STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525523	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avina of Milwaukee	9255 N 76th St Milwaukee, WI 53223

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure 2 (R96 & R19) of 6 sampled residents had adequate supervision to prevent accidents. *R96 had an unwitnessed fall on 10/19/25 and was diagnosed with a right hip fracture. R96 had care plan interventions to wear hip protectors and to be in high traffic areas in line of sight of nursing staff to prevent falls. The facility did not provide any evidence that these interventions were in place at the time of R96's fall on 10/19/25. The facility did not conduct thorough investigations of R96's falls on 9/22/25, 10/4/25, 10/18/25, and 10/19/25. *R19 is a smoker, the facility lacked ongoing smoking supervision and assessments. Findings include: The facility policy titled Fall Policy with implemented date 2/11/25 and reviewed/revised date 1/2/26 documents: .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. an individualized care plan will be implemented according to the risk factors identified on the fall assessment tool. interventions will be monitored for effectiveness and reviewed/revised following a fall event, quarterly, annually and with significant change or as needed. potential fall interventions . purposeful staff rounding . proper seating if in wheelchair – feet flat on the floor, lowering the back of the seat, etc. ensure proper footwear . hip protectors . helmets if applicable . increased observation . room closer to nursing station . toileting program: scheduled, cueing . increased activities . 1:1 supervision . provide high back chairs . hourly rounding for the 4 P's: Pain, Potty, Personal Items, Positioning . When any resident experiences a fall, the following will result: . complete a post-fall investigation which may include witness statements as applicable. complete an incident report. document all assessments and actions. complete a root cause analysis (RCA) with IDT (interdisciplinary team) Team and update the plan of care based on RCA. R96 was admitted to facility on 5/27/25 with diagnoses including nontraumatic subarachnoid hemorrhage (bleeding in the fluid-filled space surrounding the brain), seizures, cognitive communication deficit, difficulty in walking, weakness, and unspecified lack of coordination, generalized anxiety. R96's admission Minimum Data Set (MDS) dated [DATE] documents R96 has short- and long-term memory problems, fluctuating inattention behavior, fluctuating altered level of consciousness, and R96 is dependent with bed mobility and transfers. The MDS documents R96 had a fall in the last month prior to admission and R96 had a fall in the last 2-6 months prior to admission. R96's falls Care Area Assessment (CAA) was triggered, but no rationale regarding care planning was documented in the CAA. R96's risk for falls assessment dated [DATE] documents a score of 14, indicating R96 is at (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	high risk for falls. On 3/10/26 at 3:05 PM, Nursing Home Administrator (NHA)-A stated the facility changed electronic health records (EHR) systems on 8/1/25, and the facility does not have access to any documentation prior to 8/1/25. R96's risk for falls care plan was initiated 8/1/25 with the following interventions: -bed in lowest position (initiated 8/1/25)-bolster mattress (initiated 8/1/25)-fall mats on both sides of bed (initiated 8/1/25)-keep commonly used items within reach (initiated 8/1/25)-soft touch call light (initiated 8/1/25)-encourage resident to be in high traffic areas when awake (initiated 8/17/25)-room move to third floor (initiated 9/2/25)-high back reclining wheelchair (initiated 9/3/25) R96's care plan for activities of daily living (ADL) self-care performance documents the following interventions initiated 8/2/25:-bed mobility: the resident is maximum assistance of 1 staff for repositioning and turning in bed and as necessary-toilet use: the resident requires maximum assistance by 1 staff for toileting-transfer: the resident is maximum assistance of 1 staff for transferring R96's care plan for delirium documents the following intervention initiated 8/5/25:-provide appropriate level of supervision or surveillance to monitor resident and allow for therapeutic actions as needed A nurse's note in R96's EHR dated 9/11/25 at 11:50 PM documents [R96] had a witnessed fall at 7:30 PM in front of the dining room next to the medication cart. [R96] is highly anxious and confused, continuously attempting to get out of the wheelchair. [R96] would benefit from 1:1 (one on one) staff. A progress note in R96's EHR dated 9/22/25 at 2:35 PM documents [R96] yelling for help in bedroom. Upon entering bedroom, [R96] was found lying on right side on the floor mat. [R96] complained of pain to right hip and lower back. NP updated, new order received to send [R96] out to the hospital. [R96] was transported to the hospital at approximately 9:00 AM. A progress note in R96's EHR dated 9/22/25 at 3:57 PM documents [R96] returned to the facility from the emergency room (ER) without any evidence of findings. No new injury noted. The notes section of the fall investigation for 9/22/25 documents IDT (Interdisciplinary Team) met and reviewed the fall incident. [R96] stated [R96] was trying to self-transfer and [R96] was found lying on the floor mat with a blanket. Surveyor notes there is no documentation regarding the last time R96 was rounded on by staff or offered toileting or why R96 was not in a high traffic area per R96's care plan. R96's risk for falls care plan documents the following interventions initiated 9/22/25:-offer toileting upon rising, before and after meals, and at bedtime, and NOC (night shift) rounding times-prompted and purposeful rounding (pain, potty, positioning, and possessions) A progress note in R96's EHR dated 10/4/25 at 3:17 PM documents [R96] laying on hallway floor in prone (on stomach) position. Hematoma noted on right side of the frontal lobe. New order received to send R96 to the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor notes there is no documentation regarding the last time R96 was rounded on by staff, offered toileting or who was observing in the high traffic area. A progress note in R96's EHR dated 10/4/25 at 5:54 PM documents [R96] returned from ER, no changes. A progress note written by NP-Y dated 10/6/25 at 8:45 AM documents [R96] had another fall over the weekend, fortunately without injuries. Memory retention remains limited, requires frequent redirection throughout the day. continues to require close monitoring for safety due to cognitive impairment and fall risk. Generalized Anxiety Disorder: continue non-pharmacological interventions including redirection and environmental modifications to reduce anxiety triggers. Repeated falls: multifactorial fall risk continues with cognitive impairment, medication side effects, and generalized weakness. Maintaining fall precautions including Broda chair for positioning. On 3/11/26 at 2:00 PM, Surveyor placed a phone call to NP-Y but was unable to leave a voicemail to return Surveyor's phone call. On 3/12/26 at 8:57 AM, Surveyor placed a phone call to NP-Y and left a voicemail to return Surveyor's call. At the time of this write up, Surveyor did not receive a return phone call from NP-Y. R96's care plan for focus area The resident has a behavior problem (specify behavior; yells/calling out, anxious, impulsive) . was initiated on 10/6/25 with the following interventions:-administer medications as ordered. Monitor/document for side effects and effectiveness -anticipate and meet the resident's needs-intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed-monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes-provide interventions to redirect triggered behavior such as 1 on 1, encourage to attend activities, return to room, toilet, offer food/snack(s), offer fluids, change position, adjust room temperature, offer back rub to aid comfort R96's risk for falls care plan documents the following interventions:-resident to wear helmet at all times (initiated 10/10/25)-resident to wear hip protectors (initiated 10/13/25) R96's care plan for focus area The resident is resistive to care (refuses to wear helmet) . was initiated 10/13/25 with the following interventions:-allow the resident to make decisions about treatment regime to provide sense of control-give clear explanation of all care activities prior to and as they occur during each contact-if resident refuses, reassure resident, leave and return 5-10 minutes later and try again-praise the resident when behavior is appropriate R96's Treatment Administration Record (TAR) for dates 10/1/25-10/31/25 documents resident to wear helmet at all times, every shift, start date 10/10/25. The TAR documents a checkmark for day, evening, night shift on all dates 10/10/25-10/18/25 and day shift 10/19/25. A checkmark on the TAR is to mean the treatment was administered. Surveyor notes no documentation on the October TAR that R96 refused to wear the helmet. Surveyor notes there is no care plan regarding R96 refusing to wear hip protectors. Surveyor notes between the dates of 9/1/25-10/13/25, R96 had 10 falls which did not result in major (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	injury. A progress note in R96's EHR dated 10/16/25 at 12:34 AM documents [R96] yelling, screaming out, attempts to redirect resident unsuccessful. At about midnight, [R96] became aggressive, hitting staff, very agitated, tried throwing self to the floor. Staff lowered [R96] to the floor after multiple attempts of redirection. Obtained order to send to ER for evaluation. The fall investigation dated 10/16/25 documents no injuries observed at the time of incident or after the incident, and R96 had no pain. The notes section in the fall investigation dated 10/16/25 documents [R96] impulsive and goal is to prevent major injury. [R96] returned to facility with UTI (Urinary Tract Infection) diagnosis. Surveyor notes the fall investigation dated 10/16/25 does not document if R96 was wearing a helmet and hip protectors at the time of the fall per R96's care plan. R96's risk for falls assessment dated [DATE] documents a score of 16, indicating R96 is at high risk for falls. A post-fall investigation form dated 10/18/25 documents R96 had a witnessed fall on 10/18/25 at 10:04 AM. The witness statement documents went to change resident, went to grab towels, came back and resident was on floor. Surveyor was unable to locate a progress note in R96's EHR regarding this fall on 10/18/25. Surveyor notes the post-fall investigation form dated 10/18/25 does not document if R96 sustained any injuries or complained of any pain after the fall, or if R96 was wearing a helmet and hip protectors at the time of the fall per R96's care plan. Surveyor was unable to locate IDT notes documenting a root cause analysis or assessment of appropriateness of fall interventions. A progress note in R96's EHR dated 10/19/25 at 6:55 AM documents [R96] complaining of pain at right hip/bottom area while in dining room. NP was updated and order obtained for an x-ray on the right hip. A progress note in R96's EHR dated 10/19/25 at 11:56 AM documents [R96] had a fall in the dining room, complained of pain and discomfort, facial grimacing noted. [R96] became tachycardic (fast heart beat) and wished to be sent to the hospital as [R96] became more anxious. [R96's] right hip/leg is the area of concern; however, nurse could not conduct a proper evaluation of the extent of the injury. Primary physician contacted and agreed resident should be sent to the hospital for further evaluation. Surveyor notes the fall on 10/19/25 occurred prior to the facility obtaining an x-ray on R96's right hip. The hospital history and physical (H&P) dated 10/19/25 documents under the assessment section [R96] was sent to the hospital from [nursing facility] after mechanical fall. Per the nursing home [R96] had an unwitnessed fall in the dining room. X-ray of the hip was notable for right impacted subcaptial fracture (a stable hip fracture where the ball of the hip joint is broken and forced into the neck of the thigh bone). [R96] is being admitted to hospital for further management. The hospital Discharge summary dated [DATE] documents right subcapital fracture: evaluated by orthopedics and palliative care. No plans for operative intervention. Continue pain control . goals of care were discussed, and plan is for comfort focused care. [R96] will return to [nursing facility] with hospice later today. Condition at discharge: stable. Surveyor was unable to locate a fall investigation regarding the fall in the dining room on 10/19/25 in R96's EHR. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/12/26 at 11:11 AM, NHA-A, Director of Nursing (DON)-B, Director of Operations-C, and Regional Nurse Consultant-D informed Surveyor that the facility did not have a fall investigation for R96's fall on 10/19/25. NHA-A, DON-B, Director of Operations-C and Regional Nurse Consultant-D confirmed no additional information is available regarding the last time R96 was rounded on or offered toileting prior to the fall. Director of Operations-C stated no documentation can be found if R96 was wearing hip protectors per R96's care plan at the time of the fall. Surveyor asked if R96 was in a high back wheelchair or Broda chair on 10/19/25, and NHA-A stated NHA-A will look into it. On 3/12/26 at 12:16 PM, NHA-A and DON-B informed Surveyor R96 was in a high back wheelchair at the time of the fall on 10/19/25. NHA-A and DON-B stated since R96 was in the dining room prior to lunch, R96's wheelchair would have been in an upright position and there is no indication the high back wheelchair would have been tilted back. Surveyor requested the manufacturer guidelines for R96's high back wheelchair, and NHA-A and DON-B stated they would try to locate it. On 3/12/26 at 12:25 PM, Surveyor interviewed Director of Rehabilitation (DOR)-W who stated therapy staff assists the facility to assess if a resident would be appropriate for a high back wheelchair. DOR-W stated a high back wheelchair would typically be indicated for a resident with poor trunk support or for pressure relief. Surveyor asked DOR-W if it would be possible for a resident to fall out of a high back wheelchair if the wheelchair were in an upright position, and DOR-W responded yes. On 3/12/26 at 1:32 PM, NHA-A informed Surveyor that manufacturer guidelines for the high back wheelchair R96 was using at the time of R96's fall on 10/19/25 were unable to be located. A progress note in R96's EHR dated 10/21/25 at 7:41 PM documents [R96] readmitted to the facility at 4:00 PM with diagnosis of hip fracture. [R96] admitted on to hospice services. Surveyor notes between the dates of 10/21/25-12/18/25, R96 had an additional 6 falls that did not result in major injury or hospitalization. R96 passed away on hospice services on 2/10/26. On 3/11/26 at 3:18 PM, Surveyor interviewed certified nursing assistant (CNA)-AA who has worked in the facility since September 2025. CNA-AA recalled working with R96 and stated R96 needed a lot of assistance for ADLs (Activities of Daily Living) and transfers and was a fall risk. CNA-AA stated R96 had fall mats in place and wore a helmet, and staff tried to keep R96 in supervised areas. CNA-AA stated R96 was not very cooperative and was difficult to redirect, R96 would try to get up independently and fall. CNA-AA stated R96 needed to be supervised 24/7 but the facility was not able to do that. On 3/12/26 at 9:06 AM, Surveyor interviewed licensed practical nurse (LPN) supervisor-I who recalled working with R96. LPN supervisor-I stated R96 never seemed comfortable at the facility and would get up out of the wheelchair even if a staff member was right next to R96. LPN supervisor-I stated the facility did talk about having 1 on 1 supervision for R96 but it was never implemented because the facility did not have the staff availability to do that. LPN supervisor-I stated the nursing staff tried to supervise R96 throughout the day as much as possible, but nursing staff gets pulled in many different directions throughout the day, so that was not always able to be provided. In an interview on 3/12/26 at 10:03 AM, DON-B stated R96 was not safe to walk and used a wheelchair, was easily agitated, and impulsive. DON-B stated a care plan was in place for R96 to be in high traffic areas in line of sight, and nurses would take turns watching R96 throughout their shifts. Surveyor shared concern with NHA-A, DON-B, Director of Operations-C and Regional Nurse (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Consultant-D that R96 sustained an unwitnessed fall on 10/19/25 and was found to have a right hip fracture when R96 was admitted to the hospital. NHA-A, DON-B, Director of Operations-C and Regional Nurse Consultant-D did not provide any additional information regarding if R96 was in the line of sight of nursing staff at the time of the fall per R96's fall care plan or if 1 on 1 assistance was provided at the time of the fall to redirect R96's triggered behaviors of anxiousness and impulsiveness per R96's behavior care plan. Surveyor shared concern with NHA-A, DON-B, Director of Operations-C and Regional Nurse Consultant-D regarding incomplete fall investigations on 9/22/25, 10/4/25, 10/18/25, and 10/19/25. No additional information was provided. 2.) The facility's policy and procedure titled, (name of facility) Resident Smoking, implemented 2/1/26 documents in part: Policy: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and nonsmoking residents. Policy Explanation and Compliance Guidelines: 7. Residents will be asked about tobacco use during the admission process, and during each quarterly comprehensive MDS assessment process and on an as needed basis. 8. Residents who smoke will be further assessed, using the Smoking Assessment, to determine whether resident is safe to smoke at all. 10. Any resident who is deemed safe to smoke will be allowed to smoke in designated smoking areas (weather permitting) and in accordance with his/her care plan. 11. If a resident who smokes experiences any decline in condition or cognition, he/she will be reassessed by the clinical team for the ability to smoke independently and/or to evaluate whether any additional safety measures are indicated. 12. If residents are found to be unsafe with smoking/vaping/chewing materials then smoking/vaping/chewing privileges will be evaluated by clinical team. 13. If a resident demonstrates noncompliance with this policy, he/she will receive re-direction and counseling interventions. Noncompliance may result in the discharge from the facility (30 Day discharge). Conduct that threatens and/or offends the health, safety, and welfare of others and/or interferes with the professional management of the facility will jeopardize the resident's placement at this health care facility and may result in an immediate discharge. 14. The following actions that will be considered unsafe practice by residents who smoke are.: h. Any reasonable action that would be deemed unsafe to self or others by a reasonable process. On the last page of the policy is the statement I have read and agree with all components and consequences outlined in this document. Followed by lines to be completed for Resident Name/Date, Resident Signature, Witness Signature/Date. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R19 was admitted to the facility on [DATE]. with pertinent diagnoses that include delirium (an acute, fluctuating disturbance in attention, awareness, and cognition that develops rapidly (hours to days), often caused by underlying medical conditions, infections, or medication side effects), dementia (a syndrome that can be caused by a number of diseases which over time destroy nerve cells and damage the brain, typically leading to deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from the usual consequences of biological ageing), and cognitive communication deficit (difficulty with communication that stems from impaired thinking skills, such as memory, attention, and problem-solving, rather than from physical speech problems). R19's Medicare 5 day Minimum Data Set (MDS) with an assessment reference date of 1/8/26 documented R19 had a Brief Interview for Mental Status score of 10 (moderate cognitive impairment). R19 has an activated Power of Attorney. R19 is documented to be understood and understands others. During the look back period of the MDS no behaviors were exhibited by R19. R19's care plan tobacco use initiated on 1/12/2026, has the following interventions: Conduct smoking safety evaluation on admission and PRN (as needed). Date Initiated: 1/12/2026 Educate resident/responsible party on the facility's tobacco/smoking policy(s). Date Initiated: 1/12/2026 Monitor resident's oral hygiene. Date Initiated: 1/12/2026 R19's care plan the resident is a smoker/vapes initiated on 1/12/2026, has the following interventions: Declines a smoking cessation patch. Date Initiated: 1/25/2026 Instruct resident about smoking/vaping risks and hazards and about smoking cessation aids that are available. Date Initiated: 1/12/2026 Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. Date Initiated: 1/12/2026 Observe clothing and skin for signs of cigarette burns. Date Initiated: 1/12/2026 R19's care plan the resident has a behavior problem (noncompliant with smoking policy) initiated on 1/25/2026, has the following interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 1/25/2026 Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Date Initiated: 1/25/2026 Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Date Initiated: 1/25/2026 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted the tobacco use and the resident is a smoker/vapes care plans were initiated on 1/12/26. Neither address R19's ability to smoke independently or where smoking materials will be stored. On 1/12/26, the form Smoking Evaluation was completed for R19. Under the Planning and Interventions section: -Intervention: The resident can smoke UNSUPERVISED -Intervention: The resident is able to: (SPECIFY light own cigarette, keep lighter at bedside .) -Intervention: The resident's smoking supplies are stored (SPECIFY). Surveyor noted two of the interventions were not completed to reflect the plan of care for R19. R19's progress note written on 1/25/2026, at 07:52 AM, documents Upon entering resident's room this AM, room heavily smelled of cigarette smoke. Asked resident if he had been smoking in his room, resident denied smoking in his room. Cigarette smell wafted down B hallway. Staff attempted to spray air freshener in the hallway with no success in removing smell. R19's progress note written on 1/25/2026, at 10:17 AM, documents Reeducated resident on importance of only smoking outside as oxygen is in use in the area and could cause an explosion and a fire could start. Educated resident that there are resident's with asthma and lung issues that are intolerant to the smoke as his window does not open to allow ventilation. Writer offered to talk to the doctor about getting a nicotine patch for resident, if the cold was the reason he began to smoke in his room. Resident stated, I don't know about that. I just love smoking so much. Writer was able to convince resident to go outside to smoke for safety. R19's progress note written on 1/25/2026, at 11:17 AM, documents Per Assistant Director of Nursing (ADON)-G, started physical paper of safety checks every 30 minutes during day shift and 15 minutes NOC (night shift). Paper at nurses station to be placed under DON (Director of Nursing) office door upon shift completion. Facility provided document regarding the 1/25/26 smoking in room issue. The Incident Description documents Per (name of), started physical paper of safety checks every 30 minutes during day shift and 15 minutes NOC. Paper at nurses station to be placed under DON office door upon shift completion. Reeducated resident on importance of only smoking outside as oxygen is in use in the area and could cause an explosion and a fire could start. Educated resident that there are resident's with asthma and lung issues that are intolerant to the smoke as his window does not open to allow ventilation. Writer offered to talk to the doctor about getting a nicotine patch for resident, if the cold was the reason he began to smoke in his room. Resident stated, I don't know about that. I just love smoking so much. Writer was able to convince resident to go outside to smoke for safety. The Resident Description documents Resident denied smoking. Denied having lighter or smoking materials. The Immediate Action Taken documents Reeducated resident on smoking policy, completed smoking assessment, MDS Coordinator met with resident same day reeducated on smoking rules and asked if we could keep smoking materials in med cart. Resident denied having any smoking materials. Offered nicotine patch. Safety checks initiated when resident returned to building. The notes section documents on 1/26/26, IDT (interdisciplinary team) met to review incident regarding alleged smoking in resident room. Resident was not witnessed smoking in room nor does he have his own smoking (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	materials. Staff completed smoking assessment deeming safe to smoke 1/25. Resident reeducated on smoking policy. Social Services met with resident 1/26 to review smoking policy. Safety checks were initiated to ensure resident compliant with smoking policy. Resident went out with sister after incident and safety checks initiated around 1900 (7pm) when resident returned. Doctor met with resident, resident denied smoking in room, Doctor offered nicotine patch and resident declined. Surveyor noted the Immediate Action Taken documents Reeducated resident on smoking policy, the smoking policy has a signature section on the last page and this was not provided as documentation that the policy had been reviewed with R19. Surveyor noted on 1/25/26, R19 allegedly smoked in room, the the resident has a behavior problem (noncompliant with smoking policy) care plan was added. No interventions directly related to smoking or materials were added. On the the resident is a smoker/vapes care plan an intervention was added declines a smoking cessation patch. On 1/25/26, the form Smoking Evaluation was completed again, after R19 allegedly smoked in room. The Smoking Related Incidents section documents Is the resident free of smoking/e-cigarette/vaping related incidents? No is selected. The next question If no: the reason Smoking in unauthorized areas is selected. The Instructions section documents A response of no to any of the questions above indicates the need for implementation of interventions to safely accommodate the resident's desire to smoke. Surveyor noted no new interventions were selected. The same were selected as on the 1/12/26 evaluation. R19's progress note written on 1/29/2026, at 3:48 PM, documents Staff CNA (Certified Nursing Assistant) reported to writer that resident is smoking in the room. Writer went to resident room and found resident sitting near the window with smoke ash all over the room floor, the room and hallway smell cigarette smoke. Writer sent for ADON-G, and he came in to the room immediately and asked the resident if he was smoking? Resident answer No. ADON-G asked again do you have a lighter? Resident answer Yes. ADON-G asked again how many lighters? Resident answer Two. ADON-G pleaded with resident if he can have the lighter back. Resident finally gave the lighters to ADON-G. R19's progress note written on 1/29/2026, at 5:21 PM, documents During a routine 30-minute safety check, writer was called to the resident's room due to a strong odor of smoke that was noticeable both inside the room and lingering in the hallway. Upon initial inquiry, the resident denied smoking. Following further discussion, the resident did surrender two lighters to the writer these items along with the cigarettes (which were already in staff possession), were secured in the locked medication cart. It remains unclear how the resident obtained the additional lighter or the cigarette used during the incident Education was provided to the resident regarding facility policy emphasizing that smoking is strictly prohibited on the premises and represents a significant fire and safety hazard. The resident voiced understanding and stated he agreed with the safety requirements. Social Services has been notified of the incident. Safety checks will continue as scheduled to ensure ongoing compliance and a safe environment. Surveyor noted no care plan intervention was initiated for storing R19's smoking materials, this was the second time R19 allegedly smoked in room. This time it was documented that smoke ash was all over the room floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R19's progress note written on 1/29/2026, at 5:44 PM, documents Writer spoke with POA (Power of Attorney) and shared that it was believed that R19 was smoking in his room. POA shared she would most certainly speak to her dad and apologized. Facility provided document regarding the 1/29/26 smoking in room issue. The Incident Description documents During a routine 30-minute safety check, writer was called to the resident's room due to a strong odor of smoke that was noticeable both inside the room and lingering in the hallway. Upon initial inquiry, the resident denied smoking. Following further discussion, the resident did surrender two lighters to the writer these items along with the cigarettes (which were already in staff possession), were secured in the locked medication cart. It remains unclear how the resident obtained the additional lighter or the cigarette used during the incident. Education was provided to the resident regarding facility policy emphasizing that smoking is strictly prohibited on the premises and represents a significant fire and safety hazard. The resident voiced understanding and stated he agreed with the safety requirements. Social Services has been notified of the incident. Safety checks will continue as scheduled to ensure ongoing compliance and a safe environment. The Resident Descri

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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 ensure food was stored, prepared and served in a sanitary manner in accordance with professional standards for food safety requirements. *Dietary staff was observed with no a hair net or beard/mustache guard in food preparation areas. *Observations of no labeling, dating or use by date for opened food items located in the cooler and freezer. *An ice scoop was observed resting inside of the ice bucket touching the ice on the third-floor dining area. This deficient practice has the potential to affect residents residing on the third floor of the facility who receive ice in their water. This deficient practice has the potential to affect 87 out of 88 residents whom receive food from the main kitchen in the facility. Findings include: The Facility Policy titled, Nutrition Care, updated 11/06/25, documents: 4.3 Label and Dating. Policy: All RTE (Ready to Eat) and TCS (Time/Temperature Control for Safety) foods stored greater than 24 hours must be labeled and date-marked per FDA (Federal Drug Administration) Food Code 3-501.17 and Wisconsin Food Code. Purpose: To prevent the use of expired, spoiled, or contaminated product from being used, thus, preventing the potential of hazardous food going into circulation. Procedure: 1. Label with product name, open/prep date or discard date and initials. 2. Day 1 is day prepared/opened. 3. Discard date must be on product. Consult storage chart for shelf life. 3 days for prepped items, 7 days from open for dairy and premade products, and single day for anything on units or down hallways. 4. Manufacturer use-by cannot be exceeded. 5. Responsibility: Dietary staff; oversight by FSD (Food Service Director). Documentation: Date-marking logs. Documentation: Date and covered refrigerator log. 4.4 Hair Restraints and Staff attire. Policy: Staff must wear hairnets/hair restraints, clean uniforms, non-slip shoes, and minimize jewelry. Purpose: Prevent contamination and comply with hygiene standards. Procedure: Hair fully covered; beard guards as needed; clean apron; no artificial nails in prep areas. Responsibility: Dietary staff and manager. Documentation: Hygiene audits. Documentation: Daily Quality Walkthrough done by management or leadership team.Infection Prevention and Emergency Preparedness. 5.1 Food Service: Infection Control: Policy: Food service operations follow infection control practices aligned with CMS F812/F880. Purpose: to prevent cross-contamination and infection transmission. Procedure: Follow hand hygiene, PPE use for isolation trays, sanitize surfaces, avoid bare-hand contact with RTE foods, Date and label food, report any incidents to your manager, and completing annual and item specific educations staying up to date. Documentation: Daily Quality Walkthrough done by management and leadership team. 1.) On 3/9/26 at 8:20 AM, Surveyor completed an initial tour of the kitchen. Surveyor observed the following: Dishwasher-Q was walking through food preparation area pushing a cart without a hair net or beard/mustache guard. Dishwasher-Q donned a hairnet at 8:27 AM but no beard guard. Dietary Aide-R was observed prepping food and not wearing a mustache guard. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor noted that Dishwasher-Q and Dietary Aide-R have facial hair and both were observed not wearing beard/mustache guards while in food preparation areas. On 3/9/26 at 8:31 AM, Surveyor observed the following in the produce cooler: sweet potatoes, green peppers, cucumbers, carrots, green cabbage, romaine lettuce, bread, coleslaw dressing and milk were opened and not labeled with a use by date. Surveyor observed the following in the freezer: Chicken quarters, cut chicken, hot dogs, naan bread and tortilla shells were opened and not labeled with a use by date. On 3/9/26 at 8:37 AM, Surveyor asked Kitchen Supervisor-S if the facility's practice is to label all food items if not already labeled by supplier. Kitchen Supervisor-S stated yes. Surveyor asked if the product is open, if it is the facility's practice to date the container or box. Kitchen Supervisor-S stated yes. Kitchen Supervisor-S acknowledged many food items were either not dated, initialed or sealed after opening and Kitchen Supervisor-S stated dating, labeling and sealing will occur immediately. Surveyor asked Kitchen Supervisor-S if it's the facility's policy to cover hair, including facial hair while in the kitchen. Kitchen Supervisor-S stated, all people in kitchen need to wear hair nets or facial hair restraints. On 3/12/26 at 9:38 AM, Surveyor notified Nursing Home Administrator (NHA)-A, Director of Operations (Director of Ops)-C, and Nurse Consultant-D of observations made of cooler and freezer items not dated or initialed once opened and observations of two dietary staff members not wearing the appropriate hair nets and/or beard/mustache guards while in food preparation areas. No additional information was provided. 2.) The Wisconsin Food Code, dated November 2024, documents: In-Use Utensils, Between-Use Storage . during pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: . in a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not time/temperature control for safety food; On 3/10/26 at 9:00 AM, Surveyor observed a bucket of ice resting on a counter in the third-floor dining area with the ice scoop resting inside of the ice bucket touching the ice. On 3/10/26 at 12:50 PM, Surveyor observed a bucket of ice resting on a counter in the third-floor dining area with the ice scoop resting inside of the ice bucket touching the ice. On 3/11/26 at 9:30 AM, Surveyor observed a bucket of ice resting on a counter in the third-floor dining area with the ice scoop resting inside of the ice bucket touching the ice. On 3/11/26 at 9:36 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-M regarding what the ice in the dining area is used for. CNA-M stated it is used for filling up resident water cups. CNA-M stated the kitchen staff brings up the ice bucket daily for nursing staff to utilize. CNA-M stated the ice scoop is always inside of the ice bucket. On 3/11/26 at 9:40 AM, Surveyor interviewed Regional Culinary Manager-N. Regional Culinary Manager-N stated the facility follows the Wisconsin Food Code. Regional Culinary Manager-N stated ice is brought to the third-floor dining area from the main kitchen daily for nursing staff to utilize for resident drinks. Surveyor shared the concern with Regional Culinary Manager-N of several (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	observations of the ice scoop resting inside of the ice bucket touching the ice in the third-floor dining area. On 3/11/26 at 3:05 PM, Surveyor shared concern with NHA-A, Director of Nursing (DON)-B, Regional Nurse Consultant-D, and Director of Operations-C regarding several observations of the ice scoop resting inside of the ice bucket touching the ice on the third-floor dining area. No additional information was provided.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility did not ensure the medical record contained signed advanced directive election forms for 4 (R4, R8, R60, and R82) of 18 residents reviewed. R4's medical record showed no evidence of being offered the option to formulate an advance directive. R8's medical record showed no evidence of being offered the option to formulate an advance directive. R60's medical record showed no evidence of being offered the option to formulate an advance directive. R82's medical record showed no evidence of being offered the option to formulate an advance directive. Findings include: The Facility Policy titled Communication of Code Status implemented [DATE] documents (in part): Policy:It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information. Policy Explanation and Compliance Guidelines:1. The facility will meet with resident/resident decision makers to determine code status upon admission. Code status will be reviewed quarterly and as needed.3. In the absence of an Advance Directive or further direction from the physician, the default direction will be Full Code.1.) R4 was admitted to the facility on [DATE] with pertinent diagnoses that include hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (a serious neurological condition characterized by paralysis (hemiplegia) or weakness (hemiparesis) on the left side of the body, with the left hemisphere of the brain being nondominant), severe protein-calorie malnutrition (a life-threatening condition caused by inadequate intake or absorption of protein and energy), cerebellar stroke syndrome (occurs when blood flow to the cerebellum is blocked (ischemic) or a vessel bursts (hemorrhagic), causing sudden vertigo, severe nausea, vomiting, and acute loss of balance or coordination (ataxia)), dysphagia (difficulty swallowing), and type 1 diabetes mellitus (a chronic autoimmune condition where the immune system destroys insulin-producing beta cells in the pancreas, leading to little or no insulin production and high blood sugar).R4's Annual Minimum Data Set (MDS) with an assessment reference date of [DATE] documented R4 had a Brief Interview for Mental Status score of 06 (severe cognitive impairment). R4 has an activated Power of Attorney. R4 is documented to be sometimes understood and sometimes understands others. Surveyor reviewed R4's electronic medical record (EMR) and was unable to locate a signed advanced directive form indicating whether CPR (cardiopulmonary resuscitation) should be performed or not. On [DATE], at 3:15pm, during the end of day meeting with facility, Nurse Consultant-D stated a couple weeks ago they discovered that there were no CPR election forms on file for residents and started an action plan to fix. On [DATE], at 8:57am, Surveyor was waiting in the hall to talk to the social worker and overheard a phone call with a family member regarding whether a resident's advance directive status paperwork should be emailed or mailed out. On [DATE], at 1:58 PM, Surveyor informed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Nurse Consultant-D and Director of Operations-C of the concern that R4 did not have a CPR election form completed notating right to choose. No additional information was provided regarding R4 being offered the option to formulate an advance directive. 2.) R8 was admitted to the facility on [DATE] with pertinent diagnoses that include orthopedic aftercare following surgical amputation, osteomyelitis right ankle and foot (a serious bone infection), metabolic encephalopathy (a group of conditions that cause brain dysfunction. Brain dysfunction can appear as confusion, memory loss, personality changes and/or coma in the most severe form), hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (a serious neurological condition characterized by paralysis (hemiplegia) or weakness (hemiparesis) on the left side of the body, with the left hemisphere of the brain being nondominant), and cognitive communication deficit (difficulty with communication that stems from impaired thinking skills, such as memory, attention, and problem-solving, rather than from physical (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	speech problems). R8's Medicare 5 day Minimum Data Set (MDS) with an assessment reference date of [DATE] documented R8 had a Brief Interview for Mental Status score of 15 (cognitively intact). R8 is documented to be understood and understand others. Surveyor reviewed R8's electronic medical record (EMR) and was unable to locate a signed advanced directive form indicating whether CPR (cardiopulmonary resuscitation) should be performed or not. On [DATE], at 3:15pm, during the end of day meeting with facility, Nurse Consultant-D stated a couple weeks ago they discovered that there were no CPR election forms on file for residents and started an action plan to fix. On [DATE], at 8:57am, Surveyor was waiting in the hall to talk to social worker and overheard a phone call with a family member regarding a resident's advance directive status paperwork should be emailed or mailed out. On [DATE], at 1:58 PM, Surveyor informed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Nurse Consultant-D and Director of Operations-C of the concern that R8 did not have a CPR election form completed notating right to choose. No additional information was provided regarding R8 being offered the option to formulate an advance directive. 3.) R60 was admitted to the facility on [DATE] with pertinent diagnoses that include palliative care (specialized medical care for people living with a serious illness), dementia (a syndrome that can be caused by a number of diseases which over time destroy nerve cells and damage the brain, typically leading to deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from the usual consequences of biological ageing), dysphagia (difficulty swallowing), and adult failure to thrive (a syndrome of decline marked by unintended weight loss, malnutrition, cognitive impairment, and functional decline). R60's Quarterly Minimum Data Set (MDS) with an assessment reference date of [DATE] does not document a Brief Interview for Mental Status (BIMS) assessment. R60 has an activated Power of Attorney. R60 is documented to rarely/never be understood and rarely/never understand others. Surveyor reviewed R60's electronic medical record (EMR) and was unable to locate a signed advanced directive form indicating whether CPR (cardiopulmonary resuscitation) should be performed or not. Surveyor reviewed a progress note indicting even though R60 is hospice the family elects CPR. On [DATE], at 3:15pm, during the end of day meeting with facility, Nurse Consultant-D stated a couple weeks ago they discovered that there were no CPR election forms on file for residents and started an action plan to fix. On [DATE], at 8:57am, Surveyor was waiting in the hall to talk to social worker and overheard a phone call with a family member regarding a resident's advance directive status paperwork should be emailed or mailed out. On [DATE], at 9:07am, Surveyor reviewed the hospice communication binder for R60. A tab for Advanced Directive was in the binder, however no documentation of the advance directive choice was included. On [DATE], the form CPR Cardiopulmonary Resuscitation Consent was provided to Surveyor for R60. Resuscitation was the desire chosen. A note at the bottom of the form indicated this was verbal (sic) obtained from POA (Power of Attorney) on [DATE]. Surveyor noted this form was completed after Surveyor brought the issue to the Facility's attention. 4.) R82 was admitted to the facility on [DATE] with pertinent diagnoses that include hypertensive chronic kidney disease with stage 5 chronic kidney disease (kidney damage caused by long-term high blood pressure (hypertension), type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), and dependence on renal dialysis (refers to the mandatory, long-term reliance on artificial blood filtration-hemodialysis or peritoneal dialysis-because the kidneys have permanently failed, usually due to end-stage renal disease). R82's Quarterly Minimum Data Set (MDS) with an assessment reference date of [DATE] documented R82 had a Brief Interview for Mental Status score of 12 (moderate cognitive impairment). R82 is documented to be understood and understand others. Surveyor reviewed R82's electronic medical record (EMR) and was unable to locate a signed advanced directive form indicating whether CPR (cardiopulmonary resuscitation) should be performed or not. On [DATE], at 3:15pm, during the end of day meeting with facility, Nurse Consultant-D stated a couple weeks ago they discovered that there were no CPR election forms on file for residents and started an action plan to fix. On [DATE], at 8:57am, Surveyor was waiting in the hall to talk to social (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	worker and overheard a phone call with a family member regarding a resident's advance directive status paperwork should be emailed or mailed out. On [DATE], at 1:58 PM, Surveyor informed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Nurse Consultant-D and Director of Operations-C of the concern that R82 did not have a CPR election form completed notating right to choose. No additional information was provided regarding R82 being offered the option to formulate an advance directive.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not consistently provide or offer a substantial evening snack to residents within a timeframe greater than 14 hours between evening supper meal and breakfast. *R67 is not offered a substantial snack routinely between meals as care planned which created a gap of more than 14 hours between the supper and breakfast meals. *The facility failed to provide a nourishing snack at bedtime to residents between the dinner meal and breakfast the following day. This resulted in a 14.5 hour time-lapse in meals for second floor residents and a 15.5 hour time-lapse in meals for third floor residents. This deficient practice has the potential to affect 87 out of the 88 residents residing at the facility. Findings include: The State Operating Manual documents, 483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. The facility could not provide a snack timing policy. 1.) R67 was admitted to the facility on [DATE] with a diagnoses that include hemiplegia (severe or complete paralysis of one side of the body) and hemiparesis (neurological condition characterized by mild to moderate weakness or reduced control of one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side, chronic obstructive pulmonary disease, mild protein-calorie malnutrition, heart failure and vascular dementia. R67's Minimum Data Set (MDS) dated [DATE] documents R67 has a Brief Interview for Mental Status (BIMS) of 3, indicating severe cognitive impairment. R67's MDS assessment indicates that it is very important for snacks to be available between meals for R67. R67's Care Plan initiated 9/22/25, documents: Resident with the potential for altered nutritional status related to diagnoses/history of cerebral infarct, COPD , mild protein-calorie malnutrition, vascular dementia, and HLD. The goal for R67 is the resident will maintain adequate nutritional status with diet and/or supplement tolerance. Interventions include; Monitor intake of food/fluids, Monitor weight trends, Offer Ensure supplements BID (twice a day), Offer snacks between meals, Provide and serve diet as ordered (general diet, regular texture, regular/thin liquids), Weigh as directed. Notify MD (Medical Doctor), RD (Registered Dietician) of significant weight changes. Surveyor located mealtimes in the facility survey binder that was provided by Nursing Home Administrator (NHA)-A. The mealtimes for the third floor are documented as breakfast from 8:30-9:30 AM, lunch from 12:30-1:30 PM, and dinner from 4:00-5:00 PM. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor noted R67 resides on the third floor and there is a 15.5-hour time lapse between dinner ending at 5:00 PM and breakfast starting at 8:30 AM for residents on the third floor. On 03/10/26 at 12:08 PM, Surveyor interviewed Dietary Aide-O who stated she delivers snacks to kitchen areas on floor 2 and 3 every morning and checks to see if there is more snacks needed throughout her shift. Dietary Aide-O stated she does not pass out the snacks to residents and the staff on the unit do this. On 03/10/26 at 12:15 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-P. LPN-P stated she does not pass out snacks but if a resident asks for snacks, she will get a snack from the unit kitchen for them. LPN-P stated that snacks are based upon request and not passed out. Surveyor asked if residents have access to the kitchen and LPN-P stated, no, just the staff. On 03/10/26 at 12:23 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-G who stated, there is no structure for snacks. If a resident asks for a snack, it is provided to them. ADON-G stated, dietary staff used to pass out the snacks but now rely on the unit staff to do this. ADON-G stated dietary staff stopped providing snacks directly to the residents at least a few weeks ago and there is no current structured plan to distribute. On 03/11/26 at 9: 38 AM, Surveyor notified NHA-A, Director of Operations (Director of Ops)-C, and Nurse Consultant-D of concerns relating to R67 not being offered or provided nourishing evening snack with approximately 15.5 hours in between dinner and breakfast. Director of Ops -C, stated, I am not sure if it is true that residents are not provided snacks. Surveyor stated, the dietary staff, unit staff and residents have been interviewed and verified the practice of providing evening snacks stopped several weeks ago. Director of Ops-C could not validate this information. No additional information was provided. 2.) R44 admitted to the facility 9/17/25. R44's quarterly Minimum Data Set (MDS) dated [DATE] documents R44 has a Brief Interview for Mental Status (BIMS) score of 04 indicating severe cognitive impairment. R51 admitted to the facility on [DATE]. R51's admission MDS dated [DATE] documents R51 has a BIMS score of 12 indicating moderate cognitive impairment. R65 admitted to the facility 2/18/24. R65's quarterly MDS dated [DATE] documents R65 has a BIMS score of 15 indicating intact cognition. On 3/10/26 at 11:03 AM, Surveyor conducted resident council at the facility with R44, R51, and R65 in attendance. R65 stated the facility used to come to resident rooms twice a day with a snack cart, but since the facility was bought by a new owner this has stopped. R51 stated the only time residents get an extra snack is during Bingo. R44, R51, and R65 stated the facility does not offer snacks at bedtime. Surveyor located mealtimes in the facility survey binder that was provided by Nursing Home Administrator (NHA)-A. The mealtimes for second floor are documented as breakfast from 8:00-9:00 AM, lunch from 12:00-1:00 PM, and dinner from 4:30-5:30 PM. Surveyor notes there is a 14.5-hour time lapse between dinner ending at 5:30 pm and breakfast starting at 8:00 AM for residents on the second (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	floor. The mealtimes for the third floor are documented as breakfast from 8:30-9:30 AM, lunch from 12:30-1:30 PM, and dinner from 4:00-5:00 PM. Surveyor notes there is a 15.5-hour time lapse between dinner ending at 5:00 PM and breakfast starting at 8:30 AM for residents on the third floor. In an interview on 3/10/26 at 12:08 PM, Dietary Aide (DA)-O stated the kitchen staff deliver snacks to the kitchen area on the second floor and snacks are restored as needed. DA-O stated kitchen staff do not pass out snacks to residents and nursing staff is responsible for that. In an interview on 3/10/26 at 12:15 PM, Licensed Practical Nurse (LPN)-P stated LPN-P does not pass out snacks to residents, but if a resident requests a snack, LPN-P would get a snack from the second-floor kitchen. LPN-P stated snacks are based upon request and not passed out throughout the day or at bedtime. In an interview on 3/10/26 at 12:23 PM, Assistant Director of Nursing (ADON)-G stated there is no structure for snacks. ADON-G stated if a resident asks for a snack, it is provided to them, or if there is a physician order for a snack, a resident would be provided with one, otherwise the residents must ask for a snack. In an interview on 3/11/26 at 9:40 AM, Regional Culinary Manager-N confirmed dinner ends at 5:30 PM and breakfast starts at 8:00 AM on the second floor, and dinner ends at 5:00 PM and breakfast starts at 8:30 AM on the third floor. Regional Culinary Manager-N stated residents can request snacks during business hours, and a nighttime snack is stocked in the second-floor kitchen nightly. Regional Culinary Manager-N stated the nursing staff is responsible for providing the residents with snacks and kitchen staff does not supply snacks directly to residents. Surveyor shared the concern with Regional Culinary Manager-N a nourishing snack is not served to residents at bedtime between the evening meal and breakfast the following day, which has a 14.5-hour time lapse for second floor residents and a 15.5-hour time lapse for third floor residents. On 3/11/26 at 3:05 PM, Surveyor shared concern with NHA-A, Director of Nursing (DON)-B, Regional Nurse Consultant-D, and Director of Operations-C that a nourishing snack is not served to residents at bedtime between the evening meal and breakfast the following day, which has a 14.5-hour time lapse for second floor residents and a 15.5-hour time lapse for third floor residents. No additional information was provided.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview and record review, the facility did not ensure 1 Resident (R45) in a sample of 18 residents received activities offered based upon assessment of individual preferences and interests.R45 was observed sitting in the dining room with no activities being offered to R45 during that time other than music playing in the background. Interviews indicate R45 has interest in music and preferences for activities and routines based on history that were not assessed or care planned for R45.Findings include: R45 was admitted to the facility on [DATE] with diagnoses of dementia, anxiety, peripheral vascular disease, and type 2 diabetes. The quarterly Minimum Data Set (MDS) dated [DATE] documents R45 is severely cognitively impaired. R45's admission MDS with an assessment reference date of 9/23/25 includes as part of the assessment under section F0500 interview for daily activity preferences: having books, newspapers and magazines to read, listening to music R45 likes, being around animals and pets, keeping up with the news, doing things with groups of people, doing favorite activities and participating in religious services are somewhat important to R45. R45 answered it is very important to R45 to go outside and get fresh air when the weather is good. The MDS indicates R45 was able to be interviewed and provide the responses to answer the questions regarding preferences for activities. On 3/9/26 at 1:36 p.m. Surveyor interviewed R45's guardian. R45's guardian voiced concern R45 is in the dining area all day.On 3/11/26 at 11:04 a.m. Surveyor observed R45 in a Broda chair in the dining area with music playing from the radio. Other residents and staff were in the area there was no direct interaction with R45 or other activities occurring involving R45 observed. On 3/12/26 at 7:59 a.m. Surveyor observed R45 in a broda chair in the dining area with music playing on the radio. Other residents and staff were in the area there was no direct interaction with R45 or other activities occurring involving R45 observed. On 3/11/26 at 1:45 p.m. Surveyor interviewed Activity Director-Q. Surveyor asked Activity Director-Q, what sort of activities does R45 engage in. Activity Director-Q stated R45 loves music and when he is in the dining area she will make sure the radio is on to his preference. Activity Director-Q stated R45 also loves activities that involve food. Activity Director-Q was getting ready to have a cookie decorating activity, that R45 was going to participate in. On 3/12/26 at 10:11 a.m. Surveyor interviewed Director of Nursing (DON)-B. DON-B stated R45 is very social and when he was first admitted they tried to put him to bed after meals but R45 would not want that and wanted to be up and socializing.On 3/12/26 at 10:30 a.m. Surveyor interviewed Social Worker (SW)- K and SW-R. SW-K stated R45 used to be a musician and is used to staying up late. SW-R stated R45 likes to go to bed late and get up early. SW-R stated R45 doesn't sleep much. SW-R stated R45 is very social and likes music so he likes to stay up and socialize. SW-R stated R45 will socialize with the nurses when the other residents have gone to bed. SW-R stated this was explained to R45's guardian. Surveyor explained to SW-R, SW-K and DON-B this information is not in R45's care plan. SW-R and SW-K agreed and stated they will make the changes to R45 care plan.

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F 0684 Level of Harm - Minimal harm or potential for 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 observation, interview and record review the facility did not ensure 1 (R12) of 1 residents at risk for diabetic wounds received the necessary services to prevent diabetic wounds. R12 was admitted to the facility on [DATE]. On 1/22/26 diabetic wounds were identified to R12's bilateral heels. There are no documented interventions that were in place to prevent diabetic wounds from developing despite R12 having a diagnosis of diabetes type 2. Findings include:The facility's Skin Integrity-Foot Care dated 2/2/26 documents: 2. Assessment of Riskb. The comprehensive assessment process will be utilized for identifying additional risk factors or conditions that increase risk for impaired skin integrity of the foot. Examples include, but are not limited to: diabetes, peripheral vascular disease, peripheral arterial disease, venous insufficiency, peripheral neuropathy and lack of sensation in feet.3. Interventions for Prevention and to Promote Healinga. Interventions will be based on specific factors identified in the risk assessment, skin assessment and assessment of any foot ulcers (e.g. impaired sensation, immobility, foot deformity, wound characteristics).ii. Appropriate offloading or orthopedic devices, diabetic shoes, or pressure relieving devices will be utilized as indicated.R12 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes, Alzheimer's disease and anxiety. The admission Minimum Data Set (MDS) dated [DATE] documents R12 is moderately cognitively impaired and R12 needs moderate assistance to move in bed. It also documents R12 did not have any diabetic wound upon admission.The admission assessment dated [DATE] documents R12 was admitted with a pressure injury to the sacrum area but does not indicate any skin integrity concerns with the feet.Wound Advanced Practical Nurse Practitioner (APNP)-J assessment note dated 1/22/26 documents R12 having a diabetic wound to the right heel, deep purple area measuring 3.5 cm by 1.0 cm with intact skin no drainage, periwound pink and blanchable. No signs or symptoms of infection. Status: new. Plan: Betadine daily, heel offloading boots at all times when in bed. R12 also had a diabetic wound to the left posterior heel, dry eschar measuring 1.0 cm by 1.0 cm, intact skin no drainage. No signs or symptoms of infection. Status: New. Plan: betadine daily heel offloading boots at all times.The potential/actual impairment to skin integrity care plan dated 1/12/26 documents turn and position as necessary as one of the interventions. There is no documentation in the care plan that addresses offloading of the feet. Wound APNP-J's assessment note dated 3/5/26 documents the diabetic wound to the right heel as a full thickness wound measuring 1.6 cm by 3.0 cm by 0.1 cm with 90% slough and 10% granular. Light serosanguineous drainage with periwound pink and blanchable. No signs or symptoms of infection. Status: stable. Plan: medihoney on border gauze change three times a week. The diabetic wound to the left posterior heel with dry eschar measuring 4.0 cm by 2.5 cm 100% eschar. Intact with no drainage and no signs or symptoms of infection. Status: stable. Plan Betadine daily heel offloading boots at all times. (R12) is not very compliant with position changing (sic) and utilizing heel offloading boots. (R12) is very resistant and verbally unpleasant using swear words and stating leave me alone. She can be resistant to utilizing offloading measures.The previous wound assessments document R12 non compliance with offloading and repositioning. The care plan does not address R12's offloading devices or R12 being not compliant with interventions. On 3/9/26 at 2:14 pm Surveyor observed R12 in bed with air mattress on. Surveyor observed R12's feet offloaded. On 3/12/26 at 8:44 a.m. Surveyor observed Wound APNP-J assess R12's wounds and apply the treatment as ordered. Wound APNP-J stated she has been seeing R12 since admission. Wound APNP-J stated she thought R12 heel wounds were present upon admission [DATE]). Surveyor explained Wound APNP-J documented the heel wounds were first discovered on 1/22/26. Wound APNP-J clarified her answer and agreed with Surveyor that was the case. Wound APNP-J stated R12 is not complaint with interventions like repositioning and offloading. Wound APNP-J stated R12's heel wounds are stable.On 3/11/26 at 1:03 p.m. Surveyor interviewed Assistant Director of Nursing (ADON)-G. Surveyor asked ADON-G when it was discovered that R12 developed heel wounds. ADON-G (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated it was discovered on 1/22/26 by Wound APNP-J. Surveyor asked ADON-G when were heel offloading interventions implemented for R12. ADON-G stated after the heel wounds were discovered. Surveyor explained the heel wounds and intervention of offloading are not on the care plan. ADON-G stated he was not aware and will adjust the care plan. ADON-G stated he's not sure why offloading was not implemented prior to 1/22/26. ADON-G agreed R12 was at risk for skin impairments due to her diagnoses.On 3/11/26 at 3:10 p.m. during the daily exit meeting with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, Surveyor explained the concern R12 developed diabetic heel wounds and there's no documented evidence R12 had any offloading device used prior to the development of the wounds. Surveyor also explained that the care plan does not address the heel wounds or offloading devices. The care plan also does not address R12's non compliance with interventions.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 1 (R43) of 6 residents had necessary interventions to monitor weight.R43's physician order dated 1/27/26 documents that R43 is to be weighed Monday, Wednesday and Friday for two weeks and then weekly thereafter. R43's medical record reveals R43 has a documented weight on 1/21/26, 2/2/26 and 2/3/26. Weights were not obtained per physician orders.Findings include:R43 was admitted to the facility on [DATE] with diagnoses of dementia, congestive heart failure, chronic obstructive pulmonary disease and cardiomyopathy. R43 was discharged home during the survey on 3/11/25.R43's admission Minimum Data Set (MDS) dated [DATE] documents that R43 is cognitively intact, needs maximum assistance with toileting and moderate assistance with dressing.R43's care plan for potential for altered nutritional status related to diagnoses/history of cardiomyopathy, adult failure to thrive, congestive heart failure (CHF), cardiovascular accident (CVA), chronic obstructive pulmonary disease (COPD), hyperlipidemia (HLD), dementia and coronary artery disease (CAD) dated 1/12/26 documents under the Interventions section: Monitor weight trends.weigh as directed. Notify Medical Doctor (MD), Registered Dietician (RD) of significant weight changes.R43's physician order dated 1/27/26 documents R43 to be weighed Monday, Wednesday and Friday for two weeks and then weekly thereafter due to history of heart failure.R43's medical record documents weights on 1/21/26 of 143.2 lbs., 2/2/26 historical weight data of143 lbs. and 2/3/26 of 137.6 lbs. No other weights were documented in R43's medical record.On 3/10/26 at 3:00 p.m. during the daily exit meeting, Surveyor asked to see R43 weight data. On 3/11/26 at 12:47 p.m. Nursing Home Administrator (NHA)-A informed Surveyor that there are no other weights obtained for R43. On 3/11/26 p.m. Surveyor interviewed Assistant Director of Nursing (ADON)-G. Surveyor explained R43 had an order for weekly weights, and it wasn't obtained. ADON-G Stated this was missed and had no other information as to why the weights were not obtained as ordered.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that residents who require dialysis receive such services, consistent with professional standards of practice, including the ongoing communication with the dialysis center before and after dialysis treatments, for 1 (R82) of 2 residents reviewed for dialysis. R82 has a physician order for dialysis on Monday, Wednesday and Friday. Communication between the facility and the dialysis center was not being shared with each dialysis visit.Findings include:The Facility Policy titled Hemodialysis implemented 1/31/2026 documents: Policy- This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis.Purpose:The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include:-The ongoing assessment of the resident's condition and observing for complications before and after dialysis treatments received at a certified dialysis facility.-Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices: and-Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.5. The licensed nurse will communicate to the dialysis facility via dialysis communication form or other form, that will include, but not limit itself to:a. Changes and/or declines in condition unrelated to dialysis.b. The occurrence or risk of falls and any concerns related to transportation to and from the dialysis facility.c. Dialysis treatment outcomes as indicated may include pre-post weights and pre-post vital signs.d. Changes in orders.R82 was admitted to the facility on [DATE] with pertinent diagnoses that include hypertensive chronic kidney disease with stage 5 chronic kidney disease (kidney damage caused by long-term high blood pressure (hypertension), type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), and dependence on renal dialysis (refers to the mandatory, long-term reliance on artificial blood filtration-hemodialysis or peritoneal dialysis-because the kidneys have permanently failed, usually due to end-stage renal disease).R82's Quarterly Minimum Data Set (MDS) with an assessment reference date of 2/25/26 documented R82 had a Brief Interview for Mental Status score of 12 (moderate cognitive impairment). R82 is documented to be understood and understand others and not to have behaviors exhibited during the MDS assessment period. R82's care plan documents The resident goes to [name] dialysis (SPECIFY type hemo) Tue-Thur-Sat revision on 8/21/2025.Interventions include: Check and change dressing daily at access site. Document. Date initiated: 8/19/2025 Do not draw blood or take B/P (blood pressure) in arm with dialysis site. Date initiated: 3/2/2026 Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis (). Revision on: 12/11/2025 Monitor labs and report to doctor as needed. Date initiated: 3/2/2026 Monitor VITAL SIGNS, per orders. Notify MD (medical doctor) of significant abnormalities. Revision on: 3/2/2026 Monitor/document report to MD s/sx (signs and symptoms) of depression. Obtain order for mental health consult if needed. Date initiated: 3/2/2026 Monitor/document/report PRN any s/sx of infection to access site: Redness, Swelling, warmth or drainage. Date initiated: 3/2/2026 Monitor/document/report PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Date initiated: 3/2/2026 Monitor/document/report PRN for s/sx of the following: Bleeding, Hemorrhage, Bacteremia, septic shock. Date initiated: 3/2/2026 Monitor/document/report PRN new/worsening peripheral edema. Date initiated: 3/2/2026 Surveyor noted the wrong dialysis days for R82 were indicated on R82's care plan.R82's physician order documents: Fill out bottom of dialysis communication sheet, then place in medical records at bedtime (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every Mon, Wed, Fri.Surveyor reviewed the last 3 full months that R82 was scheduled for dialysis for the communication forms being uploaded to R82's medical record. Surveyor noted: 12/1 None12/3 completed12/5 None12/8 upon return section not completed 12/10 completed12/12 completed12/15 None12/17 upon return section not completed 12/19 completed12/22 None12/24 None12/26 None12/29 None12/31 completedFor December, seven dialysis communication forms were unable to be located and 2 more forms were not completed by staff after R82 returned from dialysis.1/2 upon return section not completed1/5 None1/7 None1/9 None1/12 completed1/14 None1/16 None1/19 None1/21 completed1/23 None1/26 completed1/28 None1/30 completedFor January, eight dialysis communication forms were not accounted for, with 1 more not completed by staff after R82 returned from dialysis.2/2 None2/4 completed2/6 upon return section not completedR82's progress note dated 2/9/2026, at 10:05 PM, documents Resident is alert and oriented. Went to dialysis clinic today. The resident was not given the dialysis form to bring back to the facility. No issues noted, denies pain or discomfort.2/11 upon return section not completed2/13 None2/16 upon return section not completedR82's progress note dated 2/18/2026, at 10:20 PM, documents Resident came back from dialysis without but her dialysis form b/p 166/81 hr/89 resident ate dinner and received her medication tolerated well.2/20 upon return section not completed2/23 None2/25 upon return section not completed2/27 NoneFor February, four dialysis forms were unable to be located, two were not returned and 5 more were not completed by staff after R82 returned from dialysis.3/2 None3/4 None3/6 completed3/9 NoneFor March, three dialysis communication forms were unable to be located. On 03/11/2026, at 8:55 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E regarding when R82 goes to dialysis. Per LPN-E, R82 is given an envelope with a paper in that that the nurse has put vital signs and an assessment on. R82 is supposed to give the envelope to dialysis center staff and have them complete a section. R82 then brings back the form to the facility and gives to a nurse who puts it in a file.On 03/11/2026, at 9:24 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-G and asked about the dialysis communication form and was told when a resident comes back from dialysis the form goes to medical records to be put into their medical record. Surveyor let ADON-G know several of R82's were missing and was told ADON-G will look into.On 03/11/2026, at 1:58 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Nurse Consultant-D and Director of Operations-C about the concern regarding R82's dialysis communication forms missing from R82's medical record. On 03/12/2026, at 9:45 AM, Surveyor interviewed R82 about the dialysis communication forms. Per R82, facility staff provide an envelope that R82 takes to dialysis. The dialysis facility staff fill out the form and R82 brings it back to the facility. R82 feels this works out as R82 keeps the enveloped in her purse with a blanket and headphones that R82 takes with to appointments.No additional information was provided regarding R82's missing dialysis communication forms.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review the facility did not ensure its medication error rate was not 5 percent or greater. The medication error rate was 14.81%.Findings include:The facility policy titled Medication Administration dated 1/1/26 documents: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.10. Ensure that the six rights of medication administration are followed:a. Right residentb. Right drugc. Right dosaged. Right routee. Right timef. Right documentationOn 3/10/26 at 7:45 AM, Surveyor observed Medication Technician (MT)-H prepare medications for R7. While preparing the medications, MT-H stated he did not have a 6 mg (milligram) tablet of Austedo and went to talk to nurse. After talking to the nurse, MT-H reported the medication cannot be broken in half because it is not scored, and pharmacy would deliver the medication this afternoon.Surveyor verified the number of tablets with MT-H. R7 was observed to swallow the tablets whole with water. On 3/10/26 at 8:00 AM, Surveyor reconciled R7's medications ordered. Surveyor noted MT-H signed out the following medications as administered:Duloxetine HCl (Hydrochloride) capsule Delayed Release Particles 30 MG. Give 1 capsule by mouth two times a day for depression/pain related to Major Depressive Disorder.Austedo Oral Tablet 12 MG (Deutetrabenazine). Give 1 tablet by mouth two times a day for tardive dyskinesia along with 6 mg tablet for total dose of 18 mg BID (twice daily).Advair Diskus Inhalation Aerosol Powder Breath Activated 250-50 MCG (micrograms)/ACT (Fluticasone Salmeterol). 1 puff inhale orally every 12 hours related to Chronic Obstructive Pulmonary Disease.Surveyor noted Duloxetine HCL and Advair inhaler were signed out as administered, but neither were observed given and Austedo 18 mg was signed out as administered, but only 12 mg was given. On 3/10/26 at 8:45 AM, Surveyor informed MT-H of the above medications signed out as administered but were not given. Surveyor and MT-H viewed R7's Medication Administration Record (MAR) together. MT-H viewed R7's medication cards and was not able to find a card for Duloxetine. MT-H stated, How did I miss that? I don't know why I signed that out. While viewing R7's MAR, MT-H stated, Oops, I signed out that other medication too, the Austedo. I don't know why I did that; I'll have to change it. MT-H searched the medication cart for the Advair inhaler and stated, I don't know why I signed that out, didn't I give it? Surveyor advised the Advair inhaler was not given during observation of medication pass. On 3/10/26 at 8:50 AM, MT-H approached Surveyor and reported he gave R7 her inhaler after Surveyor left medication pass observation. On 3/10/26 at 8:53 AM, Surveyor asked R7 (who has a Brief Interview for Mental Status score of 15, indicating no cognitive impairment) if she got her Advair inhaler this morning. R7 stated, No, not yet. On 3/11/26 at 8:23 AM, Surveyor observed Registered Nurse (RN)-F prepare medications for R4. Surveyor verified the number of tablets with RN-F. RN-F crushed all the tablets and administered them through R4's G-tube (gastrostomy tube). Surveyor reconciled R4's medications and noted Calcium with vitamin D 600 mg /5mcg was observed given, however R4's physicians order reads: Vitamin D-3 Tablet (Cholecalciferol) Give 1 tablet enterally one time a day for prophylactic Vitamin D3 with Calcium 500-5mg-mcg via GT. On 3/11/26 at 10:29 AM, DON-B was advised of the above concerns and the medication error rate. No additional information was provided.

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	525523	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avina of Milwaukee	9255 N 76th St Milwaukee, WI 53223

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not ensure that drugs and biologicals used in the facility were stored under proper temperature controls, were labeled in accordance with currently accepted professional principles, and include the expiration date when applicable for 1 of 2 medication rooms and 2 of 6 medication carts observed.Insulin was not dated when opened and/or was expired and the medication refrigerator temperature was above the recommended temperature.Findings include:The facility policy titled Storage of Medication Requiring Refrigeration dated [DATE] documents (in part): It is the policy of this facility to assure proper and safe storage of medications requiring refrigeration and to prevent the potential alteration of medication by exposure to improper temperature controls.2. The facility will ensure that all drugs and biologicals used will be labeled in accordance with professional standards, including expiration dates (when applicable).3. The facility will ensure that all medications and biologicals will be stored at proper temperatures and other appropriate environmental controls according to manufacturers' recommendations to preserve their integrity.4. Refrigerators used for the storage of medications and biologicals:c. Temperature should be maintained between 36 - 46 degrees F (Fahrenheit).The facility provided a form which was not titled or dated. The form documents:Insulins:Most insulins should have an expiration date of 28 days after opening. According to manufacturer different insulins have different times before they expire; only if the medication is maintained according to manufacturer instructions. Practice O's and X's. O = open date, X = expiration date. Nurses must write on the product the open and expire dates. On [DATE] at 7:45 AM, Surveyor observed the 3rd floor C medication cart. In the top drawer of the cart, Surveyor located a Glargine insulin vial belonging to R5 opened [DATE].On [DATE] at 10:20 AM, Surveyor observed the 2nd floor medication room refrigerator which contained medications, including insulin. Surveyor noted the refrigerator temperature was 54 degrees. The log sheet on top of the refrigerator documented the temperature is to be between 32 - 40 degrees. On [DATE] at 8:03 AM, Surveyor noted the refrigerator temperature read 48 degrees.On [DATE] at 8:17 AM, Surveyor advised Director of Nursing (DON)-B of the temperature and viewed together. The temperature was 58 degrees. DON-B reported she wanted to wait 15 minutes and recheck the temperature.On [DATE] at 8:46 AM, Surveyor and Licensed Practical Nurse (LPN) Supervisor-I observed the refrigerator temperature which was 48 degrees. LPN Supervisor-I stated, What is it supposed to be? She looked at the log which documented 32-40 degrees. LPN Supervisor-I stated, I'm not sure how we fix that. Surveyor advised LPN-Supervisor-I would inform DON-B. On [DATE] at 8:07 AM, Surveyor observed the 2nd floor treatment cart. On top of the cart was a plastic bin containing: A Glargine insulin vial and 2 Lispro insulin vials belonging to R68 which were open and used but not dated when opened.A Glargine insulin pen which was not labeled with a resident name. The insulin pen was open and used but not dated when opened.A Lispro insulin Kwik pen with a name written in black marker (which was not legible) dated opened [DATE] expired [DATE]. On [DATE] at 10:29 AM, Surveyor advised DON-B of concern insulins were not dated when opened and/or were expired and the refrigerator temperature was above the recommended temperature. No additional information was provided.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that a resident continued to receive specialized rehabilitative services for 1(R67) of 1 residents reviewed for rehabilitation services.R67 was discharged from Occupational Therapy services on 3/3/26 when goals were not met and R67 was cooperative in participation.Findings include:R67 was admitted to the facility on [DATE] with diagnoses that include hemiplegia (severe or complete paralysis of one side of the body) and hemiparesis (neurological condition characterized by mild to moderate weakness or reduced control of one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side, chronic obstructive pulmonary disease, mild protein-calorie malnutrition, heart failure and vascular dementia.R67's Minimum Data Set (MDS) assessment, dated 3/28/25, documents R67 has a Brief Interview for Mental Status (BIMS) of 3, indicating severe cognitive impairment. The MDS documents the following assessments: R67 has no upper and lower extremity functional limitation in range of motion and uses a wheelchair; R67 needs partial to moderate assistance with upper and lower body dressing, showering/bathing, personal and oral hygiene and putting on footwear; R67 partial to moderate assistance with the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed and with the ability to move from lying on the back to sitting on the side of the bed and with no back support.R67's Care Plan, date initiated 3/9/25, documents: The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) impaired mobility, dementia, and antidepressant use. The goal for R67 is to maintain current level of function through review date. Interventions include; resident has personal refrigerator, check nail length and trim and clean on bath day and as necessary, Report any changes to the nurse, . BED MOBILITY: The resident uses 2 grab bars to maximize independence with turning and repositioning in bed, EATING: The resident is able to: setup assist, staff to remind her to eat, TRANSFER: The resident is stand pivot of 1 staff for transferring.R67's Physician Orders, date initiated 7/29/25, documents, THERAPY - PT (Physical Therapy) eval and treat. No directions specified for order. OtherActive7/29/2025, THERAPY - OT (Occupational Therapy) eval and treat. No directions specified for order. OtherActive7/29/2025R67's progress note, dated 2/5/26 at11:05 AM, written by Nurse Practitioner (NP)-X, documents: Health Status Note.rehabilitation evaluation after a functional decline. She has been working with the OT team at the facility since 1/31/2026 on functional goals including improved balance, increased trunk and bilateral upper extremity strength, safe wheelchair mobility, and increased participation in her ADLs such as dressing, hygiene, and self-feeding. She previously received PT and OT in 2025, and after discharge from therapy she remained wheelchair dependent, required maximal assistance for all ADLs, required supervision for wheelchair mobility, and was able to stand-pivot transfer with moderate assistance. Currently at the facility, she remains wheelchair dependent and requires substantial assistance with all ADLs.R67's progress note, dated 2/19/26 at 11:10 AM, written by NP-X, documents: Health Status Note.rehabilitation follow-up.R67 states OT is going well, but it is unclear if she remembers her recent sessions. She denies pain and states she has a good appetite. She remains pleasantly confused, stating that she is going back to work at [NAME] hospital and needs to find someone to keep the baby while I'm gone. Per therapy notes, she tolerated wheelchair mobility training during her last OT session on 2/18 this week.Prior level of function: after previous course of PT/OT in 2025: wheelchair dependent, maximum assist for all ADLs, required supervision for wheelchair mobility, required moderate assist with stand-pivot-transfer. Current level of function: requires substantial-total assistance with transfers, mobility, toileting, hygiene, and clothing management. Uses a wheelchair for mobility.continue OT plan of care to increase participation in activity tolerance, strength, coordination, and ADLs.R67's Occupational Therapy Discharge summary, dated [DATE], documents: Short term goal not met, patient will improve ability to safely and efficiently perform UB dressing with Supervision or Touching Assistance with the use of (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no adaptive equipment in order to be able to return to prior level of living and facilitate ability to live in environment with least amount of supervision and assistance. Discharge evaluation: Partial/moderate assistance.Short term goal not met, patient will increase trunk strength to 4+/5 in order to increase performance of ADL/self care tasks, increase flexibility for functional activity performance, achieve and maintain upright posture, facilitate reaching during ADL/mobility tasks and increase core strength for mobility tasks. Discharge evaluation: 4/5. Long term goal not met, patient will increase BUE strength to 4+/5 for increased safety and IND with self-cares and ADL tasks. Discharge evaluation: 4/5.Assessment and Summary of Skilled Services: Patient Progress, Progress and response to treatment: patient has improved strength generally, some of her goals are met.R67's Progress Note, dated 3/5/2026 at 10:20 AM, written by NP-X, documents: Health Status Note.rehabilitation follow-up.I encountered [R67] sitting in her wheelchair in no distress at her baseline mental status. She denies pain and states she has a good appetite. She does not recall how she transferred out of bed this morning or other details of her day. Per her OT re-evaluation on 2/28, she continues to require partial assistance with clothing, hygiene, and reaching/balance tasks. She requires supervision assistance with wheelchair mobility and is noted to be self-propelling with her bilateral feet in her room and the hallways at the facility.prior level of function: after previous course of PT/OT in 2025: wheelchair dependent, maximum assist for all ADLs, required supervision for wheelchair mobility, required moderate assist with stand-pivot-transfer. Current level of function: requires continued assistance with transfers, mobility, toileting, hygiene, and clothing management. Uses a wheelchair for mobility. Continue OT plan of care to increase participation in activity tolerance, strength, coordination, and ADLs.On 03/11/26 at 8:15 AM, Surveyor interviewed Director of Rehabilitation (Director of Rehab)-W. Surveyor asked why was R67 discharged from OT. Director of Rehab-W stated, R67 was seen for OT from 1/31/26 to 3/3/26 and Director of Rehab-W stated Director of Rehab-W believes R67 was discharged from OT because R67 achieved R67's highest potential and R67 was not cooperating or engaging in therapy. Surveyor asked for the therapy progress notes.On 03/11/26 at 8:32 AM, Director of Rehab-W provided Surveyor R67's progress notes. Director of Rehab-W stated, there must have been a mistake with discharging R67. Director of Rehab-W stated that Director of Rehab-W was told by Certified Occupational Therapist Assistant-(COTA)-Z that R67 had reached highest practical potential and R67 was not cooperative, therefore Director of Rehab-W discharged R67. Director of Rehab-W stated that after just reviewing the progress notes, Director of Rehab-W realized there was a mistake and R67 had not reach highest practical potential and R67 is willing to participate in therapy. Director of Rehab-W will now begin the process to get R67 reestablished with therapy services.On 03/11/26 at 2:23 PM, Surveyor asked Director of Rehab-W for R67's OT care plan. Surveyor asked Director of Rehab-W if R67 has an active order to evaluate and treat for PT (physical therapy), why did R67 only have OT services provided. Director of Rehab-W stated she would review and let Surveyor know. Surveyor asked Director of Rehab-W how Director of Rehab-W feels the mistake may have occurred regarding the discharge of R67 from OT services. Director of Rehab-W stated COTA-Z told Director of Rehab-W that in COTA- Z's opinion, R67 had reached full potential and was also not cooperative, but after Director of Rehab-W reviewed progress notes today, Director of Rehab-W realized R67 had not reached goals and was willing to cooperate.On 03/12/26 at12:46 PM, Surveyor met with Director of Rehab-W. Director of Rehab-W informed Surveyor at the time R67 was having OT, there was not a need for additional PT services and as of yesterday, Director of Rehab-W is screening/initiating PT services. Surveyor asked why Director of Rehab-W switched from OT to PT for resumption of therapy services. Director of Rehab-W stated that OT was not able to address R67 issues adequately and now with resumption of therapy, PT will be able to progress R67's needs more efficiently to a point of safety. Director of Rehab-W stated there is no need for R67 to have both OT and PT.On 03/11/2026 at 3:38 PM, Surveyor notified NHA-A, Director of Operations-C, and Nurse Consultant-D that R67 was discharged from OT services on 3/3/26 when R67 had not met goals and was a willing participant. Surveyor also stated (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Rehab-W was in the process of reinstating therapy services.No additional information was provided at this time.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure a resident's hospice notes were readily available for communication and collaboration of care in accordance with professional standards of practice for 1 (R60) of 2 residents reviewed for hospice services.*Hospice visit notes were not updated or ready available in R60's medical record or in R60's hospice binder until Surveyor requested the information.Findings include:The facility's policy and procedure titled, Coordination of Hospice Services, implemented 1/31/26, documents: Policy: When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being.Policy Explanation and Compliance Guidelines:4. The facility will communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility.5. The facility will maintain communication with hospice as it relates to the residents' plan of care and services to ensure each entity is aware of their responsibilities.R60 was admitted to the facility on [DATE] with pertinent diagnoses that include palliative care (specialized medical care for people living with a serious illness), dementia (a syndrome that can be caused by a number of diseases which over time destroy nerve cells and damage the brain, typically leading to deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from the usual consequences of biological ageing), dysphagia (difficulty swallowing), and adult failure to thrive (a syndrome of decline marked by unintended weight loss, malnutrition, cognitive impairment, and functional decline).R60's Quarterly Minimum Data Set (MDS) with an assessment reference date of 2/13/26 does not document a Brief Interview for Mental Status (BIMS) assessment. Per the MDS, R60 is assessed to rarely/never be understood and rarely/never understand others and no behaviors were exhibited by R60 during the assessment period. Surveyor reviewed R60's Hospice communication binder located in the nursing station. Upon opening the binder, Surveyor observed a Visit Record log for home health aides, Chaplain etc. to sign and date when visit. Toward the end of the binder, Surveyor observed Hospice Progress Note forms, with the most recent dated 4/14/25.Surveyor noted that R60's Hospice Progress Notes, which are used by hospice staff to communicate with facility staff, were not updated and the last note was dated over 11 months ago (4/14/25). On 03/11/2026, at 9:07 AM, Surveyor interviewed Registered Nurse (RN)-F about how hospice communicates after visits. RN-F replied that they communicate with hospice via phone calls if there are any changes. On 03/11/2026, at 9:24 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-G regarding how facility staff communicate with hospice. ADON-G replied there is a binder that is updated if there are changes. Per ADON-G, there is no nurse to nurse report when hospice visits unless there are changes. On 03/11/2026, at 1:58 PM, Surveyor informed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Nurse Consultant-D and Director of Operations-C regarding R60's lack of updated documentation of communication between hospice providers and facility after each visit.On 03/11/2026, at 3:00 PM, NHA-A provided Visit Note Report forms printed on 3/11/26. Surveyor asked if they were available to floor nurses and was told no, they are in the portal and NHA-A printed them today. Surveyor reiterated that the Visit Note Report should be an accessible part of R60's medical record or in the hospice binder.No additional information regarding R60's hospice visit notes not being updated in R60's medical record or in R60's hospice binder was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to provide a safe and sanitary environment to reduce the development and transmission of communicable diseases and infections for 2 (R4 & R7) of 2 residents reviewed during medication pass. *Medication Technician (MT)-H was observed dropping a medication cup onto floor, picking it up then using the same medication cup, and placing R7's medications into MT-H's bare hand when administering R7's medications.*Registered Nurse (RN)-F did not wear a gown when administering R4's medication through a gastrostomy tube. Findings include:The facility policy titled Enhanced Barrier Precautions dated 1/1/26 documents:It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and gloves use during high contact resident care activities.2. Initiation of Enhanced Barrier Precautions:b. Enhances Barrier Precautions will be implemented for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO.3. Implementation of Enhanced Barrier Precautions:a. Make gowns and gloves available near or outside of the residents' room. Note: Face protection may also be needed if performing activity with risk of splash (i.e., wound irrigation, tracheostomy care).b. PPE (Personal Protective Equipment) for enhanced barrier precautions is only necessary when performing high-contact activities and may not need to be donned prior to entering the resident's room.4. High-contact resident care activities include:g. Device care or use: Central lines, urinary catheters, feeding tubes.On 3/10/26 at 7:45 AM, Surveyor observed Medication Technician (MT)-H prepare medications for R7. MT-H obtained a plastic medication cup, dropped it on the floor, picked it up and used the same medication cup for R7's medications.While preparing R7's medications, Surveyor observed MT-H place the following tablets into his bare hand before placing them in the medication cup: Mucous relief 600 mg (milligrams) ER (extended release) tablet, Austedo 12 mg tablet, Aspirin 81 mg tablet, Loratadine 10 mg tablet, Montelukast 10 mg tablet and Vitamin B1100 mg tablet. Surveyor advised MT-H of infection control concerns/observations during medication pass, picking up the medication cup off the floor and placing tablets into his bare hand before placing them in the medication cup.On 3/11/26 at 8:23 AM, Surveyor observed Registered Nurse (RN)-F prepare R4's medications.Surveyor noted a PPE cart and sign posted outside of R4's room for Enhanced Barrier Precautions which documented: Clean hands before entering and when leaving room. Providers and staff must also wear gloves and a gown for the following high contact resident care activities: Device care or use - Central line, urinary catheter, feeding tube, tracheostomy. After preparing R4's medications, they were crushed and mixed with water. RN-F picked up the medication cup and entered R4's room wearing a mask and gloves, but no gown. RN-F proceeded to administer R4's medications through her G-tube (Gastrostomy tube) while not wearing the proper PPE (gown).On 3/11/26 at 10:29 AM, Surveyor advised Director of Nursing (DON)-B of the above infection control concerns. No additional information was provided.