STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2026
NAME OF PROVIDER OR SUPPLIER Avina on Division		STREET ADDRESS, CITY, STATE, ZIP CODE 517 E Division St Fond Du Lac, WI 54935	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the local police department's body worn camera (BWC) report, and policy review, the facility failed to ensure one of five sampled residents (Resident (R) 2) was treated with dignity related to toileting needs. R2 was care planned to use the toilet; however, staff used a bedpan and/or incontinence pad. This caused R2 to feel discomfort and embarrassment. Findings include:Review of the facility's policy titled Dignity, revised 01/2025, revealed, The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The facility shall consider the resident's lifestyle and personal choices identified through the assessment processes to obtain a picture of his or her individual needs and preferences. Staff shall carry out activities in a manner which assists the resident to maintain and enhance his/her self-esteem and self-worth.Review of R2's admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R2 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD), osteomyelitis of the vertebra, lumbar region, pan lobular emphysema, and chronic myeloid Leukemia, not having achieved remission.Review of the local police department's narrative, dated 11/28/25 at 1:27 PM and transcribed from body worn camera (BWC) footage, revealed police officers responded to a call at the facility for a complaint about lack of care. The report recorded that upon arriving at the facility, the officer spoke to one of the nurses and was told they (the facility) were following up as best they could, but that there could have been miscommunication with the prior shift that resulted in R2 not getting the care that she needed. It was recorded the police officer spoke with the facility's Administrator who stated R2 needed constant care for her condition and that it was difficult to get her that amount of care due to lack of staffing. The report recorded that R2 told the police officer that the facility put down the chucks (an absorbent incontinence pad) instead of a bedpan and that she had been sitting in her bowel movement for quite some time. The report recorded that R2 told the officer that the last time that she had her chucks changed was around 11:30 AM or 12:00 PM, and it had been over three hours since she had been cared for. The report recorded the officer spoke with nursing staff and told them they should try and follow up with R2 as soon as possible to make sure she is taken care of.Review of R2's Care Plan dated 01/22/26 and located in the EMR under the Care Plan tab, revealed a focus of, The resident has constipation r/t (related to) opioid use. The goal was, The resident will have a normal bowel movement at least every 3-4 days through the review date. Interventions included, Encourage resident to sit on the toilet to evacuate bowels if possible.Review of R2's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/28/26 and located in the EMR under the MDS tab, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R2 was cognitively intact. It was recorded R2 had functional limitations in range of motion to her lower extremities on both sides, was mobile by wheelchair, and was frequently incontinent of bowel. The assessment revealed R2 was dependent on staff for chair/bed-to-chair transfers and toilet transfer was not attempted due to medical condition or safety concerns.Review of R2's undated Kardex (an (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avina on Division	517 E Division St Fond Du Lac, WI 54935

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abbreviated care plan used by nursing staff) located in the EMR under the Care Plan tab, revealed, TOILET USE: The resident requires assistance by 2 staff using a bed pan for toileting. The information recorded on the Kardex was inconsistent with the interventions listed on R2's Care Plan. During an interview on 03/25/26 at 9:00 PM, R2 stated she was aware of when she needed to have a bowel movement. R2 stated that sometimes staff would give her the bedpan to use, but other times, staff would place an incontinence pad underneath her. R2 was asked how using the bedpan or incontinence pad made her feel. R2 stated that it was uncomfortable and embarrassing. She stated she would prefer to be gotten out of bed with the lift and use the toilet. R2 stated that recently someone transferred her using the sit-to-stand lift and that it worked well. R2 stated if staff would use the sit-to-stand lift to get her up, then maybe she could use the toilet.During an interview on 03/26/26 at 11:55 AM, Licensed Practical Nurse (LPN) 1 confirmed she was working on 11/28/25 when the police responded to a call from R2. LPN1 confirmed she told the police there had been a miscommunication and R2 did not get the care she needed. LPN1 stated she felt like the residents needed more attention than staff could provide.

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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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct an assessment for a patient-reported change in condition for one of five residents (Resident (R) 2) reviewed for change in condition. On 02/17/26, R2 complained to Licensed Practical Nurse (LPN) 1 that she might need to go to the hospital. LPN1 did not immediately assess the resident to determine if R2 had an emergent need after R2 reported respiratory symptoms. This resulted in R2's Family Member (F1) calling 911. R2 was transferred to the hospital and was diagnosed with acute hypoxic respiratory failure, chronic pulmonary emboli (PE) without acute cor pulmonale, and bronchiectasis with acute lower respiratory infection.Findings Include:According to BOARD OF NURSING N 6.03 Chapter N 6 STANDARDS OF PRACTICE FOR REGISTERED NURSES AND LICENSED PRACTICAL NURSES> N 6.04 Standards of practice for licensed practical nurses. (1) PERFORMANCE OF ACTS IN BASIC PATIENT SITUATIONS. In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a provider: (a) Accept only patient care delegated acts which the L.P.N. is competent to perform. (b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient. N 6.03 Standards of practice for registered nurses. (1) GENERAL NURSING PROCEDURES. An R.N. 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.Review of R2's admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses including osteomyelitis of the vertebra, lumbar region; chronic obstructive pulmonary disease (COPD); panlobular emphysema; and chronic myeloid leukemia, not having achieved remission.Review of R2's Care Plan, dated 12/14/25 and located under the Care Plan tab in the EMR, revealed a focus of, The resident and resident's spouse display socially inappropriate and maladaptive behavior related to making inappropriate phone calls to the emergency medical system (EMS 911) when an actual emergent/crisis situation does not exist. The goals included, The resident will communicate needs to staff and follow his/her recommended treatment plan without abusing the EMS by the next review. Interventions included, Educate the resident about the role and purpose of the EMS, specifically for its use for persons with serious injuries and life or death situations. Explain the consequences of diverting fire, police and paramedic resources away from an emergency. This behavior may place an innocent citizen in serious jeopardy.Review of R2's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/28/26 and located in the EMR under the MDS tab, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. It was recorded R2 had functional limitations in range of motion to her lower extremities on both sides and was mobile by wheelchair.Review of R2's Progress Note, dated 02/17/26 at 8:09 AM and located under the Progress Notes tab of the EMR, revealed R2 received a nebulizer treatment of Ipratropium-Albuterol Inhalation Solution, 0.5-2.5 (3) mg (milligrams)/3ml [milliliter] 1 [one] application inhale orally every 6 [six] hours as needed for SOB [shortness of breath]/whezzing [sic] . At 8:59 AM, it was documented that the nebulizer treatment was effective.Of note, the LPN did not collect data or alert a Registered Nurse of R2's report of feeling SOB with wheezing. The facility did not complete a comprehensive respiratory assessment or vital signs despite R2's complaint of SOB. Review of a Progress Note, dated 02/17/26 at 1:52 PM, located in the resident's EMR under the Progress Notes tab, and signed by Licensed Practical Nurse (LPN) 1, revealed, .Resident transferred out to hospital after husband called ambulance for them to come get her for resident stating she was having increasing shortness of breath . Review of R2's hospital Discharge summary, dated [DATE] and provided by the facility, revealed, .came to the ER [Emergency Room] with dyspnoea [sic] [shortness of breath] and wheezing. She denied any chest (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	pain or leg swelling. No nausea or vomiting .She came to the ER where CTA [Computerized Tomography Angiography, a type of medical test to help diagnose and evaluate blood vessel disease or related conditions, such as aneurysms or blockages] showed no acute PE [pulmonary emboli] but possibility of chronic PE and lung nodule. [Physician name withheld, pulmonologist] was contacted and recommended starting the patient on heparin drip. Whilst in the ER she was hypoxic with SAO2 [oxygen saturation of arterial blood] in the low 80's .Patient was then transition [sic] to Eliquis prior to discharge. Patient has been off oxygen through the night and maintain saturations at 98% on room air .Of note, R2 was found to have hypoxia, low oxygen saturation, and a pulmonary embolism upon admission to the emergency room. According to https://www.mayoclinic.org/diseases-conditions/pulmonary-embolism/symptoms-causes/syc-20354647, A pulmonary embolism is a blood clot that blocks and stops blood flow to an artery in the lung. Because one or more clots block blood flow to the lungs, pulmonary embolism can be life-threatening. However, prompt treatment greatly reduces the risk of death. Review of a facility grievance file, dated 02/17/26, with a report date of 02/20/26 and provided by the facility, revealed, Grievance Details .Resident [R2] stated that when she was sent to the hospital, on 2/17/26, her requests to be sent out to the hospital were 'Ignored' .Summary of Investigation .Resident stated to a staff member that she was trying to be sent out to the hospital on 2/17/[26], but 'nobody listened to her.' .Summary of Findings .the nurse on duty and CNA [Certified Nursing Assistant] was in and out of her room providing cares. There was at no time she was noticed to be in distress. She never let the nurse know either way, and the next thing the facility knew was that the husband had called EMS [Emergency Medical Services]. Before the nurse could even get in to assess the resident, the EMTs [Emergency Medical Technicians] were here and taking [R2] to the hospital .Summary of Actions Taken .Staff interviews conducted. [R2] did not mention to any staff members that she wanted to go out . This grievance had a resolved date of 02/20/26 by the Administrator. The Resolved Note recorded, [R2]'s husband came in on the 20th. Was happy with the resolution to concern and has no other concerns at this time. [R2] expresses no concerns.Contained within the grievance file were statements dated 02/19/26 from the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Medication Technician (MT) 2. Each statement recorded that R2 did not tell any of them she wanted to go to the hospital. A statement from MT1 was also contained within the file. The statement recorded R2 told MT1 that she needed a nebulizer treatment. It was recorded that MT1 told R2 that the nurse would provide the nebulizer treatment. MT1 recorded that R2 received her nebulizer treatment as ordered. MT1 stated R2 did not tell her that she needed to go to the hospital. A statement from LPN1 was also contained in the file. LPN1's statement recorded, [R2] stated she 'may need to go to the hospital' I told her to let me know if she does. Next thing I knew, EMS had been called by her husband. She never told me that she wanted to officially go to the hospital.Review of a Progress Note, dated 02/19/26 at 1:11 PM and located in the Progress Notes tab of the EMR, revealed, .Writer did not have time to assess resident as EMT's had already arrived . During an interview on 03/26/26 at 8:30 AM, R2 was asked to tell Surveyor what happened in February when she wanted to go to the hospital. R2 stated she asked LPN1 to come to her room and told her what was going on. R2 was asked what she specifically told LPN1 about how she was feeling. R2 stated she told LPN1 she needed to go to the hospital. R2 stated she was wheezing a lot but not gasping for air. She stated she tried to take deep breaths and stay calm. When asked if LPN1 did any type of assessment, like listening to her lungs, R2 stated LPN1 did not do anything. R2 stated LPN1 said she would have to wait to hear from the doctor to get permission to send her over (to the hospital.) R2 asked how long she waited. R2 stated she waited for about an hour but then called her husband, told him what was going on, and he called 911. R2 was asked what they found at the hospital. She stated the hospital found a blood clot in her lung.During an interview with FM1 on 03/26/26 at 9:00 AM, FM1 was asked about calling 911 for R2 in mid-February. FM1 stated that R2 called him, was crying, and she was calling out to anyone in the hallway. FM1 stated he called 911 for R2 because she was saying she needed to go to the hospital (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	and staff was not doing anything.During an interview on 3/26/26 at 11:55 AM, LPN1 stated R2 was pretty independent. LPN1 stated that if staff were not responsive, R2 would call on the facility's phone. LPN1 was asked if she was working on the day R2 stated she was not feeling well and was short of breath. LPN1 stated she was completing the medication pass when R2 told her she may need to go to the hospital. LPN1 stated that R2 told her she was feeling short of breath. LPN1 stated she could see R2 was not in dire need and by the time she went down to the resident's room, which was in maybe five minutes, the resident's husband had already called 911. LPN1 stated R2 had just came back in from smoking and stated her chest had been feeling funny lately. LPN1 stated R2 will say things like that a lot and nothing seemed different. When asked what the resident specifically said to her, the LPN stated that all the resident said was, I may need to go out. LPN1 stated that because R2 complained about different things and ailments and was talking fine and was not short of breath, she figured she had a few minutes to get down there (to the resident's room.) LPN1 was asked if she would have responded differently if this had been any other resident. LPN1 stated she would have assessed them. LPN1 was asked if anything had happened as a result of this incident. She stated that the Administrator and DON talked to her about it. LPN1 stated she had been instructed that an assessment should have been completed.During an interview on 03/28/26 at 4:39 PM, the Medical Director stated it was her expectation that when a resident stated they wanted to go to the hospital, staff would conduct an assessment, obtain vital signs, and report to her or the Nurse Practitioner. The Medical Director stated this was the first time she had heard about the incident with R2 but that the Nurse Practitioner might be aware.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review including review of the Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) report, review of the documented narrative from the local police department's body-worn camera, review of job descriptions, review of facility policies and procedures, and facility document review, the facility failed to ensure sufficient nurse staffing was available to meet the immediate care needs of the residents, failed to ensure staff had the appropriate competencies and skill sets to provide nursing and related services to assure resident safety, and failed to ensure Licensed Practical Nurses (LPNs) and Certified Medication Aides/Medication Technicians (CMAs/MTs) provided services that met professional standards of practice. These deficient practices had the potential to affect all 34 residents currently residing in the facility. Findings include:The facility's undated job description titled, Certified Medication Aide included: .Purpose of Your Job Position .The primary purpose of your job position is to assist in the administering of medications to residents as ordered by the attending physician, under the direction of the attending physician, the nurse supervisor or charge nurse, and the Director of Nursing Services. The administration of medications shall be in accordance with established nursing standards, the policies, procedures, and practices of this facility, and the requirements of this state . The facility's policy titled, Delegation of IV Therapy to Licensed Practical Nurses in Wisconsin, reviewed on June 2024 included: Purpose: To ensure a consistent and compliant delegation process of specific IV related nursing tasks from the Registered Nurse to the Licensed Practical Nurse .1. Delegation: is the act of allowing the Licensed Practical Nurse to perform a skill or task that would be outside their traditional role or not be part of their normal routine. 2. Delegated Responsibility: a nursing activity, skill or procedure that is transferred from a licensed nurse to delegatee. 3. Delegatee: the Licensed Practical Nurse that accepts the delegated task. 4. Delegator: the Registered Nurse delegating the nursing task. 5. Basic Patient Situation: As determined by an RN, physician .means the following three conditions prevail at the same time in a given situation: a. The patient's clinical condition is predictable; b. Medical or nursing orders are not changing frequently and do not contain complex modifications; AND c. The patient's clinical condition requires only basic nursing care .8. General Supervision: Regularly coordinates, directs, and inspects the practice of another .2. Nursing tasks related to IV therapy may be delegated to the LPN by the RN under general supervision if it is determined that the task is within the criteria of a Basic Patient Situation. This is determined by assuring the following: a. The IV skill/task has been performed prior without resident complication. b. Medication infusion is not a first dose and the resident has demonstrated tolerance of the first dose. c. The resident is medically stable as it relates to the IV task being delegated. d. The task does not require IV push medication administration .5. The LPN accepting delegation of IV tasks must be properly trained. This training will include but not be limited to: a. Didactic knowledge of principles and complications of peripherally inserted IV lines. b. Able to identify resident data that signals fluid overload or intolerance of IV administered medications c. Knowledge of complications and data that would suggest compromised or infected IV line. d. Must be able to demonstrate skill in administering IV flushes, administration of IV antibiotics, discontinuation of peripheral IV line, and operation of infusion pump. e. Knowledge of when to update RN about issues related to IV tasks. f. Knowledge of overall emergency procedures related to resident change in condition. The facility's policy titled, Medication Tech Policy for WI (Wisconsin), dated 01/05/25, included: Policy: It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by ensuring residents receive care and services safely and ensuring medication technicians assist in providing medications to the residents within their scope of practice .Allowed (under RN Delegation and Competency) Administer routine oral medications they've been trained for per Wisconsin training curricula. Perform (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	tasks that the RN has delegated after confirming competency. Additional Training Needed .PRN medication decisions (medication aides are not trained in PRN judgment.) RNs may decide to delegate tasks not included in base training only after documented training and competency validation, and only with appropriate supervision. This is a decision that warrants additional scrutiny .Ensure competency documentation is available for all medication aides, including agency or floating aides .Be sure licensed nurses understand the restrictions medication aides have so that they do not ask them to practice outside of their scope .Also included in the above Med Tech policy under Additional Training Needed is: Injections .RNs may decide to delegate tasks not included in base training only after documented training and competency validation, and only with appropriate supervision. This is a decision that warrants additional scrutiny .Ensure competency documentation is available for all medication aides, including agency or floating aides .Be sure licensed nurses understand the restrictions medication aides have so that they do not ask them to practice outside of their scope .Review of the State of Wisconsin Department of Health Services, Medication Administration by Unlicensed Assistive Personnel (UAP), dated 05/2023, revealed .All nursing homes providing administration of a medication by an UAP (Medication Aide/Nurse Aide) must meet the following conditions: 1. The nursing home has written policies and procedures designed to provide safe and accurate administration of medication. Personnel assigned to administer medications shall follow these policies .2. There is a written delegation of this nursing act (medication administration) by the registered nurse. ((DHS 132.62(2)(a)3) 3. There is documentation to support the educational preparation of the caregiver that administers medications. (DHS 132.60(5)(d)1) 4. There is immediate and accessible supervisory support available to the caregiver administering medications. (42 CFR 483.45) .A state-approved nursing home medication administration course covers medication administration technique including: oral, sublingual, topical, rectal suppositories, eye drops, eye ointments, ear drops, vaginal suppositories, multi dose oral inhalers, and nasal inhalers. All unlicensed personnel who administer medications in a nursing home must take this State of Wisconsin approved course or meet the course requirements. If these individuals will administer other types of medications (e.g., nebulizers, intravenous injections, oxygen, medication via a tube, insulin), they must receive additional training, and that training must be documented .The facility's Facility Assessment, last updated on 02/18/25, included: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies with a Staffing Plan which indicated a ratio of one CNA for ten to sixteen residents on the evening shift.The census on Surveyor entry on 03/25/26 at 8:25 PM was 34 residents. The posted staffing for 03/25/26 on the evening shift listed three Certified Nursing Assistants (CNAs) with one of the three working 4:30 PM to 10:00 PM, or a partial shift. The surveyors validated the staff working on that shift was as posted.Wis. Stat. ch. N6 Standards of Practice for Registered Nurses and Licensed Practical Nurses provides guidance as to which nursing tasks can be performed by a licensed practical nurse (LPN) and also defines what measures must be taken in order for certain nursing tasks to be delegated to LPNs. According to Wis. Stat. ch. N6, LPNs are able to perform acts of basic patient care, under the general supervision of a Regsitered Nurse (RN) which is defined in N6 as, care that can be performed following a defined nursing procedure with minimal modification in which the responses of the patient to the nursing care are predictable.Example 1:Resident (R) 2 was admitted to the facility on [DATE] with diagnoses including osteomyelitis of the vertebra lumbar region, chronic obstructive pulmonary disease (COPD,) pan lobular emphysema, and chronic myeloid leukemia, not having achieved remission. R2's admission Minimum Data Set (MDS) dated [DATE] documented R2 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (intact cognition,) functional limitations in range of motion to her lower extremities on both sides, was mobile by wheelchair, and was frequently incontinent of bowel. R2 was dependent for chair/bed-to-chair transfers.On 11/28/25, the local police department responded to a call at the facility from R2. According to the report, R2 reported that she had been waiting for assistance after a bowel movement for over 3 hours. Transcription from the (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	officers' body worn camera shows the officer spoke with NHA-A. NHA-A told the officer R2 needed constant care for her condition and that it was difficult to get her that amount of care due to lack of staffing. The report also included a conversation with LPN1 (Licensed Practical Nurse,) .Upon arriving, I spoke with one of the nurses, who later identified as LPN1. LPN1 told me that they have been following up as best they can, but that there could have been miscommunication with the prior shift that resulted in her (R2) not getting the care she needed. On 03/26/26 at 8:30 AM, Surveyor spoke with R2. R2 said it usually took a long time, about a half hour to 45 minutes before call lights were answered. R2 indicated she would not even be dressed right now, but because the state is here, it's different today. On 03/26/26, Surveyor spoke with Family Member (F) 1. F1 stated it takes staff forever to get down here (R2's room.) FM1 said he can't go and drag somebody down here to help R2, so he tries to be as patient as possible. F1 stated he complained to the Assistant Director of Nursing (ADON) about the length of time it takes for staff to assist R2. F1 stated when he notified the staff, R2 was provided care. On 03/26/26 at 11:55 AM, Surveyor interviewed LPN1 (Licensed Practical Nurse) and LPN1 was asked about R2 and the type of care she needed. LPN1 stated R2 was pretty independent but needs assistance when she is in bed. LPN1 stated R2 will call the facility from her cell phone if staff are not responsive. LPN1 stated she was working the day the police officers came into the building and acknowledged she made the statement referenced in the police narrative. LPN1 told Surveyor she felt like the residents needed more attention than the staff can provide. Example 2: R2's physician's orders include an order dated 03/13/26 for oxycodone (a narcotic pain medication) 5 mg (milligram) oral tablet, give 2 tablet [sic] by mouth every 4 hours as needed for pain.As part of as needed pain medication administration, nursing staff must assess the resident's pain prior to administration and after administration. This is an important assessment to ensure a resident's pain management regime is effective for the resident. R2's MAR (Medication Administration Record) found that CMA/MT1 administered as needed pain medication to R2 on the following dates with documented pain level assessment:~03/17/26 at 10:57 AM and 12:11 PM~03/18/26 at 11:52 AM (no follow up documented)~03/19/26 at 11:32 AM and 12:57 PM~03/24/26 at 11:18 AM and 1:42 PM~03/25/26 at 11:14 AM (no follow up documented)~03/27/26 at 11:22 AM and 12:56 PMWis. Stat. ch. N6 Standards of Practice for Registered Nurses and Licensed Practical Nurses indicates that LPNs may collect data regarding a resident's condition and only RNs (Registered Nurses) may complete an assessment of a resident's condition. Assessments cannot be delegated to unlicensed assistive personnel such as Certified Medical Assistants or Medication Technicians.On 03/27/26 at 11:56 AM, CMA/MT1 told Surveyor she had been employed at the facility since 2015 and had been assessing residents' pain and administering pain medications since her employment began. CMA/MT1 also stated that when she assessed residents' pain, she asked the resident what their pain level was, where the pain was, and reported this to the nurse. Then she administered the PRN pain medication to the resident and documented both the pain level and the administration of the PRN pain medication on the resident's MAR. Surveyor asked about residents who are nonverbal or who may be able to report the location or quality of their pain. CMA/MT1 stated she went by a nonverbal pain scale that went from smiley faces to frowning with tears. CMA/MT1 also stated it was within her scope of practice as a CMA to assess for pain and then to administer PRN pain medication. During an interview on 03/28/26 at 11:34 AM, the [NAME] President of Clinical Operations (VPCO) stated it was not in a CMA/MT's scope of practice to assess residents' pain or to administer PRN pain medications. During an interview on 03/28/26 at 7:16 PM, FDON was asked what tasks were delegated to CMA/MT1. FDON stated CMA/MT1 had completed the required course to become a CMA/MT, and FDON was her preceptor. When asked about CMA/MT1 assessing residents' pain and administering PRN pain medications, FDON stated a CMA/MT was only allowed to give PRN pain medication after a nurse had completed an evaluation for pain. FDON also stated all LPNs were educated that nurses had to complete the pain assessments on residents. When asked if a CMA/MT assessed a resident's pain and documented they assessed the pain, would that be out of the CMA/MT's scope of practice, the FDON stated yes it (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	would be. Example 3:R5 admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses to include diabetes type 2, osteomyelitis of vertebra, and orthopedic aftercare. R5's 72 HR (hour) Admission/re-admission Charting, progress note dated 03/24/26 was completed by LPN2. There was no evidence that the assessment had been completed by an RN.Example 4: R5 had a physician's order dated 03/24/26 of Ertapenem (a broad-spectrum carbapenem antibiotic used to treat severe or moderate bacterial infections) Sodium Injection Solution Reconstituted .use 1 gram intravenously at bedtime for abscess.R5's MAR dated March 2026 indicated R5 was administered the intravenous (IV) antibiotic medication by an LPN on 03/25/26 (LPN1,) 03/26/26 (ADON, who is an LPN,) and 03/27/26 (LPN.) Review of LPN1's employee file revealed no documented evidence that LPN1 received any additional training related to administering IV medications. During an interview on 03/26/26 at 4:20 PM, the ADON stated LPN1 was not certified to be able to administer medications via IV/peripherally inserted central catheter (PICC) lines.During an interview on 03/27/26 at 3:14 PM, LPN1 stated she had been hanging IV medications to be administered via PICC lines since she was employed at the facility. LPN1 stated she had not received any type of formal training from the facility on administering IV medications, however, this was something she had learned while in school to become an LPN. Continued interview revealed at times she was the only nurse in the facility to be able to administer medications to residents with PICC lines; the other staff person was a CMA/MT.During an interview on 03/28/26 at 7:16 PM, the FDON stated during her employment at the facility she was responsible for the oversight and supervision of licensed nursing staff. When asked if LPN1 and LPN2 had received additional training/certification to be able to administer medications intravenously, the FDON stated she had observed both LPNs administer IV medications and had no concerns. Example 5:R6 admitted to the facility on [DATE] with diagnoses to include sepsis, diabetes type 2, congestive heart failure, and end stage renal disease (ESRD).R6's NRSG (nursing): admission Data Collection Progress Notes, dated 03/24/26 was completed by LPN4.R6's Nurses Note, dated 03/24/26 was completed by LPN1 and included details of R6's admission to the facility.There was no evidence that an RN completed R6's assessment.Example 6:R8 admitted to the facility on [DATE] with diagnoses to include chronic congestive heart failure.R8's NRSG: admission Data Collection Progress Notes, dated 03/17/26 was completed by LPN4.R8's NRSG: admission Data Collection and Baseline Care Plan Tool-V 11, dated 03/17/26 was completed and signed by LPN4.There was no evidence that an RN completed R8's assessment.Example 7: R9 admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD) and traumatic ischemia of muscle.R9's NRSG (Nursing): admission Data Collection Progress Notes, dated 03/17/26 was completed by LPN1.R9's NRSG: admission Data Collection and Baseline Care Plan Tool-V 11, dated 03/17/26 was completed and signed by LPN1.There was no evidence that an RN completed R9's assessment. During an interview on 03/28/26 at 7:16 PM, the FDON stated during her employment at the facility she was responsible for the oversight and supervision of licensed nursing staff. When asked who should be completing admission assessments on newly or readmitted residents, the FDON stated LPNs complete a lot of them because 99% of admissions are on the evening shift. FDON stated she would always review admission assessments completed by LPNs on her next scheduled day of work. When asked per an LPN's scope of practice, were LPNs permitted to complete residents' admission assessments, the FDON stated probably not, but she was the only RN employed by the facility. During an interview on 03/26/26 at 4:20 PM, ADON stated since the facility has been without a DON who was the facility's only employed Registered Nurse (RN,) LPNs have been completing all initial nursing assessments for newly admitted residents. During an interview on 03/27/26 at 3:14 PM, LPN1 stated she completes residents' admission assessments when they are admitted to the facility. During an interview on 03/28/26 at 8:12 PM, LPN6 stated they (LPNs) started doing all of residents' admission assessments approximately seven or eight years ago.During an interview on 03/28/26 at 8:20 PM, LPN5 stated prior to her being educated this date, LPNs could complete residents' admission assessments.

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F 0727 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to employ a Registered Nurse (RN) ensuring the minimum requirement of having an RN providing services at least eight consecutive hours a day, seven days a week and failed to employ an RN who was designated to serve as the Director of Nursing (DON) on a full-time basis. These failures caused the facility's nursing staff department to have no oversight of Licensed Practical Nurses (LPNs) and non-licensed personnel (Certified Medication Aide/Medication Technician [CMA/MTs]) who administered medications which placed all residents at risk of not being able to attain or maintain their highest practical physical, mental, and psychosocial well-being. This had the potential to affect 34 of 34 residents who resided at the facility. The facility failed to have adequate nursing oversight of licensed nurses who administered medications and cared for residents with high acuity needs, including Peripherally Inserted Central Catheters (PICC lines,) dialysis shunts, and stage III or higher pressure injuries. Additionally, during the time the facility employed a fulltime DON/RN and during the time the facility did not employ a fulltime DON/RN, LPNs were administering intravenous (IV) medications and completing nursing assessments which were outside of their scope of practice and CMA/MTs were injecting insulin medications, completing residents' pain assessments, and administering PRN (as needed) pain medications which was outside of their scope of practice. The facility's failure to employ a Registered Nurse to provide services and nursing oversight created a finding of immediate jeopardy that began on 03/14/26. Surveyor notified the Regional Director of Operations (RDO) and the [NAME] President of Clinical Operations (VPCO) of the immediate jeopardy on 03/27/26 at 10:45 AM. The immediate jeopardy was removed on 03/28/26, however, the deficient practice continues at a scope/severity of F (potential for more than minimal harm/widespread) as the facility continues to implement its action plan. Findings include:Review of the Centers for Medicare and Medicaid (CMS) Payroll Based Journal (PBJ) Staffing Data Report, dated for the first quarter of 2026 (10/01/25-12/31/25), revealed a one star staffing rating and no RN hours were triggered (four or more days within the quarter with no RN hours.)Review of the Daily Staffing schedules, dated 03/22/26 through 03/27/26, revealed there was not an RN scheduled to work on any of the dates. This indicated there was no RN assigned to supervise the nursing staff and the overall care of the residents.Review of the facility's policy titled, Nursing Services and Sufficient Staff, dated 01/05/26, revealed, Policy: It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility's census, acuity, and diagnoses of the resident population will be considered based on the facility assessment.Policy Explanation and Compliance Guidelines: .8. Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. 9. The Director of Nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. 10. The facility must designate a registered nurse (RN) to serve as the DON on a full-time basis. Additionally, the facility may permit the DON to serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.1. LPNs completing admission Assessmentsa. Review of Resident (R) 5's admission Record, located in the resident's Electronic Medical Record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses to include diabetes type 2, osteomyelitis of vertebra, and orthopedic aftercare.Review of R5's 72 HR [hour] Admission/re-admission Charting, progress note, dated 03/24/26, revealed documented evidence the assessment was completed by LPN2. b. Review of R9's admission Record, located in the resident's EMR under the Profile tab, revealed the resident was (continued on next page)

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F 0727 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD) and traumatic ischemia of muscle.Review of R9's NRSG [Nursing]: admission Data Collection Progress Notes, dated 03/17/26 and located in the resident's EMR under the Progress Notes tab, revealed documented evidence the assessment was completed by LPN1.Review of R9's NRSG: admission Data Collection and Baseline Care Plan Tool-V 11, dated 03/17/26 and located in the resident's EMR under the Forms tab, revealed documented evidence the assessment was completed and signed by LPN1.Review of R9's Late Entry Health Status Note, created on 03/24/26 (seven days post admission), with an effective date of 03/17/26, and located in the resident's EMR under the Progress Notes tab, revealed the note was completed by the facility's Sister Facility DON (SFDON).c. Review of R8's admission Record, located in the resident's EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses to include chronic congestive heart failure.Review of R8's NRSG: admission Data Collection Progress Notes, dated 03/17/26, revealed the note was completed by LPN4.Review of R8's NRSG: admission Data Collection and Baseline Care Plan Tool-V 11, dated 03/17/26 and located in the resident's EMR under the Forms tab, revealed the document was completed and signed by LPN4.d. Review of R6's admission Record, located in the resident's EMR under the Profile Tab, revealed the resident was admitted to the facility on [DATE] with diagnoses to include sepsis, diabetes type 2, congestive heart failure, and end stage renal disease (ESRD.)Review of R6's NRSG: admission Data Collection Progress Notes, dated 03/24/26 and located in the resident's EMR under the Progress Notes tab, revealed the note was completed by LPN4.Review of R6's Nurses Note, dated 03/24/26 and located in the resident's EMR under the Progress Notes tab, revealed the note was completed by LPN1 and included details of the resident's admission to the facility. 2. LPNs Administering IV Medications with no RN oversighta. Review of R5's Order Listing Report, located in the resident's EMR under the Reports tab, revealed an order dated 03/24/26 of Ertapenem (a broad-spectrum carbapenem antibiotic used to treat severe or moderate bacterial infections) Sodium Injection Solution Reconstituted.use 1 gram intravenously at bedtime for abscess.Review of R5's Medication Administration Record (MAR,) dated March 2026 and located in the resident's EMR under the Orders tab, revealed the resident was administered the IV antibiotic medication on 03/25/26 by LPN1 (out of the LPN's scope), 03/26/26 by the Assistant Director of Nursing (LPN,) and on 03/27/26 by the ADON. 3. CMA/MTs Assessing Pain, Administering PRN Pain Medications, and Administering Insulina. Review of R2's admission Record, located in the resident's EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include diabetes type 2, stage II pressure ulcer of right heel, stage II pressure ulcer of left heel, chronic pulmonary embolism, and osteomyelitis of vertebra.Review of R2's Order Listing Report, located in the resident's EMR under the Reports tab, revealed an ordered dated 03/13/26 of oxycodone (narcotic pain medication) 5 mg [milligram] oral tablet, give 2 tablet [sic] by mouth every 4 hours as needed for pain.Review of R2's Pain Level Summary, located in the resident's EMR under the WTS [weights]/Vitals tab, revealed CMA/MT1 completed six pain assessments on R2 from 03/14/26 through 03/27/26 with no RN employed to provide direct supervision of the CMA/MT.Review of R2's MAR, dated March 2026, located in the resident's EMR under the Orders tab, revealed CMA/MT1 administered six doses of PRN pain medication to R2 between 03/14/26 and 03/27/26 with no RN employed by the facility to provide direct supervision of the CMA/MT.Review of R2's Order Listing Report, located in the resident's EMR under the Reports tab, revealed an order dated 03/13/26 of Insulin Lispro Injection Solution 100 unit/ML [milliliter] .Inject 4 unit [sic] subcutaneously with meals related to Type 2 Diabetes Mellitus. The ordered was discontinued on 03/19/26.Review of R2's Order Listing Report, located in the resident's EMR under the Reports tab, revealed an ordered dated 03/19/26 of Insulin Lispro Injection Solution 100 unit/ML.Inject as per sliding scale.Review of R2's MAR, dated March 2026 and located in the resident's EMR under the Orders tab, revealed CMA1 administered six doses of insulin to R2 without the facility having a RN employed to provide direct supervision of CMA/MT1.During an interview on (continued on next page)

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F 0727 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	03/25/26 at 8:45 PM, the Administrator stated the facility did not currently have a DON. The Administrator stated the DON resigned and her last day working was 03/13/26.During an interview on 03/26/26 at 4:20 PM, the ADON stated that since the resignation of the Former DON (FDON) on 03/13/26, there had not been an RN employed by the facility. This indicated there had not been a RN who worked in the facility eight consecutive hours a day, seven days a week. The ADON also stated when the facility did employ a DON, most weekends did not have an RN who worked in the facility. When asked who completed the initial admission assessments for newly admitted residents and/or readmitted residents, the ADON stated LPNs completed the nursing assessments when residents were admitted to the facility. When asked what the nurses were supposed to do if a resident had a change in condition, the ADON stated the LPNs were to notify the Nurse Practitioner (NP,) the Physician, or the FDON when she was employed by the facility. When asked if LPNs were within their scope of practice to administer IV medications through PICC lines, the ADON stated all but two LPNs for the facility were certified or trained to administer IV mediations. The ADON identified LPN1 and LPN2 as not having the required certification/additional training to administer IV medications. During an interview on 03/26/26 at 7:02 PM, when asked who had been responsible for supervising the nursing staff since the FDON's resignation, the Regional Director of Operations (RDO) stated two DONs from their sister facilities had been helping out. When asked if she could provide any documented evidence of either DON being in the facility and for how long each time they were in the facility, the RDO stated she could not. When asked who had been responsible for the clinical care and well-being of the residents, the RDO again stated she had two DONs from sister facilities helping out and both were just a phone call away and one DON was just a short distance away from the facility. During an interview on 03/28/26 at 4:39 PM, the Medical Director stated it was her understanding the facility was having other RNs/DONs from other facilities covering the RN position. The Medical Director stated it was her expectation the corporate leadership would have ensured there was RN coverage until the facility could hire a DON/RN. The Medical Director stated it was important the facility would have RN coverage as RNs complete resident nursing assessments, IVs, and supervise staff to ensure they are staying within their scope of practice. During an interview on 03/28/26 at 7:16 PM, when asked if the facility met the minimum regulatory requirement of having an RN who worked eight consecutive hours a day, seven days a week during her tenure, the FDON stated she was at the facility Monday through Friday and rarely called in. The FDON stated if the facility was short nurses on the weekends, she would have to come in and work as a floor nurse. When asked what duties and tasks she delegated to the LPNs, the FDON stated if she had observed an LPN apply a wound vac and felt they were competent, she would allow the LPNs to independently apply them. The FDON stated there was not any type of documentation or formal training, just demonstration by her and return demonstration by the LPNs. When asked about LPNs administering medications through PICC lines, the FDON stated most of the LPNs employed by the facility had received extra training through a third party contracted by the facility, however, she would still demonstrate and require a return demonstration prior to the LPNs being able to independently administer IV medications. When asked if LPN1 and LPN2 had received additional training/certification to be able to administer medications intravenously, the FDON stated she thought they were certified and she had observed both LPNs administer IV medications and had no concerns. When asked what tasks were delegated to the CMAs, the FDON stated there were only three or four employed by the facility, however, CMA1 was the only one who was utilized regularly for medication administration. Continued interview revealed that the CMAs had completed the required course to become CMAs and she was their preceptor. When asked if CMA1 had completed any type of additional education or courses for insulin administration, the FDON stated not that she was aware of. The FDON stated she had completed competencies on CMA1. When asked if the CMA should have completed some type of additional training or education on insulin administration since it was the route of injection, the FDON stated she went with the principle that it had always been done just by return demonstration (continued on next page)

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F 0727 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	competency at the facility. When asked about CMA1 administering PRN pain medications, the FDON stated CMAs were only allowed to give PRN pain medication after a nurse had completed an evaluation for pain. The FDON also stated all LPNs had been educated that nurses had to complete the pain assessments on residents. When asked who should be completing admission assessments on newly or readmitted residents, the FDON stated that LPNs complete a lot of them because 99% of admissions are on the evening shift. The FDON stated she would always review admission assessments completed by LPNs her next scheduled day of work. The facility's failure to employ a Registered Nurse ensuring the minimum requirement of having an RN providing services at least eight consecutive hours a day, seven days a week, the the failure to employ an RN who was designated to serve as the Director of Nursing on a full-time basis created a likelihood for serious harm, thus leading to a finding of immediate jeopardy beginning on 03/14/26. The facility removed the immediate jeopardy on 03/28/26, however, the deficient practice continues at a scope/severity of F (potential for more than minimal harm/widespread) as the facility continues to implement the following action plan: Employ a full-time interim DONProvide staff education on notification of changes in conditionAssessments of nurses' IV competencyEmployment of an agency RN to ensure RN coverage on Saturdays and SundaysReassess all residents with IVs, pressure injuries, new admissions since 03/14/26Reassess all residents with a documented change in condition since 03/14/26

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to have an effective system in place to ensure residents were free from significant medication errors for 1 of 5 sampled residents (R2). R2's infectious disease doctor ordered two oral antibiotics on 01/15/26 upon completion of an intravenous (IV) antibiotic for discitis osteomyelitis (a serious spinal infection affecting vertebrae and intervertebral discs, characterized by severe, persistent back pain). The facility did not transcribe the order or administer the antibiotics until after R2 was sent to the emergency room (ER) with redevelopment of previously cleared osteomyelitis. Additionally, R2 was intravenously administered another resident's antibiotic on 01/13/26.Review of the facility's policy titled, Medication Errors, dated 2025, revealed, Policy: 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 .Definitions: .'Significant medication error' means one which causes the resident discomfort or jeopardizes his/her health and safety .Policy Explanation and Compliance Guidelines: 1. The facility shall ensure medications will be administered as follows: a. According to physician's orders . Review of the facility's policy titled, Physician Orders-Entering and Processing, revised 01/31/18, revealed, Purpose: To provide general guidelines when receiving, entering, and confirming physician or prescriber's orders. (a prescriber is noted as physician, nurse practitioner, and a physician's assistant.) Guidelines: .5. Following a physician visit, a licensed nurse will check for any orders that require confirmation under Clinical>orders>pending orders. The orders will be confirmed by the nurse and the instructions for the order will be completed . 1. R2 was originally admitted to the facility after a hospital stay on 10/22/25 with diagnoses which included osteomyelitis of vertebra, lumbar region, and chronic myeloid leukemia, not having achieved remission. R2's hospital Discharge summary, dated [DATE], stated, R2 .was admitted for management of lumbar discitis/osteomyelitis at L2-L3 (lumbar discs) .Infectious Disease (ID) recommended continuation of IV vancomycin (an antibiotic medication) .with plans to transition to IV daptomycin (an antibiotic medication) via PICC (peripherally inserted central catheter) line for a minimum of six weeks . A repeat MRI (magnetic resonance imaging) and ID follow-up are planned prior to completion of the antibiotic course . R2 had a follow up MRI on 1/12/26. MRI results, dated 01/14/26, indicated, .IMRESSION: 1. Evolving L2-L3 discitis/osteomyelitis .compared to prior [MRI] there is only trace residual fluid signal in the disc space. The findings are indicative of improvement. Progress notes from R2's ID visit stated, .Progress Notes documented this encounter .1/12/26 MRI lumbar spine .Evolving changes of discitis/OM [osteomyelitis] as expected with only trace residual fluid in disc space. Suspect area of enhancement and myositis (chronic muscle inflammation causing muscle weakness, fatigue, and pain) are likely from residual inflammatory changes rather than persistent infection as she has completed over 3 months of antibiotics and endorsed improved back pain .I contacted Neurosurgery who noted improvement compared to MRI 10/01/25. Neurosurgery agreed that ongoing changes are likely inflammatory rather than infectious .Will discontinue daptomycin and monitor off antibiotics. Will arrange follow up visit in 4-6 weeks to reassess her symptoms off antibiotics. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 1/14/26, R2's ID Physician faxed orders to the facility that were located in R2's EMR. The orders stated, .DC (discontinue) daptomycin, remove PICC. Please follow up in 4-weeks. DC weekly labs. R2's ID notes dated 01/15/26 indicated, .I reviewed MRI with radiology on call who stated that overall MRI is significantly improved compared to study from October (2025) .Daptomycin was discontinued and PICC was removed. Given inability to completely rule out persistent infection based on MRI findings and elevated, although somewhat improved, inflammatory markers would recommend transition to oral antibiotics for another 4-6 weeks for ongoing treatment .will transition to PO (oral) levofloxacin (an antibiotic medication) 750 mg (milligrams) daily.Will also add daily PO vancomycin 125 mg for C diff prophylaxis given history of C diff colonization. Review of R2's faxed order from the ID Physician, dated 01/15/26 and provided by the facility (after requested from the facility's fax company), revealed, .start PO levofloxacin 750 mg daily for at least 4 weeks .add PO vancomycin 125 mg daily for c. diff prophylaxis. R2's Medication Administration Record (MAR) for January 2026 found no evidence that levofloxacin and vancomycin were administered to R2 as ordered by the physician. R2's ID progress notes, dated 02/03/26 stated, .This is a telemedicine encounter.(R2) states she is doing well. Denies back pain. Reports ongoing pain in her legs and weakness in her legs which is unchanged .(R2) states she is currently tolerating levofloxacin well without any side effects. Will continue PO levofloxacin 750 mg daily to complete at least 6 weeks tentative EOT (end of treatment) 2/27/26. Continued PO vancomycin 125 mg daily for C diff prophylaxis while on levofloxacin . R2's MAR for February 2026 found no evidence that levofloxacin and vancomycin were administered to R2 as ordered by the physician. Based on R2's ID progress notes, R2 was not aware that levofloxacin and vancomycin were not being administered. Review of R2's physician Order Listing Report, from 01/01/26 through 03/31/26, indicated orders for PO levofloxacin and PO vancomycin were not included until 03/13/26. On 3/13/26, R2 was sent to the ER related to fever and left knee pain. The hospital discharge summary stated, .Patient is chronically on Levaquin, PO vancomycin for discitis .follows with infectious disease .CT (computed tomography) L-spine (lumbar spine) reconstruction: Showed extensive osseous erosion at the L1-2 highly concerning for discitis/osteomyelitis .ER physician discussed the case with on-call orthopedic surgery and neurosurgeon .Broad-spectrum antibiotics started .Continued vancomycin, cefepime (antibiotic used to treat severe bacterial infection) started in the ER .Recommended discharge back on levofloxacin 750 mg daily and follow-up with infectious disease .Also resumed po vancomycin 125 mg daily prophylaxis. Previous imaging in January found R2 had inflammation but did not have an infection. Imaging on 3/13/26 found R2 again developed osteomyelitis. Evidence in the MAR found R2 had not received levofloxacin or vancomycin for 2 months. R2's MAR for March 2026 indicated levofloxacin and vancomycin were first administered to R2 on 03/14/26. During an interview on 03/25/26 at 9:00 PM, R2 stated while she was hospitalized for knee pain, she learned she had not been receiving the two oral antibiotics ordered by her ID Physician once hospital (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Avina on Division		STREET ADDRESS, CITY, STATE, ZIP CODE 517 E Division St Fond Du Lac, WI 54935	

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F 0760 Level of Harm - Actual harm Residents Affected - Few	staff asked why she was not taking them. On 03/27/26 at 2:10 PM, Surveyor spoke with R2 who stated she had a telehealth appointment with her ID Physician in January 2026. R2 stated the Social Services Director (SSD) was present during her telehealth appointments as they were completed using the SSD's computer. R2 indicated during the January 2026 appointment, the ID Physician told her he was going to have her PICC line removed because the MRI showed the spinal infection was gone, and he was going to order two oral antibiotics to make sure the infection did not return. R2 stated she did not know she had not received them as she would just take the medication the facility gave to her. When asked if she had follow-up appointments between January 2026 and March 2026 and if the oral antibiotics were discussed, R2 stated she did have follow-up appointments; however, when the doctor asked how she was doing with the antibiotics, she told him she was doing good because she thought she was taking them. (Of note, R2's Minimum Data Set (MDS) assessment, dated 01/28/26, has a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicates R2 is cognitively intact.) On 03/27/26 at 10:04 AM, Surveyor spoke with the Assistant Director of Nursing (ADON) who verified R2 had not received oral antibiotics of levofloxacin and vancomycin in January 2026 and February 2026. The ADON verified the first time they were administered was on 03/13/26 when R2 was readmitted to the facility from the hospital. The ADON stated the orders for the two oral antibiotics came with R2 from the hospital. The ADON also stated the facility never received any orders from the ID Physician on 01/15/26 for R2 to start oral antibiotics. During an interview on 03/27/26 at 1:45 PM, Consultant Pharmacist (CP) 1 verified there were no orders in January 2026 received by the pharmacy from the facility for levofloxacin or vancomycin. When asked why oral antibiotics would be ordered by the Infectious Disease doctor if the osteomyelitis was resolved, CP1 stated if the infection was clear, oral antibiotics may have been ordered prophylactically, or if R2 had continuous infections and was on IV antibiotics for a long time, it would be prudent to start oral antibiotics to prevent reccurrence of the infection. During an interview on 03/28/26 at 4:39 PM, the Medical Director stated she was not aware R2 was supposed to have started two oral antibiotics on 01/15/26 that were ordered by the Infectious Disease doctor. The Medical Director stated it was her expectation that if the facility received a faxed order for R2 to start oral antibiotics, the orders would have been processed and administered to R2 as ordered. When asked why it would be important for the oral antibiotics to be administered to R2 as ordered in January 2026, the Medical Director stated because there could still have been infection in the spine. On 03/27/26 at 2:26 PM, Surveyor interviewed the Business Office Manager (BOM) who indicated she was responsible for scanning residents' medical records into their EMR. The BOM stated when a resident had a telehealth appointment, nursing staff would receive the visit notes and any orders via fax. The BOM stated nursing staff would place the received records in a bin at the nurses' station and she would retrieve the records throughout the day and scan them into the resident's medical record under the miscellaneous tab. The BOM was asked if there was a way to retrieve faxes that were received at the facility. The BOM with the assistance of the fax machine company retrieved faxes that were sent to the facility on [DATE]. It was confirmed that a fax from R2's ID physician was received by the facility on 01/15/26 and stated, .start PO levofloxacin 750 mg daily for at least 4 weeks .add PO vancomycin 125 mg daily for c. diff prophylaxis. 2. R2's MAR for the month of January 2026 included an order for Daptomycin (antibiotic) Intravenous (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Solution Reconstituted (Daptomycin) Use 540 mg intravenously one time a day for cholecystitis related to osteomyelitis of vertebra, lumbar region, psoas muscle abscess. The medication was ordered to be given from 12/18/25 to 01/14/26. A Medication Occurrence, dated 01/13/26 at 8:30 AM, revealed Licensed Practical Nurse (LPN) 1 prepared the report and identified R2 as the resident. The Incident Description section noted, Nurse gave IV from another resident to resident. Resident was to get daptomycin and got ertapenum (antibiotic). The Medication Occurrence indicated the Nurse Practitioner (NP) and resident were notified of the error. The document also noted there were no injuries observed at the time of the incident. A 01/14/26 Risk Management review included, IDT (Interdisciplinary Team) met and discussed the circumstances related to medication occurrence noted 1/13/26 at 0830 (8:30 AM). Resident received another resident's IV medication. Resident was to receive Daptomycin 540 mg IV and was administered Ertapenem 1gm (gram) instead. No adverse reactions noted from receiving IV Ertapenem.APNP (Advanced Practice Nurse Prescriber) called regarding medication occurrence. Continue to monitor resident. No further orders received. All nurse education provided regarding the 6 rights of medication administration. Resident updated and declined family to be updated. CM (Case Manager) updated. Resident monitored (for) 72 hours for any changes. No changes noted. During an interview with LPN1 on 03/27/26 at 3:14 PM, LPN1 was asked about the wrong antibiotic being given to R2. LPN1 stated it was an honest mistake and the facility previously only had one resident with an IV. LPN1 stated on that day, she didn't check thoroughly enough and grabbed the wrong one out of the refrigerator. When LPN1 was asked what happened after she realized the wrong antibiotic was given to R2, she said the DON had her notify the on-call physician to see if there would be an issue. LPN1 stated she was educated on the five patient rights. When asked if others were trained, she stated it was just her, adding that it was a stupid mistake and should not have happened.

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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, interview, and review of the facility's policy, the facility failed to ensure expired food was discarded and the kitchen was maintained in a clean and sanitary manner. These failures placed 34 of 34 residents who resided at the facility at risk of foodborne illnesses.Findings include:Review of the facility's undated policy titled, Food Safety and Sanitation, revealed .All local, state and federal standards and regulations will be followed in order to assure a safe and sanitary food and nutrition services department .4. Food Storage .Food is protected from contamination .Perishable foods with expiration dates are used prior to the use by date on the package .Review of the facility's undated policy titled, Labeling and Dating, revealed, .2. All foods will be monitored for expiration date, use-by-date. Foods that are out of date will be discarded .Observation on 03/26/26 at 3:19 PM of the kitchen's walk-in cooler revealed the following items that were either labeled by the facility to be past the use-by date or expired per the manufacturer's expiration date:A one-gallon clear juice pitcher with a red lid labeled, Cranberry Juice date: 03/22 [26] .use by date of 03/24 [26].A one-gallon clear juice pitcher with a red lid labeled, OJ [orange juice]: date:03/20 [26] .use by 03/22 [26].A one-gallon clear juice pitcher with a red lid labeled, Apple Juice: date 03/23 [26] .use by 03/25 [26].A one-gallon clear plastic container labeled, Concentrated Lemon Juice, with a manufacturer's expiration date of 03/07/26. Continued observation revealed the container had a facility label of use by: 04/27/26.Observation on 03/26/26 at 3:23 PM of the kitchen's walk-in freezer revealed the following:A package of hot dog buns, torn open from the middle of the package, exposing several buns to air.An opened box of fish with a manufacturer's expiration date of 03/05/26. Observation on 03/26/26 at 3:33 PM of the kitchen revealed multiple cobwebs and dead insects on the wall behind the portable shelving where clean dishes were stored, extending from the window to the edge of the window seal, directly behind the shelving. Continued observation revealed a build up of black and gray dust and debris. To the left of the shelving were two window unit air conditioners which had the potential to blow debris and pests onto clean dishes if the air conditioners were turned on.During observations and an interview on 03/26/26 at 3:38 PM, Dietary Aide (DA) 1 observed the concerns listed above in the walk-in cooler and walk-in freezer. DA1 stated all dietary staff should be checking use-by and expiration dates and removed the items from the cooler and freezer.During an observation and interview on 03/26/26 at 3:45 PM, DA1 observed the wall behind the shelving with clean dishes. DA1 stated with the air conditioners so close to the shelving, the air conditioners could possibly blow debris and bugs onto clean dishes. The facility's Dietary Manager resigned on 03/23/26; therefore, there was no interview with the Dietary Manager. During an interview on 03/28/26 at 8:52 PM, the Regional Director of Operations (RDO) stated it was her expectation that the kitchen would not have items beyond the use-by and expiration dates and would not have dust and dead bugs.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview, and record review of the facility's Administrator's Job Description, the Administrator failed to administer the facility in a manner that ensured a Director of Nursing (DON) and/or a Registered Nurse (RN) was employed to provide oversight of nursing staff that enabled the facility to attain and maintain the highest practicable care and well-being of each resident. The lack of nursing oversight due to the Administrator's decisions caused or is likely to cause serious injury, harm, impairment, or death to residents. Administration was aware the facility did not have a qualified Director Nursing overseeing resident care since 3/13/26.Administration was aware there was not an RN in the building for a minimum of 8 hours a day, 7 days a week. On 03/27/26, the facility was notified that an Immediate Jeopardy was identified in the area of S483.35 Nursing Services and was related to Administration of the facility. Findings include:Review of an undated job description titled, Job Description-Administrator, provided by the facility, revealed, Purpose of your job description. The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times. Delegation of Authority: As Administrator, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. Job Functions: .Assist in the recruitment and selection of competent department directors, supervisors, facility non-licensed staff, consultants, etc .Ensure that an adequate number of appropriately trained licensed professional and non-licensed personnel are on duty at all times to meet the needs of the residents .The following failures were identified:1. The facility failed to ensure a Director of Nursing (DON) was employed to supervise the facility's nursing staff. During an interview on 03/25/26 at 8:45 PM, the Administrator confirmed the facility did not currently have a DON. The Administrator confirmed the last day the facility had a DON was 03/13/26.During an interview on 03/26/26 at 7:02 PM, the Regional Director of Operations (RDO) confirmed the facility did not have a DON. The RDO stated two DONs from sister facilities were helping out but confirmed there was no documented evidence of the two DONs presence in the facility. (Refer to F727)2. The facility failed to ensure a Registered Nurse (RN) was employed to meet the minimum requirements of having an RN on duty eight consecutive hours each day, seven days a week. During an interview on 03/26/26 at 4:20 PM, the Assistant Director of Nursing (ADON) confirmed the facility had not had an RN on staff since the Former DON (FDON) left on 03/13/26. The ADON confirmed that while the FDON was in her position, the facility did not have an RN for most weekends. (Refer to F727)3. The facility failed to ensure Licensed Nurses and Certified Medication Aides/Medication Technicians (CMAs/MTs) provided care and services only in their respective scope of practice. Review of clinical records for Resident (R) 2 revealed documented evidence CMA/MT1 assessed R2's pain levels, administered as needed narcotic pain medications, and reassessed pain levels following the administration of as needed narcotic pain medications.During an interview on 03/27/26 at 11:56 AM, CMA/MT1 confirmed she had been assessing pain levels and administering as needed narcotic pain medications throughout her employment. During an interview on 03/28/26 at 11:34 AM, the [NAME] President of Clinical Operations (VPCO) stated it was not in the scope of practice for a CMA/MT to assess pain or administer as needed pain medications. (Refer to F658)4. The facility failed to ensure the facility had sufficient staffing. Review of the local police department's narrative, dated 11/28/25 at 1:24 PM and transcribed from body-worn camera (BWC) footage, revealed a police officer responded to a call at the facility for a complaint about lack of care. The narrative recorded, .I [police officer] then spoke to a nurse administrator for the Manor (former facility name). Her name was (Administrator's first name) and she told me that (R2) needs constant care for her condition and that it is very difficult to get her that amount of care due to the lack of staffing .An interview on 03/26/26 at 8:30 AM with R2 revealed it took between one-half hour to 45 minutes for call lights to be answered.An interview on 03/26/26 (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	at 3:50 PM with R18 revealed during mealtimes, all staff go to the dining room leaving no staff on the halls to assist residents if they need help.During an interview on 03/26/26 at 11:55 AM, Licensed Practical Nurse (LPN) 1 was asked if there were enough staff to meet residents' needs. LPN1 stated she felt like the residents needed more attention than the staff could provide. (Refer to F725)During an interview on 03/28/26 at 8:52 PM, the RDO stated it was her expectation the facility would have been in compliance with the regulatory requirements.