Carbidopa-Levodopa. LPN F indicated the medications on the bedside table were left from the evening shift yesterday. LPN F cannot account for the time when the Carbidopa-Levodopa found under R31's electric wheelchair should have been administered. On 6/10/25 at 12:10 PM, Surveyor interviewed R31 regarding her medications. R31 indicated the medications were left from last night. R31 indicated she was too tired and forgot to take them. On 6/11/25 at 7:43 AM, Surveyor interviewed LPN J regarding medication errors. LPN J indicated an omitted medication is a medication error. On 6/10/25 at 2:47 PM, Surveyor interviewed DON B (Director of Nursing) regarding R31's medications. DON B indicated R31 had previously been able to self-administer her medications, but it became unsafe due to her tremors. DON B indicated in December 2024, R31 was assessed to not be able to self-administer her medications. DON B indicated staff were finding medications under R31 when she would take her medications in bed and on the floor also. Surveyor shared the observation of medications on R31's bedside table from the previous day and medication being found on the floor. DON B indicated omitted medications were a medication error. Example 2 R41 admitted to the facility on [DATE] and has a diagnosis of encounter for surgical aftercare following surgery on the digestive system. R41's Progress notes include: *5/27/25 1:28 PM received call from lab that wound culture contained klebsiella (a bacteria that can cause infection) . *5/27/25 3:46 PM .new orders for meropenem (antibiotic used to treat serious bacterial infections) . R41's Physician's Orders include: Meropenem Intravenous Solution Reconstituted 500 mg (milligrams) every 8 hours for incision infection. Start date: 5/28/25. End date: 6/4/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R41's June 2025 Medication Administration Record (MAR) shows a blank for the 6/1/25 10:00 PM dose of Meropenem Intravenous Solution. On 6/12/25 at 8:22 AM, Surveyor interviewed LPN H (Licensed Practical Nurse) and asked if documentation is needed when administering medications. LPN H stated that the medication needs to be signed out on the MAR. Surveyor asked what a blank on the MAR means. LPN H stated it wasn't given. On 6/12/25 at 8:30 AM, Surveyor interviewed ADON I (Assistant Director of Nursing) and asked about a blank on the MAR. ADON I stated it means it was not given. On 6/12/25 at 9:24 AM, Surveyor interviewed DON B (Director of Nursing) and asked if documentation is needed when administering medications. DON B stated the medication needs to be signed out on the MAR. Surveyor asked what a blank on the MAR means. DON B stated no one signed it out. Surveyor asked if a medication has been given if the MAR is blank. DON B stated no, if it is not documented, it was not done.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that each resident receives food and drink that is palatable and at a safe and appetizing temperature. This has the potential to affect 4 of 4 sampled residents (R56, R23, R37, R29) reviewed for food palatability and 4 of 4 supplemental residents (R2, R8, R14, and R5). R56, R23, R37, R29, R2, R8, R14, and R5 voiced concerns with their food not being palatable. Surveyors conducted 2 test trays and both test trays were not palatable. Evidenced by: Facility policy, titled Record Food Temperatures, implemented 5/28/25, includes: . Hot foods will be held at 135 degrees Fahrenheit or greater . Potentially hazardous cold food temperatures will be kept at or below 41 degrees Fahrenheit. Example 1 R29 admitted to the facility on [DATE]. His most recent Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 4/9/25, indicates his cognition is moderately impaired with a Brief Interview for Mental Status (BIMS) score of 11 out of 15. It also indicates he understands others and is understood by others. On 6/9/25 at 12:26 PM, R29 indicated their meat was too tough to chew. Surveyor observed R29's plate to have beef cut in bite size pieces pushed to the side. Example 2 R8 admitted to the facility on [DATE]. His most recent MDS with ARD of 3/8/25, indicates R8 is cognitively intact with a BIMS score of 13 out of 15. On 6/9/25 at 12:26 PM, R8 indicated the meat was too tough to chew. Surveyor observed R8's plate to have beef cut in bite size pieces pushed to the side. R8 demonstrated trying to pass a fork through the meat and was unsuccessful. Example 3 On 6/9/25 at 12:29 PM, Surveyor ordered a test tray. On 6/9/25 at 12:30 PM, Surveyor observed DA S (Dietary Aide) walking down the hallway with a room tray. The room tray had a plate of hot food on it and over the top of the food was the bottom of a heat holding cambrio. DA S indicated the cambrio should have a top that goes over the plate and a bottom that goes under the plate to keep the hot food hot, but the facility often runs out of cambrio bottoms and tops because there are more residents than cambrios in the facility. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/9/25 at 12:33 PM, Surveyor conducted a test tray in the facility's main dining room. The mixed vegetables temperature was 122 degrees Fahrenheit. The beef with gravy over rice was 130 degrees Fahrenheit. Surveyor tried to pass a fork in a piece of beef. With some pressure, Surveyor was able to pick up the meat with the fork. Surveyor was not able to chew the meat down enough to swallow as the meat was tough and difficult to chew. This test tray was not palatable. On 6/10/25 at 10:52 AM, [NAME] W indicated he partially cooked the beef the day prior to serving it and then finished it yesterday when it was served. [NAME] W indicated he knew the meat was tough, dry, and he thought he cooked it too long. [NAME] W indicated the recipe did not say to cook the meat two separate times. [NAME] W indicated the temperature of the food should be about 160 when it is plated. Example 4 R5 admitted to the facility on [DATE]. His most recent MDS with ARD of 4/4/25 Indicates R5 usually understands others and is usually understood by others. On 6/9/25 at 2:10 PM, R5 indicated the meat was terrible and tough in his noon time meal. R5 also indicated he eats most meals in his room and his hot food comes cold at times. Example 5 R14 admitted to the facility on [DATE]. Her most recent MDS with ARD of 4/4/25 indicates R14's cognition is intact with a BIMS score of 14 out of 15. On 6/9/25 at 2:15 PM, R14 indicated her meat was chewy at her noon lunch meal. R14 stated, I eat in my room, but the meal is cold a lot of the time. I have people bring me in food. I can't eat a lot of the food here it is terrible. At lunch, I couldn't swallow the meat, chewed and chewed and chewed. Example 6 On 6/10/25 at 11:06 AM, during the Resident Council Group Task, R23, R2, R8, and R37 voiced concerns related to their hot foods being served to cold and at an undesired temperature. On 6/10/25 at 1:43 PM, District Dietary Manager U and NHA A (Nursing Home Administrator) indicated hot foods should be served hot and cold foods should be served cold. Example 7 R56 admitted to the facility on [DATE] and has diagnoses that include mild protein-calorie malnutrition and fracture of right femur. R56's admission Minimum Data Set (MDS) Assessment, dated 3/28/25, shows R56 has a Brief Interview of Mental Status (BIMS) score of 9 indicating R56 has moderate cognitive impairment. On 6/9/25, at 10:52AM, R56 indicated to Surveyor that the food and coffee is always lukewarm to cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 8 R23 admitted to facility on 4/28/25 and has diagnoses that include moderate protein-calorie malnutrition, unspecified dementia (a diagnosis of dementia where the specific type of dementia cannot be clearly determined) and need for assistance with personal care. R23's admission MDS Assessment, dated 5/2/25, shows R23 has a BIMS score of 11 indicating moderate cognitive impairment. On 6/9/25, at 11:48AM, R23 indicated to Surveyor that the beef that was served for lunch he could not chew and food is not always hot. Example 9 On 6/9/25 at 11:05 AM, Surveyor interviewed R2 regarding the meals she eats at the facility. R2 indicated the meat they are served is tough to chew. R2 indicated when eating in her room, the food is always cold. R2 was eating in the dining room on 6/9/25 for lunch and stated the food is warmer when it is in the dining room. Example 10 On 6/12/25 at 12:03 PM, Surveyor observed meal delivery on the 300 and 400 hallways. The meal trays were on an open metal rack. The last tray was delivered at 12:17 PM. On 6/12/25 at 12:17 PM, Surveyor took the temperatures of the food on the test tray. Manicotti was 167 degrees Breadstick was 133.3 degrees Milk was 52.1 degrees Cranberry juice was 51 degrees The milk and Cranberry juice were not at a palatable temperature.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not provide food that accommodates resident preferences; appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice for 3 of 17 sampled resident's (R23, R31, & R37). R23 was being served foods that were listed on his meal ticket as disliked food. R23's food preferences were not being honored. R31 was being served gravy that was listed on her meal ticket as disliked food. R31's food preferences were not being honored. R37's received foods that are on the R37 has indicated she should not have. Evidenced by: The facility policy entitled Resident Food Preferences, dated 5/28/25, states, in part: . Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the resident's or representative's consent. Policy Interpretation and Implementation: 1. Upon the resident's admission (or within twenty-four (24) hours after his/her admission) the dietician or nursing staff will identify a resident's food preferences. 2. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. 3. Nursing staff will document the resident's food and eating preferences in the care plan . The facility's policy entitled Resident Rights, dated 5/8/25, states, in part: . Policy: The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay at the facility . 5 Self- Determination. The resident has the right to, and the facility must promote and facilitate the resident self-determination through support of resident choice . Example 1 (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R23 admitted to facility on 4/28/25 and has diagnoses that include moderate protein-calorie malnutrition, unspecified dementia (a diagnosis of dementia where the specific type of dementia cannot be clearly determined), and need for assistance with personal care. R23's admission Minimum Data Set (MDS) assessment dated [DATE] shows R23 has a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. R23's Care Plan, dated 4/29/25, states, in part: . Focus: The resident is at risk for inadequate intake related to does not wear dentures, history of dysphagia. Increased nutritional needs related to skin breakdown. Date Initiated: 4/29/25. Revision on: 4/29/25 . Interventions: . *Monitor/record/report to MD (medical doctor) PRN (as needed) s/sx (signs and symptoms) of malnutrition . *Provide, serve diet as ordered . R23's meal ticket shows: . Diet: Regular- regular consistency. Liquid: Thin. Allergies: NKA (no known allergies) Likes: Bananas, toast with jelly, pancakes, French toast, waffles, peanut butter & jelly sandwiches, soups, mashed potatoes. Dislikes: all vegetables, salads . On 6/9/25 at 11:48 AM, Surveyor observed R23's lunch tray being served to him in his room. Surveyor observed vegetables (carrots, yellow carrots, and green beans), rice and cubed beef on plate. R23 told the CNA (Certified Nursing Assistant) to take the tray back because the beef is too tough to chew, and he does not like vegetables. While this Surveyor was talking with R23, RD E (Registered Dietician) came into room and offered R23 alternatives. R23 indicated wanting a peanut butter and jelly sandwich and mashed potatoes with gravy if they have it. R23 told RD E, I told you last week I don't like vegetables. RD E indicated she was aware, and the staff must get better about not serving disliked foods. Surveyor asked RD E to see the meal ticket she brought into R23's room. Surveyor pointed out the disliked foods R23 has listed, and vegetables were one. RD E indicated they must get better about this, and she was going to talk with the kitchen staff about this. On 6/9/25 at 11:48 AM, Surveyor interviewed R23 who indicated he was losing weight, and he has no teeth. R23 indicated he does not like vegetables or oatmeal, and he has told the staff this and he keeps getting served vegetables and oatmeal and items he can't chew. R23 indicated he voiced this concern to the dietician just last week. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 8:01 AM, Surveyor interviewed RD E and asked if residents should be served foods they have listed as disliked foods and RD E indicated no. Surveyor asked if preferences should be respected, and RD E indicated yes. RD E indicated R23 should not have been served vegetables as it was a dislike of his. RD E indicated she was going to educate the kitchen staff regarding this issue. Example 2 R37 was admitted to the facility on [DATE] with diagnoses that include vascular dementia, Crohn's disease (a chronic inflammatory bowel disease that causes inflammation and swelling in the digestive tract), and history of strokes. R37's most recent Minimum Data Set (MDS) dated [DATE] states that R37 has a Brief Interview of Mental Status (BIMS) of 14 out of 15, indicating that R37 is cognitively intact. R37's care plan dated 3/18/24 states in part: .Focus: The resident has an alteration in gastro- intestinal status r/t (related to) GERD (Gastroesophageal reflux disease (a chronic digestive disorder that occurs when stomach contents flow back into the esophagus, causing irritation), Crohn's .Interventions: Avoid snacks that aggravate the condition. Give medications as ordered. Monitor/document side effects and effectiveness. Obtain and monitor lab/ diagnostic work as ordered. Report results to MD and follow up as indicated . It is important to note that R37's care plan does not indicate what foods to avoid or what safe alternatives would be. R37's dietary meal ticket states in part .Instructions: Low Residue diet. No fresh vegetables, no oatmeal, no beans, no salad- or may have if resident requests . On 6/9/25 at 11:25 PM, Surveyor interviewed R37. R37 reported that she has Crohn's Disease and that sometimes the dietary staff gives her food items that are not compatible with her disease. On 6/9/25 at 12:27 PM, Surveyor observed R37's meal in the dining room. R37 was served mixed vegetables that included green beans. R37 reported to Surveyor that staff gave her mixed vegetables that she can't eat, despite it being on her meal ticket. On 6/9/25 at 12:33 PM, Surveyor interviewed RD E (Registered Dietician). Surveyor asked RD E if a resident's meal ticket says no beans, should the resident be served beans, RD E stated no. Surveyor reviewed R37's meal ticked with RD E. RD E stated that R37 should have not been served beans. Example 3 R31's meal ticket, printed 6/11/25, includes: Dislikes: Gravy Breakfast: . Cherrios [sic] . (continued on next page)

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	525519	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Care Age	1755 N. Barker Rd. Brookfield, WI 53045

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 2:13 PM, Surveyor interviewed R31 regarding her meals. R31 stated she dislikes gravy, and it is on her meal ticket. R31 stated I think they think it says I like gravy because they always give me extra. R31 expressed frustration with receiving gravy at mealtimes because she has told them she dislikes it and it is on her meal ticket yet she continues to receive gravy. R31 indicated she frequently has to ask staff to bring her Cheerios at breakfast even though it is listed on her meal ticket that she wants to receive Cheerios at breakfast.

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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 observation and interview, the facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 57 residents who reside in the facility. The facility did not have a system in place for manually monitoring the internal concentration of the chemical dishwasher. Surveyor observed staff prepping food and in food preparation areas without hair restraints. Surveyor observed food in circulation to be opened and undated or pass the expiration date. Evidenced by: Example 1 Facility's policy, titled Recording Dish Machine Temperatures, undated, includes: Dishwashing staff will monitor and record dishwasher machine temperatures to assure proper sanitizing of dishes. The food service manager will train dishwashing staff to monitor dish machine temperatures throughout the dishwashing process. Staff will be trained to record dish machine temperatures for the wash and rinse cycles at each meal. The food service manager will spot check this log to assure temperatures are appropriate and staff is actually monitoring dish machine temperatures. Dishwashing staff will be trained to report any problem with the dish machine to the food service manager as soon as they occur. The food service manager will promptly assess any dish machine problems and take action immediately to assure sanitation of dishes. (It is important to note the facility has a dishwasher set up to be a chemical sanitizing dishwasher and the facility would need a policy related to manually monitoring the concentration of the dishwasher, not the temperature.) On 6/9/25 at 10:16 AM, DA T (Dietary Aide) indicated he was unsure if the facility used anything for monitoring the internal temperature or the parts per million of the dishwasher. DA T indicated there is a log for recording dishwasher temperatures. DA T indicated there are test strips that they could use too. Surveyor observed the test strips to have expired on 10/1/21. Surveyor observed the dishes pass through the dishwasher and the dishwasher stayed at a constant temperature of about 120 degrees Fahrenheit. DA T indicated the dishwasher should be at 150 for wash and 180 for rinse. DA T indicated the nursing staff used all of the hot water for resident showers and that is why the dishwasher is not reaching temperature. Surveyor observed DA T continue to pass dishes through dish washer. On 6/9/25 at 10:31 AM, District Dietary Manager T indicated the dishwasher should reach 150 degrees Fahrenheit for wash and 180 degrees Fahrenheit for rinse. District Dietary Manager T and Surveyor observed the dishwasher noting the temperature is staying right around 120 degrees Fahrentheit. District Dietary Manager T indicated someone else was on the way and they would know the dishwasher better than her. District Dietary Manager T and Surveyor reviewed the Dish Machine Temperature Log together. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dish Machine Temperature Log Diary dated 1/1/25-6/9/25, include: Temperature must be recorded once during each meal period daily. If dishwasher does not reach minimum temperature for wash and rinse, contact manager on duty. AM- Wash 150 . Rinse 180 . PM- Wash 150 . Rinse 180 . All boxes have check marks . On 6/10/25 at 11:48 AM, District Dietary Manager U indicated the facility does not have a system for monitoring of internal temps or concentration of dishwasher, but he called Ecolab, and he will get a system going. On 6/10/25 at 1:43 PM, NHA A (Nursing Home Administrator) and District Dietary Manager U indicated the facility should be monitoring the dishwasher's concentration with test strips and not monitoring the temperature, because the dishwasher is set up to be a chemical sanitizing machine. District Dietary Manager U indicated he received some test strips from Ecolab that were not expired and he threw the expired ones out. NHA A indicated the facility has a new log now that they will be using to record the test strip results daily. Example 2 Facility policy, titled Hair Restraints, undated, includes: Policy- to ensure that proper sanitation standards are being followed in all dining department kitchens. Procedure- all staff entering a kitchen will wear a hairnet/hair restraint, ensuring that all hair is completely covered by the hair net. Hairnets/hair restraints will be available to all staff near the entrance to each kitchen. Signs will be posted on each kitchen door to alert staff to wear a hair net/hair restraint before entering. On 6/10/25 at 10:52 AM, Surveyor observed District Dietary Manager U to have very short hair and beard and to be in the food preparation area with no beard net or hair restraint. On 6/10/25 at 10:52 AM, Surveyor observed [NAME] W to be using the 3-compartment sink with no beard net. [NAME] W indicated he was washing cookie sheets. On 6/10/25 at 11:35 AM, Surveyor observed [NAME] V to have an uncovered mustache while scooping coleslaw and putting it into small bowls. [NAME] V indicated he forgot to put on a beard net, and he would get one right away. On 6/10/25 at 11:48 AM, District Dietary Manager U indicated he thinks hair over 1/2 inch needs to be covered by a hair restraint . On 6/10/25 at 1:43 PM, NHA A and District Dietary Manager U indicated all hair should be restrained when in the kitchen and especially when working with clean dishes and open food. Example 3 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility policy, titled Dining Department Storage, undated, includes: Food should be dated as it is placed on the shelves . Date marking to indicate the date or day by which a ready to eat, potentially hazardous food should be consumed, sold, or discarded will be visible on all high risk food . Leftover food . is clearly labeled and dated before being refrigerated . All food should be covered, labeled, and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded . On 6/9/25 at 9:54 AM, Surveyor observed honey wheat bread that had been opened with no open date. Surveyor observed opened breaded fish in the freezer with no open date, opened breaded chicken patties in the freezer with no open date, opened turkey brats with no open date, and opened chicken breasts in the freezer with no open date and no expiration date. In the facility's walk-in refrigerator, Surveyor observed sliced ham to be dated 5/10/25, applesauce to be removed from original container with no label/ no open date/no expiration date, and Surveyor observed potato salad that had been opened with no open date. During an interview [NAME] W indicated all food that is opened should have an opened date, the ham should have been tossed out, and any food removed from the original container should also have a label on it of what it is. On 6/10/25 at 1:43 PM, NHA A and District Dietary Manager U indicated all opened food should be labeled and dated and food pass the use by date or expiration date should be discarded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility has not established 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 3 of 19 sampled residents (R49, R23, and R41) and 1 of 1 supplemental residents (R19) observed for hand hygiene. Staff did not perform proper hand hygiene per standards of practice during wound care on R49 and R23. A nurse had a breach in infection control during medication adminstration observation for R19 when a nurse did not perform hand hygiene following a blood glucose test. A nurse had a breach in infection control during wound care for R41. Evidenced by: The facility policy entitled Hand Hygiene, dated 5/28/25, states, in part: . Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Policy Explanation and Compliance Guidelines: . 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table . 5. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . Hand Hygiene Table: . Before applying and after removing personal protective equipment (PPE), including gloves . Before and after handling clean or soiled dressings, linens, etc. After handling items potentially contaminated with blood, body fluids, secretions, or excretions. When, during resident care, moving from a contaminated body site to a clean body site . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Hand Hygiene policy, dated 5/28/25, states, in part: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.2. Hand hygien is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table.Hand Hygiene Table includes: *after handling contaminated objects *before and after handling clean or soiled dressings, linens, etc *after handling items potentially contaminated with blood, bodily fluids, secretions, or excretions . The facility's Clean Dressing Change policy, dated 5/28/25, states, in part: It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination.9. Loosen the tape and remove the existing dressing. 10. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. 11. Wash hands and put on clean gloves. 12. Cleanse the wound as ordered . Example 1 R49 admitted to the facility on [DATE] and has diagnoses that include pressure ulcer of sacral region, unstageable and Type 2 diabetes mellitus with diabetic chronic kidney disease (a long-term condition in which the body has trouble controlling blood sugar and using it for energy and develops kidney disease). R49's Quarterly Minimum Data Set (MDS) Assessment, dated 5/21/25 shows R49 has a Brief Interview of Mental Status (BIMS) score of 13 indicating R49 is cognitively intact. R49's Care Plan dated 5/22/25, states, in part: . Focus: The resident has pressure ulcer coccyx and right ischium related to immobility, ulcers present upon admission and prior admit to facility. Date Initiated: 5/22/25. Revision on: 5/22/25 . Interventions: . Administer treatments as ordered and monitor for effectiveness. Date Initiated: 5/22/25 . R49's June Medication Administration Record (MAR) shows order: Dakin's wash to right ischial wound followed by culiform packing to fill open space of wound and cover with 4 x 4 bordered gauze every day and evening shift for wound care. Order Date: 6/3/25 . On 6/10/25 at 7:24 AM, Surveyor observed NP C (Nurse Practitioner) perform wound care on R49's coccyx and right ischium. Surveyor observed NP C remove the dressing and packing from the ischium wound and measure the wound. NP C removed gloves and applied new gloves without hand hygiene. NP C applied treatment and dressing to the ischium wound then removed gloves. NP C applied new gloves without hand hygiene. NP C measured the coccyx wound and applied treatment and dressing. NP C removed gloves and applied new gloves without hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/10/25 at 8:05 AM, Surveyor interviewed NP C and asked when hand hygiene should be performed during wound care. NP C indicated you would remove gloves every time when it's dirty. NP C indicated she washes hands when she leaves the residents' rooms. NP C indicated that is the policy she follows. Surveyor asked if hand hygiene should be performed after doffing and donning gloves and NP C indicated she removes the dirty with the glove. On 6/11/25 at 8:20 AM, Surveyor interviewed DON B (Director of Nursing) and asked when hand hygiene should be performed during wound cares and peri/catheter cares. DON B indicated you would perform hand hygiene and change gloves in between cleansing the area and rinsing the area. Surveyor informed DON B of observation of NP C removing gloves and applying new gloves without hand hygiene. DON B indicated hand hygiene should be performed after doffing and donning gloves. Example 2 R23 admitted to facility on 4/28/25 and has diagnoses that include moderate protein-calorie malnutrition, unspecified dementia (a diagnosis of dementia where the specific type of dementia cannot be clearly determined) and need for assistance with personal care. R23's admission MDS assessment dated [DATE] shows R23 has a BIMS score of 11 indicating moderate cognitive impairment. R23's Care Plan dated 4/29/25, states, in part: . Focus: The resident has multiple pressure ulcers relate to immobility, deconditioning and refusals to reposition at times. Date Initiated: 4/29/25. Revision on: 4/29/25 . Interventions: . *Administer treatments as ordered and monitor for effectiveness. Date Initiated: 4/29/25 . R23's June MAR shows: Bilateral Buttock Wounds: Cleanse with saline, pat dry. Skin prep peri-wound. Apply calcium alginate to wound base, cover with bordered gauze dressing every day shift for wound care. Order Date: 6/5/25. Discontinue Date: 6/10/25 . Normal Saline Wash to left plantar foot wound followed by skin prep to peri wound followed by Purachol to wound bed followed by bordered gauze every day shift every Tuesday, Thursday, Saturday for wound care. Order Date: 5/20/25 Discontinue Date: 6/10/25 . Normal Saline Wash to left front iliac crest wound followed by skin prep to peri wound followed by Purachol and foam dressing every day shift every Tuesday, Thursday, Saturday for wound care. Order Date: 5/20/25 . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/10/25 at 7:41 AM, Surveyor observed NP C perform wound care on R23. NP C removed dressing from left foot, measured the wound and removed her right glove with gloved left hand and applied new right glove without hand hygiene. NP C measured left iliac wound and applied alginate and bordered gauze. NP C removed gloves and applied new gloves without hand hygiene. NP C removed dressings to right lower leg, cleansed wound and applied treatment and dressing. NP C removed right glove with gloved left hand and applied new glove without hand hygiene. NP C measured moisture associated dermatitis wound on R23's bottom, cleansed wound and applied treatment. NP C removed both gloves and applied new gloves without hand hygiene. NP C measured right and left buttock wounds and applied treatment and dressings. NP C removed gloves and applied new gloves without hand hygiene. On 6/10/25 at 8:05AM, Surveyor interviewed NP C and asked when hand hygiene should be performed during wound care. NP C indicated you would remove gloves every time when it's dirty. NP C indicated she washes hands when she leaves the residents' rooms. NP C indicated that is the policy she follows. Surveyor asked if hand hygiene should be performed after doffing and donning gloves and NP C indicated she removes the dirty with the gloves. On 6/11/25 at 8:20 AM, Surveyor interviewed DON B (Director of Nursing) and asked when hand hygiene should be performed during wound cares and peri/catheter cares. DON B indicated you would perform hand hygiene and change gloves in between cleansing the area and rinsing the area. Surveyor informed DON B of observation of NP C removing gloves and applying new gloves without hand hygiene. DON B indicated hand hygiene should be performed after doffing and donning gloves. Example 3 On 6/11/25 at 11:51 AM, Surveyor observed LPN J (Licensed Practical Nurse) during Medication Administration observation. LPN J performed a blood glucose test for R19 in R19's room. LPN J took the supplies to the medication cart in the hall, opened the medication cart drawer and accessed disinfectant wipes to wipe off the testing meter. LPN J did not remove gloves or perform hand hygiene after the test, prior to touching the medication cart. Surveyor interviewed LPN J and asked about hand hygiene. LPN J stated that hand hygiene is needed before resident cares, when coming out of a resident room, and before and after any procedures. Surveyor asked about hand hygiene following R19's blood glucose test. LPN J stated that gloves should have been removed and hand hygiene should have been performed prior to touching the medication cart. On 6/12/25 at 9:06 AM, Surveyor interviewed DON B (Director of Nursing) and asked about hand hygiene when performing a blood sugar. DON B indicated that gloves are contaminated following blood glucose testing. DON B stated that gloves should be removed after the test and hands cleansed prior to touching the medication cart. Example (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/11/25 at 11:10 AM, Surveyor observed LPN G (Licensed Practical Nurse) perform wound care for R41. LPN G removed R41's wound dressing, disposed of the dressing, then began to cleanse the wound. LPN G did not remove gloves and cleanse hands prior to cleansing the wound. Following the dressing change, LPN G removed gloves, then with bare hands, grabbed the outside front of the gown and pulled the gown away to remove it. Upon leaving R41's room, Surveyor asked LPN G when hand hygiene is needed during wound care. LPN G stated before starting, anytime you go from dirty to clean, and after complete. Surveyor asked if a wound dressing is considered dirty. LPN G stated yes, gloves should have been removed and hand hygiene performed after removal of the dressing. Surveyor asked about procedure for removal of PPE. LPN G stated gloves are removed first, then gown. Surveyor asked if the outside of the gown should be touched with bare hands. LPN G stated, no, the gown should be touched inside when removing. Surveyor asked if LPN G had touched the outside of the gown. LPN G stated yes. On 6/12/25 at 9:06 AM, Surveyor interviewed DON B (Director of Nursing) and asked about hand hygiene with wound care. DON B stated that there should be removal of gloves and hand hygiene after removal of a wound dressing, prior to cleansing the wound. Surveyor asked DON B about technique for removal of PPE. DON B stated that the outside of the gown is contaminated and should not be touched with bare hands.