STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525526	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chi Franciscan Villa	3601 S Chicago Ave South Milwaukee, WI 53172

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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. Based on interviews, observations, record reviews, and facility policy review, the facility 1.) failed to attach wheelchair footrests during transport for one of six residents (Resident (R) 46) who was transported by Certified Nurse Aide (CNA) 1 which resulted in the resident's right foot being dragged under her wheelchair, requiring hospitalization, further medical treatment and harm. 2.) The facility also failed to reassess the safety of R4's slide board transfers after implementing an air mattress with inflated bilateral bolster which altered the transfer surface and had the potential to cause a fall and injury. This failure had the potential to increase the risk of accidents with the potential for injury. A total of 32 residents were included in the sample. Findings include: 1. Review of R46's admission Record, located under the Profile tab in the electronic medical record (EMR), indicated that the facility admitted the resident on 09/16/24 with a diagnosis of muscle weakness. Review of R46's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/05/26 and located under the MDS tab of the EMR, indicated the resident had a Brief Interview of Mental Status (BIMS) score of 15 out of 15, which revealed the resident was cognitively intact. The assessment indicated that the resident used a wheelchair for mobility and required staff assistance. The assessment also indicated that the resident was dependent on staff for transfers from bed to her wheelchair. Review of R46's Care Plan, dated 09/18/24 and located under the Care Plan tab indicated that the resident had a self-care performance deficit related to limited mobility and was dependent on staff for all transfers. The care plan did not include interventions to address the resident's refusals to use wheelchair footrests during transport despite a history of right knee dislocation. Review of R46's Nurse Practitioner (NP) Prog (Progress) Note dated 06/02/25 and located under the Prog Notes tab of the EMR, revealed that the resident had a history of right knee dislocations. Review of R46's 72-Hour Follow Up, dated 05/15/26 following the resident's most recent hospitalization and located under the Prog (Progress) Note tab in the EMR, indicated that the resident had a history of refusing to wear a right knee brace. The documentation indicated that the resident expressed pain. The NP was onsite and assessed the resident immediately and ordered an x-ray. Review of R46's Nurse's Note, dated 05/16/26 and located under the Prog Note tab in the EMR, indicated that the resident's x-ray results were pending. (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R46's Nurse's Note, dated 05/17/26 and located under the Prog Note tab in the EMR, indicated that the NP was notified by the facility of the resident's positive x-ray results of a right knee dislocation. The NP ordered that the resident was to be sent to the emergency room immediately. The resident was admitted to the hospital on this same date for dislocated/malalignment of the femoral component of right knee arthroplasty. A review was conducted of the hospital records titled, History & Physical, dated 05/17/26 which indicated . Patient presents with knee pain. 2 days ago, patient was being pushed in a wheelchair when her right leg got caught and pulled under the wheelchair. She heard a crack and developed knee pain right away. The pain has been constant since onset but waxing and waning in severity. It is worse with bending the knee, better if she keeps it in a certain position. The pain is sharp and 10/10 at its worst, 1-2/10 at best. She had an x-ray at her facility that revealed that her knee was dislocated. No numbness or tingling. Leg has been warm and well-perfused.At baseline she is wheelchair bound and uses a Hoyer for transfers.ED (Emergency Department) attempted a reduction under anesthesia but unfortunately it was unsuccessful.Ortho consulted. Low energy mechanism, right total knee arthroplasty dislocation, failed emergency department reduction attempts. Review of R46's Post Hospital ER (emergency room)/OBS (observation)/Outpatient, dated 05/19/26 and located under the Misc tab in the EMR, indicated that the NP assessed the resident after her recent hospitalization. It was noted that the resident had acute pain from an incident on 05/15/26 in which CNA 1 transported the resident, while in her wheelchair and without her footrests attached. The note continued that the resident's right foot then dragged and twisted under her wheelchair. On 05/16/26 the x-ray revealed that the resident's right knee was dislocated and on this same date was sent to the hospital for a possible right knee manual reduction. During an interview on 05/26/26 at 1:41 PM, R46 confirmed that an unknown staff member pushed her in her wheelchair without the footrests attached. The resident stated that she lifted her legs during transport and then her right leg fell and dragged under her wheelchair. The resident stated that she had the incorrect footrests to be attached to her wheelchair. The resident stated she was taken to the hospital to have her knee put back into place. During an interview on 05/27/26 at 3:58 PM, CNA1 confirmed she was the staff member who transported R46 in her wheelchair without attaching her footrests. CNA1 stated that the resident refused to use her footrests but wanted to attend an activity program. CNA1 stated she reminded the resident that she needed to use the footrests, but again the resident refused and claimed that the footrests were not hers. CNA1 stated that the resident could bend her right knee but not too much since her legs always caused her pain. CNA1 stated she had seen other staff transfer the resident in this manner prior to her assisting her. CNA1 stated that the resident began to cry and she got a nurse to assist with the incident. During an interview on 05/28/26 at 9:37 AM, the Director of Rehabilitation (DOR) confirmed that the NP asked her to assess R46 for a knee brace in the past. The DOR presented an email to confirm this request was completed on 12/19/25. The DOR stated she ordered the knee brace, but the resident refused to wear it. The DOR stated that the resident's right leg only bent to 45 degrees. The DOR stated that the skilled therapy department assessed the resident for multiple wheelchairs and the goal was for the resident to self-propel. The DOR stated she was unsure how the resident got her right leg caught under her wheelchair. At 9:57 AM, the DOR entered R46's room and confirmed that the resident had the correct wheelchair and footrests. The DOR reminded the resident that the footrests were to be attached to her wheelchair during transport. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/28/26 at 10:46 AM, Registered Nurse (RN) 2 stated that if a resident refused to use footrests to their wheelchair the staff member was to inform the nurse. RN2 stated residents should not be transported without the use of footrests. During an interview on 05/28/26 at 12:32 PM, the Director of Nursing (DON) stated that when R46 refuses to use footrests, the DON suggested telling R46, to just use the footrests until she was in activities and then remove the footrests, so she was comfortable. The DON stated that R46's right knee was chronically dislocated. 2. Review of R4's admission Record, located under the Profile tab in the EMR, indicated that the facility initially admitted the resident on 11/06/24 with a left leg amputation. Review of R4's annual MDS, with an ARD of 04/16/26 and located under the MDS tab in the EMR, indicated that the resident had a BIMS score of 15 out of 15, which revealed the resident was cognitively intact. The assessment also indicated that the resident required supervision/touching from staff to transfer. The resident sustained no falls during this assessment period. Review of R4's Care Plan, dated 02/03/25 and located under the Care Plan tab in the EMR, indicated that the resident had skin impairments and used an air mattress. Review of R4's Care Plan, dated 10/17/25 and located under the Care Plan tab in the EMR, indicated the resident had a right above the knee amputation and was at risk of increased falls. The approaches were to have one staff member assist him with transfers, via a slide board. During an interview on 05/26/26 at 3:26 PM, R4 stated that he had an air mattress recently placed on his bed and he hated it. The resident stated that the inflatable bi-lateral bolsters got in his way to complete a slide board transfer getting in and out of bed. The resident stated he had the air mattress for the past two weeks. When in bed, the resident stated he felt pinned in and it was like laying in a trough. During an interview on 05/28/26 at 7:50 AM, R4 stated he transferred from his bed to his wheelchair using a slide board. The air mattress was observed during this interview, and it had two bi-lateral bolsters which were inflated. The resident stated he used the slide board to transfer from his bed to the wheelchair and the slide board would not be level to get into the wheelchair since the inflated bolsters caused an uneven transfer instead of the slide board being flat. The resident stated that a CNA was present, but he still felt like he might fall due to the air mattress. During an interview on 05/28/26 at 7:57 AM, the DOR stated the use of the air mattress for R4 was a nursing decision. The DOR stated that she was not aware that the resident was placed on an air mattress. The DOR also stated that the resident was previously assessed for the use of a slide board transfer and referred to the Occupational Therapist (OT). During an interview on 05/28/26 at 8:06 AM, the OT stated that she had been working with R4 with the slide board for transfers to and from his wheelchair to a commode. The OT stated she had not been working with the resident on transfers to and from the bed, with the inflatable air mattress and his wheelchair. During an interview on 05/28/26 at 8:10 AM, the DOR stated that R4 would need to be evaluated on the use of the slide board with the bolstered air mattress to ensure that the slide board was still an (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	appropriate device to use while the air mattress was on his bed. During an interview on 05/28/26 at 12:32 PM, the DON stated that the air mattress comes with inflatable bolsters, and the bolsters could be deflated. The DON stated the current air mattress was in place to address R4's pressure ulcers which had gotten better. The DON stated that the resident did voice to her that he was concerned about falling with the current air mattress and the use of his slide board. Review of a facility policy titled, Accidents and Incidents - Investigating and Reporting, dated 07/02/25 indicated . Accident' refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident.

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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, interviews, and policy reviews, the facility failed to follow proper sanitation methods for the prevention of foodborne illnesses when staff did not wear hair restraints while working in the kitchen. The facility failed to ensure the kitchen was maintained in a sanitary condition. Specifically, the facility failed to label, date, and store food properly. Finally, the facility failed to ensure [NAME] 2's personal drink was not left in the kitchen refrigerator. This failure increased the risk of foodborne illness and had the potential to affect 82 of 84 residents who ate food from the kitchen. Findings include: During an initial tour of the kitchen and interview on 05/26/26 9:20 AM, the following was noted: -Cook2 was observed preparing chicken for lunch meal without wearing a beard restraint.-Cook3 was in the food prep area, and he did not have a beard restraint on. [NAME] 2 confirmed that he did not have a beard restraint on and that he typically did. -The first refrigerator on the right side of the kitchen contained a transparent plastic container of chopped tomatoes. There was a plastic cover over this container with two dates, 05/09/26 and 05/25/26. Cook2 did not know what the used by date was. -A second transparent container of chopped cucumbers with two dates, 05/11/26 and 05/24/26 was observed. -The second refrigerator contained metal containers of the following: four containers of pureed beef dated 05/21/26; pureed chicken dated 05/16/26; breakfast sausage dated 05/16/26, and thickened gravy dated 05/17/26. Finally, a bottle of Gatorade was observed and Cook2 verified that it was his drink and it should not be stored in the kitchen refrigerator since there was a refrigerator for staff to use. During an interview on 05/28/26 at 1:38 PM, the Dietary Manager (DM) stated that staff were supposed to wear beard restraints since it was an infection control issue. The DM stated that her expectation was for staff to routinely check on the food stored in the refrigerators and toss out the food after the used by date. The DM stated Cook2's drink should have been stored in the employee refrigerator and not in the kitchen refrigerator. Review of the Food Code.US Food & Drug, dated 2017 indicated, .An employee shall eat, drink, or use any form of tobacco only in designated areas where the contamination of exposed food; clean equipment. other items needing protection cannot result. Review of a facility policy titled, Storage of Food Guidelines, dated 05/12/26 failed to contain evidence that pureed beef and chicken should be disposed of after one day. In addition, the policy failed to identify when to label and date fresh food items. Review of a facility policy titled, Hair Restraints, dated 01/14/26 indicated, .Hair shall be restrained to prevent physical contamination of food.The following are acceptable as hair restraints.Hairnets'.Beard restraints.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and facility document review, the facility failed to ensure garbage was properly contained which would affect 86 census residents and staff in the facility. This had the potential to attract pests. Findings include: During an initial tour of the kitchen on 05/26/26 at 9:20 AM, Cook2 accompanied the surveyor and went outside of the facility where there was one dumpster. The dumpster was open and contained three quarters of trash. Cook2 stated that there was typically a pole to pull the dumpster lid down but was unable to locate this device during the observation. Cook2 stated it was important to keep the dumpster lid closed to prevent pests, such as racoons, from entering the dumpster. During an interview on 05/28/26 at 1:38 PM, the Dietary Manager (DM) stated that the dumpsters were to remain closed, so pests did not enter. Review of a facility policy titled, Disposal of Garbage and Refuse, dated 05/27/26 indicated .The facility shall properly dispose of kitchen garbage and refuse.Refuse containers and dumpsters kept outside the facility and designed and constructed to have tightly fitting lids, doors, and covers. Containers and dumpsters shall be kept covered when not being loaded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and facility policy review, the facility failed to: 1.) ensure proper personal protective equipment (PPE), was donned (put on) by Certified Nurse Aide (CNA) 6 prior to entering into (Resident (R) 33's room who was under contact precaution; 2.) failed to post proper Transmission Based Precautions (TBP) signage for neutropenic isolation for R58; and 3.) failed to ensure Housekeeping Aide (HA)1 transported soiled linens without placing these items in a plastic bag. This increased the likelihood that infectious organisms could be transmitted from residents to staff, other residents, or the environment. Findings include: 1. Review of R33's admission Record, located under the Profile tab electronic medical record (EMR), indicated that the facility admitted the resident on 04/24/26. Review of R33's Physician Orders, dated 04/27/26 and located under the Orders tab in the EMR, revealed the resident was placed on contact isolation due to multi-drug-resistant organisms (MDRO). During a room tray observation on 05/26/26 at 12:13 PM, CNA6 entered R33's room without putting on a gown. CNA6 did don a mask and gloves. An interview was conducted immediately after this observation and CNA6 stated she normally put on a gown, and did not, prior to entering a resident's room that was on contact isolation and stated the PPE was to protect her and other residents from possible transmission. During an interview on 05/28/26 at 12:32 PM, the Director of Nursing (DON) stated it was her expectation that staff don a gown and gloves prior to entering a room that was under contact isolation. 2. Review of R58's admission Record, located under the Profile tab in the EMR, indicated that the facility admitted the resident on 04/04/25. Review of R58's Physician Orders, dated 01/16/26 and located under the Orders tab in the EMR, indicated to place the resident on reverse isolation (neutropenic) due to her chemotherapy treatment. Review of R58's Medication Administration Records (MAR), located under the Orders tab in the EMR, revealed from 03/26 through 05/26/26 staff documented that the resident was under reverse isolation per shift. An observation was made on 05/26/26 at 10:25 AM and a sign was posted which was for enhance barrier precautions (EBP). During an interview on 05/28/26 at 10:24 AM, Registered Nurse (RN) 2 stated that reverse isolation was placed on R58 since she was immunocompromised due to her cancer diagnosis and receiving chemotherapy. RN2 confirmed that R58 had EBP posted outside of the resident's room. During an interview on 05/29/26 at 11:32 AM, the DON stated that R58 was not in reverse isolation, and this order was not identified. The DON stated that the facility could not provide that level of care for the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of R39's admission Record, located under the Profile tab of the EMR, revealed R 39 was admitted to the facility on [DATE] with diagnosis of dementia, hyperlipidemia, and anxiety disorder. Review of R39's quarterly MDS, with an ARD of 04/10/26 and located in the EMR under the MDS tab, revealed a BIMS score of zero out of 15, which indicated severely impaired cognition. During an observation on 05/26/26 at 11:48 AM, Housekeeping (HA) 1 was observed walking from R39's room with gloves on and R39's unbagged soiled clothing. During an interview on 05/26/26 at 11:52 AM, HA1 stated, The proper way to transport soiled residents' clothes should be in a bag. Review of a facility policy titled, Isolation-Categories of Transmission-Based Precautions, dated 05/22/25 indicated, Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents.Contact precautions may be implemented for residents known or suspected to be infection with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Review of a facility policy titled, Neutropenic Precautions, dated 05/28/26 .It is the policy of this facility to ensure that residents that require neutropenic precautions are protected from the risk of infection based on current standards of practice.People that receive or have received chemotherapy or have other medical conditions that result in the decrease of the number of white blood cells are at risk for developing neutropenia. Neutropenic precautions are a mechanism to help protect the neutropenic person from the increased risk of infection.The nurse will obtain and verify the physician's order for neutropenic precautions and place signage outside the resident's door informing staff, residents, and visitors of the precautions.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews, record reviews, and policy review, the facility failed to ensure injuries and injuries of unknown origin were reported timely for two of three residents (Resident (R) 21 and R46 out of a total sample of 32 residents. This deficient practice had the potential for harm from unrecognized abuse by not identifying injuries of unknown origin. (Cross reference F689) Findings include: 1. Review of R21's admission Record, located under the Profile tab in the electronic medical record (EMR), revealed an admission date of 04/16/26 with medical diagnoses that included unspecified dementia and adult failure to thrive. Review of R21's admission Minimum Data Set (MDS), with an assessment reference date (ARD) of 05/21/26 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated severely impaired cognition. During an interview on 05/26/26 at 11:25 AM, Family Member (FM) 1 expressed concern about the big red sore on R21's breast that was observed earlier that morning while R21 was being dressed for the day. FM1 stated they asked (R21) what happened, and R21 was unable to explain what occurred. During an interview on 05/27/26 at 10:27 AM, the Occupational Therapist (OT) confirmed noticing a red line across the center of R21's breast and bruising near the nipple while she was helping dress R21. The OT confirmed she requested Registered Nurse (RN) 2 to look at the red mark. RN2 checked the red area and told the OT to notify Licensed Practical Nurse (LPN) 2 who was assigned to care for R21. During an interview on 05/27/26 at 12:09 PM, RN1 stated she spoke with LPN2, who had worked the unit for R21 the day before, and confirmed being told to assess R21 by the OT and verified she forgot to assess when notified. During an interview on 05/27/26 at 3:12 PM, RN1 assessed the red area on R21's breast and informed the Director of Nursing (DON) about the injury of unknown origin. During an interview on 05/28/26 at 12:06 PM, the DON confirmed being told about R21's injury and began a report for an injury of unknown origin in the internal system for the facility. During an interview on 05/28/26 at 12:42 PM, LPN2 verified she was told about the possible injury for R21 by the OT on 05/26/25 and that RN2 assessed R21. LPN2 stated she thought RN2 documented the assessment but RN2 did not document what was assessed. LPN2 confirmed she did not assess R21 for the injury and did not report it. During an interview on 05/28/26 at 3:51 PM, RN2 confirmed being called to R21's room on 05/26/26 to assess the injury and did not document the assessment or tell anyone else since R21 was not assigned to be his resident that day. During an interview on 05/29/26 at 9:09 AM, the Administrator confirmed he had not filed a report about the injury of unknown origin due to beginning an investigation after being notified. The (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator stated the cause of R21's injury was identified as being caused by a gait belt being placed around R21's waist, and R21's breast was caught under the belt. The Administrator confirmed the report was filed three days after the incident was originally reported. Review of the facility document titled, Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, revealed a date of discovery 05/26/26, date reported 05/29/26 at 10:38 AM. 2. Review of R46's admission Record, located under the Profile tab in the EMR, indicated that the facility admitted the resident on 09/16/24 with a diagnosis of muscle weakness. Review of R46's quarterly MDS, with an ARD of 04/05/26 and located under the MDS tab in the EMR, indicated the resident had a BIMS score of 15 out of 15, which revealed the resident was cognitively intact. The assessment indicated that the resident used a wheelchair for mobility and required staff assistance and indicated that the resident was dependent on staff for transfers from the bed to her wheelchair. Review of R46's Care Plan, dated 09/18/24 and located under the Care Plan tab in the EMR, indicated that the resident had a self-care performance deficit related to limited mobility and was dependent on staff for all transfers. The care plan indicated that the resident often refused to wear her right leg brace. Review of R46's 72-Hour Follow Up, dated 05/15/26 and located under the Prog note tab in the EMR, indicated that the resident had a history of wearing a right knee brace. The documentation indicated that the resident expressed pain. The Nurse Practitioner (NP) was onsite and assessed the resident immediately and ordered an x-ray. Review of R46's Nurse's Note, dated 05/16/26 and located under the Prog note tab in the EMR, indicated that the resident's x-ray results were pending. Review of R46's Nurse's Note, dated 05/17/26 and located under the Prog note in the EMR, indicated that the NP was notified by the facility of the resident's positive x-ray results of a right knee dislocation. The NP gave an order for R46 to be sent to the emergency room immediately. R46 was admitted to the hospital on this same date for dislocated/malalignment of the femoral component of right knee arthroplasty. A request was made by the facility to provide R46's hospital records from 05/17/26 and they did not provide them prior to survey exit. Review of R46's Post Hospital ER/OBS/Outpatient, dated 05/19/26 and located under the Misc tab in the EMR indicated, indicated that the NP assessed the resident after her recent hospitalization. It was noted that the resident had acute pain from an incident in which Certified Nurse Aide (CNA) 1 pushed the resident, while in her wheelchair and without her footrests attached on 05/15/26. The note continued and indicated that the resident's foot was dragged and her right knee twisted. On 05/16/26 the x-ray indicated that the resident's right knee was dislocated and on this same date was sent to the hospital for a possible right knee manual reduction. R46 was referred to orthopedics in which the physician attempted to undergo a closed knee reduction which was unsuccessful. The resident was sent to another orthopedic doctor, and she underwent a closed knee reduction on 05/17/26 and this procedure was successful. The resident was readmitted back to the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/26/26 at 1:41 PM, R46 stated that her leg rests to her wheelchair were missing, and she had asked an unknown staff member (CNA1) to push her to activities. The resident confirmed that no leg rests were attached to her wheelchair at the time the staff member pushed her. R46 stated she was lifting her leg, and it was pulled under her wheelchair and dragged. Review of a document titled, Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, dated 05/26/26 at 5:45 PM, provided by the facility, indicated that the Administrator reported to the State Survey Agency (SSA) an allegation of Reportable incident that was not misconduct. The report to the SSA outlined the incident dated 05/15/26 and the injury that R46 sustained by her right leg being dragged under her wheelchair by a staff member. During an interview on 05/29/26 at 9:11 AM, the Administrator stated that the incident involving R46 and CNA1 should have been reported to the SSA immediately and confirmed that it was not done. Review of the facility policy titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, revised 05/01/24, revealed . It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes.Injuries of unknown source include circumstances when both the following conditions are met; i. The source of the injury was not observed by any person or could not be explained by the resident.The Director of Nursing Services, Administrator, or designee will: a. Notify the appropriate agencies immediately as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than 2 hours after discovery or forming the suspicion.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and facility policy review, the facility failed to ensure appropriate Activities of Daily Living (ADLs) to maintain appropriate hygiene for two residents (Resident (R) 81 and R25) reviewed for ADLs out of a total sample of 32 residents. This failure had the potential for the residents to have unmet hygiene needs and affect resident care. Findings include: Review of R81's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed Resident (R) 81 was admitted to the facility on [DATE] with diagnoses of bipolar disorder, chronic respiratory failure, and major depressive disorder. Review of R81's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/17/26, and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that her cognitive function was intact. The MDS indicated R81 required partial to moderate assistance for oral care. Review of R81's Care Plan, focus initiated on 11/19/25 and located under the Care Plan tab of the EMR, revealed that R81 had the potential for dental problems related to poor oral hygiene, decayed teeth at gumline, and a tooth fractured at the gumline. Interventions in place included monitor for oral problems needing attention. Observations on 05/26/26, 05/27/26, 05/28/26, and 05/29/26, revealed R81 had debris on her teeth. During an interview on 05/27/26 at 1:50 PM R81 stated, The staff doesn't offer me to brush my teeth. If I don't ask them, they don't offer it. During an interview on 05/27/26 at 11:00 AM, Certified Nurse Aide (CNA) 3 stated, I usually check the resident roster to see which patients I am assigned to. I bring ice water in, get them washed, cleaned, and changed, wipe their face, brush their teeth, and if the resident is combative, I always bring someone in with me. During an interview on 05/27/26 at 11:47 AM, the Director of Nursing (DON) stated, The expectation is that oral care is done morning and night at least. When a resident is care planned for oral care, the staff needs to get everything set up, ask them if they are ready to have their teeth brushed and to make sure that the resident can stay as independent as they can. 2. Review of R25's admission Record, located in the Profile tab of the EMR revealed Resident (R) 25 was admitted to the facility on [DATE] with diagnoses of rheumatoid arthritis, chronic obstructive pulmonary disease (COPD), and vascular dementia. Review of R25's quarterly MDS, with an ARD of 03/18/26, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated that her cognitive function was severely impaired. The MDS indicated R25 required set-up assistance from one person for personal hygiene. Review of R25's Care Plan, initiated on 11/06/25 and located in the Care Plan tab of the EMR, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed R35 had a self-care performance deficit and was dependent on staff for ADL care related to impaired balance, limited mobility, incontinence, dementia, rheumatoid arthritis, and decreased stamina. Approaches initiated on 11/06/25 revealed that R25 required assistance by one staff member to wash her face and hands and to brush her hair, as needed. Observations on 05/26/26, 05/27/26, 05/28/26, and on 05/29/26, revealed R25 was observed with chin hair. During an interview on 05/27/26 at 11:00 AM, Certified Nurse Aide (CNA) 5 stated, I start resident care with assisting residents with their hygiene such as setting up supplies like wipes for incontinent care, helping set up with breakfast, brush their hair, help with dressing, and with cleaning their dentures. During an interview on 05/28/26 at 12:31 PM, R25 stated, If they can do it, I would like them to take it off. R25 was referring to her chin hair. Review of the facility policy titled, Activities of Daily Living (ADLs), dated 10/25, on page one of two, indicated, . The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: item A. bathing, dressing, grooming, and oral care.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and facility policy review, the facility failed to provide appropriate tube feeding management for one resident (Resident (R) 10) reviewed for tube feedings out of a total sample of 32 residents. This failure had the potential for the resident and others receiving liquid nourishment via tube feedings to receive outdated nourishment and created the risk for infection. Findings include: Review of R10's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R10 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, dementia, and atrial fibrillation. Review of R10's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE] and under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS), score of zero out of 15, which indicated severely impaired cognition. Review of R10's Care Plan, focus initiated on [DATE] and located under the Care Plan tab in the EMR, revealed that R10 received nutritional formula via tube feeding. Interventions included to ensure R10's head of bed was at least at 30 degrees, and to monitor for aspiration and nausea/vomiting. Observation on [DATE] revealed R10's tube feeding formula and water flush bag were not dated and labeled. During an interview on [DATE] at 11:20 AM, Registered Nurse (RN) 2 stated, My process with tube feeding is to disconnect R10 from the pump. I think the order is for noon. When I re-connect R10 to the pump, I check for placement, prime pump, and ensure that her head of bed is at 40 degrees. I make sure the formula is not expired and the formula is labeled with the resident's name and it is dated. Review of the facility's policy titled, dated 05/26, . The purpose of this procedure is to provide a guideline for the use of a pump for enteral feedings On item # 3, Check the enteral nutrition label against the order before administration. Check the following information: sub-item a. Resident name, identification, and room number. b. type of formula, c. date and time formula was prepared, and g. rate of administration.

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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, interviews, and policy review, the facility failed to ensure an opened vial of Tuberculin (TB) Purified Protein Derivative was labeled when opened with an expiration date in one of two medication rooms reviewed for storage and labeling. This deficient practice had the potential for inaccurate TB testing due to the vial potentially being expired and ineffective. Findings include: An observation on [DATE] at 11:40 AM, the refrigerator in the med room on the Heritage North Hallway, contained a vial of TB derivative was stored in a box on the shelf in the door. The vial was opened without a date to reflect when the vial was opened. The manufacturer expiration date was 09/27. During an interview on [DATE] at 11:40 AM, Licensed Practical Nurse (LPN) 1 verified the opened vial of TB derivative should have been dated when opened and marked for expiration 28 days after being opened, and it was not labeled. During an interview on [DATE] at 11:52 AM, Registered Nurse (RN) 1, confirmed when a vial of medication or biological (TB) was opened it should be labeled with the date opened and the expiration date should be 28 days later. During an interview on [DATE] at 12:04 PM, the Director of Nursing (DON) confirmed when a biological TB vial was first used/opened, it should be labeled with the date opened and the date to expire 28 days later. Review of the facility policy titled, Labeling of Medication Containers, revised [DATE], revealed . Labels for stock medications include all necessary information, such as:a. the name and strength of the drug; b. the lot and control number; c. the expiration date when applicable .

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on review of the facility policy, resident-specific meal service documents, and menu records, the facility failed to provide meals consistent with neutropenic precautions for one out of one resident (Resident (R) 58), out of a survey sample of 32, by serving fresh fruits and vegetables despite the resident's need to avoid those foods. The facility's failure to provide meals consistent with neutropenic isolation precautions placed the resident at increased risk for exposure to foodborne pathogens. (Cross Reference F880) Findings include: Review of R58's admission Record located under the Profile tab in electronic medical record (EMR), indicated the facility admitted the resident on 04/05/25. Review of R58's Physician Orders, dated 01/16/25 and located under the Orders tab in the EMR, indicated the physician ordered the resident to be placed on reverse (neutropenic) isolation since the resident received chemotherapy. Review of a document referred to as a Meal Ticket, provided by the facility, for R58 failed to indicate that the resident was not to be served fresh fruit and vegetables. Review of a document titled, Week at a Glance Week 1, provided by the facility, indicated that the resident was served a broccoli salad on Monday 4th for dinner. On Wednesday 6th of the month the resident was served coleslaw and watermelon for dinner. On Saturday 9th the resident was served sliced apples with dinner. Review of a document titled, Week at A Glance Week 2, provided by the facility, indicated that R58 was served tomato wedges on Monday 11th with dinner. For Wednesday13th the resident was served fresh fruit with dinner. For Thursday 14th the resident was served creamy cucumber salad for dinner. For Saturday 16th she was served sliced orange with dinner. Review of a document titled, Week at A Glance Week 3, provided by the facility, indicated that R58 was served tomato wedges with dinner on Monday 18th. On Tuesday 19th the resident was served grapes with lunch and for dinner the resident was served a cucumber/tomato salad. On Wednesday 20th the resident was served lettuce/tomato/onion with dinner. Review of a document titled, Week at A Glance Week 4, provided by the facility, indicated R58 cucumber salad was served on Wednesday 27th with dinner. During an interview on 05/28/26 at 1:38 PM, the Dietary Manager stated she was not alerted that R58 was on neutropenic isolation, therefore, could not receive fresh fruit and vegetables. Review of a facility polity titled, Nutritional Management, dated 09/16/25 indicated .The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition.Care plan implementation.Interventions will be individualized to address the specific needs of the resident.Disease specific interventions.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical record reviews and staff interviews, the facility failed to ensure the clinical records were complete for two of five residents (Resident (R) 73 and R76) reviewed for vaccination status out of a total sample of 32 residents. This had the potential for the residents not to receive accurate care. (Cross Reference F883) Findings include: 1. Review of R73's admission Record, located under the Profile tab in electronic medical record (EMR), indicated that the facility admitted the resident on 07/29/25. A review was conducted of R73's clinical record and there was no evidence that the resident was offered, received, or declined the 2025 influenza vaccine. 2. Review of R76's admission Record, located under the Profile tab in the EMR, indicated that the facility admitted the resident on 08/05/21. A review was conducted of R76's clinical record and there was no evidence that the resident was offered, received, or declined the 2025 influenza vaccine. Review of a document titled, Status, provided by the facility, indicated Registered Nurse (RN) 4 was hired on 06/11/25 as Staff Development and turned in his resignation on 01/04/26. Review of a document titled, Staff Development, job description dated 06/11/25, provided by the facility, indicated that Staff Development was to maintain staff vaccination records. There was no evidence in the job description that Staff Development was to maintain the clinical records for residents' vaccination status. There was no evidence in his employee record which would indicate he was adequately trained on the responsibilities of infection prevention and management of educating residents of the risks verses benefits of receiving the 2025 influenza vaccine. During an interview on 05/28/26 at 12:32 PM, the Director of Nursing (DON) stated that RN4 destroyed the 2025 consents/records for the 2025 influenza vaccines. The DON stated there were no records to verify if any resident was offered the 2025 influenza. During an interview conducted on 05/28/26 at 2:04 PM, the Administrator stated that RN4 destroyed all the records associated with the 2025 influenza vaccination status. A telephone call was placed on 05/28/26 at 4:05 PM and a message was left for RN4. No return call was received prior to the end of the survey. During an interview on 05/29/26 at 8:43 AM, the Health Information Manager (HIM) stated that typically the Infection Preventionist (IP) was responsible for all the resident vaccinations. The IP would gather the data of the residents' immunization and place that information in the EMR. RN4 should have entered the influenza information in each of the residents' EMR and confirmed that this was not done. During an interview on 05/29/26 at 9:59 AM, the DON stated since she was the Infection (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Preventionist (IP) at the time that RN4 was hired and she delegated all the resident vaccination responsibilities to him. The DON stated the protection of resident records was a part of RN4's competency and responsibilities as an RN. The DON stated she believed that RN4 offered and gave the influenza vaccines to the residents since she made the order from the pharmacy and the influenza vaccines, contained in boxes, went down in count. The DON stated that there were no influenza outbreaks at this time. Review of a facility policy titled, Retention of Medical Records, dated 05/12/26 indicated, . Medical records of discharged residents will be retained for a period of 7 years from the date of service. Where state law or practices require longer retention of records than those shown,state law or practice is controlling.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview, record review, facility policy review, document review and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to offer two of five residents (Residents (R) 73 and R76) reviewed for flu/pneumonia vaccinations and/or their representatives, the opportunity for the residents to be vaccinated in accordance with nationally recognized standards. This practice had the potential to increase the risk for residents to contract pneumonia. Findings include: 1. Review of R73's admission Record, located under the Profile tab in the electronic medical record (EMR), indicated that the facility admitted the resident on 07/29/25. Review of R73's Immunization, located under the Immun (Immunization) tab of the EMR, indicated that R73 received the Pneumovax 23 (PPSV23) vaccine on 04/29/11. The resident received the Prevnar 13 (PCV13) vaccine on 10/05/16. Finally, the resident received her annual influenza vaccine on 10/04/24. There was no evidence that showed the resident was offered, consented, or declined the 2025 influenza vaccine. Review of a document titled, Personal Immunization History, provided by the facility, indicated that R73 received PPSV23 on 04/29/11 and the PCV13 on 10/05/16. According to this document the resident was up to date on their pneumococcal vaccinations. 2. Review of R76's admission Record, located under the Profile tab in the EMR, indicated that the facility admitted the resident on 08/05/21. Review of R76's Immunization, located under the Immun tab of the EMR, indicated that R76 received the PCV13 on 04/05/17. The clinical record indicated that the resident received the influenza vaccine on 10/02/24. There was no evidence that showed the resident was offered, consented, or declined the 2025 influenza vaccine. Review of a document titled, Personal Immunization History, provided by the facility, indicated that R76 received the PPSV23 on 10/28/08 and the PCV13 on 04/05/17. According to this document the resident was up to date on their pneumococcal vaccinations. During an interview conducted on 05/29/26 at 9:59 AM, the Director of Nursing (DON) confirmed that R73's and R76's pneumococcal vaccines were not up to date after reviewing the CDC guidelines. The DON stated there was no documented evidence that R73 and R76 were offered an influenza vaccine and either accepted it or declined the vaccination. The DON stated that there were no influenza outbreaks during this time. Review of the CDC website titled, PneumoRecs VaxAdvisor App (Application) for Vaccine Providers, dated 02/25/26, indicated . Based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. Regardless of whether PCV20 or PCV21 is administered, their pneumococcal vaccinations are complete. Review of a facility policy titled, Pneumococcal Vaccination (Series), dated 05/12/26 indicated . It is our policy to offer our residents, staff, and volunteer workers immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled, Influenza Vaccination, dated 05/12/26 indicated .It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members, and volunteer workers annual immunization against influenza. It is the policy of this facility, in collaboration with the medical director, to have an immunization program against influenza disease in accordance with national standards of practice. Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period, or refuses to receive the vaccine.