STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525531	A. Building B. Wing	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Christian Home LLC	452 Fox Lake Road Waupun, WI 53963

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not complete a thorough investigation in response to a potential allegation of abuse for 1 of 3 Residents (R1) reviewed for abuse.On 10/1/25, the facility became aware of an alleged injury of unknown origin due to R1's subdural hematoma (a collection of blood that accumulates between the brain and the inner layer of the skull). The facility did not complete a thorough investigation. Evidenced by:The facility's Injuries of Unknown Source policy, dated 2/2025, states, in part: All unexplained injuries, including bruises, abrasions, and injuries of unknown source will be investigated.7. An injury of unknown source shall be investigated even if the resident is discharged from the facility as a result of an injury, or an injury of unknown source is identified after discharge.R1 admitted to the facility on [DATE] with diagnoses including cognitive communication deficit (a difficulty with communication caused by problems with the brain's thinking ability); repeated falls; difficulty in walking; muscle wasting and atrophy (a condition where muscles lose mass and strength).R1's Brief Interview for Mental Status, dated 9/26/25, had a score of 9, indicating R1 is moderately cognitively impaired.A facility self-report indicates on 10/1/25 the facility learned that R1 was found to have a subdural hematoma.On 10/14/25 at 7:49 AM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked about the self-report for R1. NHA A stated the facility looked at the situation as an injury of unknown origin as they did not know how the subdural hematoma occurred. NHA A stated that DON B started getting statements from staff. Surveyor requested the statements from staff. No staff statements were provided. Surveyor asked NHA A if staff statements are expected. NHA A stated, yes, statements are a part of a thorough investigation. NHA A stated that staff education was started on falls prevention as part of a process improvement project (PIP) initiated following this incident. Pre/Post Tests from the education were provided to surveyor for 21 staff members. Surveyor asked if there was training provided for the other 19 staff members who have worked between starting the training to the present. NHA A stated no, there was no additional documentation of training yet. NHA A stated that the facility was planning for additional training as they worked through their PIP, but it had not yet occurred. Surveyor asked if all staff should have the training. NHA A stated yes.On 10/14/25 at 12:32 PM, Surveyor interviewed DON B who stated that staff were talked to about the subdural hematoma, but no written statements were obtained. The facility failed to complete a thorough investigation for an injury of unknown origin.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) for 1 of 3 residents (R2) reviewed.R2 had a noted change in condition by RN C (Registered Nurse). RN C failed to perform an assessment, check vital signs, and provide an accurate assessment to the physician. R2 continued to decline and was eventually sent to the ED (Emergency Department) where he received treatment for hypothermia and IV (intravenous) fluids.Evidenced by:Surveyor requested the facilities Change in Condition policy; no policy was provided. AMDA (American Medical Directors Association) guidelines, 2003, states, in part: In the long term care setting, a primary goal of identifying ACOCs (Acute Change of Conditions) is to enable staff to evaluate and manage a patient at the facility and avoid transfer to the hospital or emergency room .Examples of Staff Roles and Responsibilities in Monitoring Patients With ACOCs .Staff nurse *Recognize condition change early, *Assess the patient's symptoms and physical function and document detailed descriptions of observations and symptoms, *Update the charge nurse or supervisor if patient's condition deteriorates or patient fails to improve within expected time frame, *Report patient status to practitioner as appropriate . State of Wisconsin Nurse Practice Act states in part: . N 6.03 Standards of practice for registered nurses (1) General nursing procedures. An R.N. shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention and evaluation. This standard is met through performance of each of the following steps of the nursing process:(a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis.(b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis.(c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s or UAPs.(d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis . R2 admitted to the facility on [DATE] with diagnoses that include Parkinson's disease (a progressive movement disorder of the nervous system; it causes nerve cells to weaken, become damaged, and die, leading to symptoms that include problems with movement, tremor, stiffness, and impaired balance), anemia, hypo-osmolality (a state of low blood solute concentration, causes hyponatremia (low sodium) symptoms by leading water into the cells, causing them to swell) and hyponatremia, chronic kidney disease stage 3b (moderate to severe loss of kidney function), congestive heart failure (the heart cannot pump blood well enough to give the body a normal supply), and hypertension (high blood pressure).R2's most recent MDS (Minimum Data Set) dated 9/12/25 states that R2 has a BIMS (Brief Interview for Mental Status) of 10 out of 15, indicating that R2 has moderate cognitive impairment. Nurse's notes state the following:10/6/25 at 8:30 AM: LATE ENTRYWhat is the resident exhibiting: Late note charting: Resident was not opening his eyes like he normally does and was shaking more than normal as well. Resident has Parkinson's, so these behaviors are exhibited, but resident was more symptomatic this morning than he had been the day before. Resident was also drooling more than normal for him. At lunch time, the resident was unable to take his Carbidopa medication as it kept falling out of his mouth and resident was unable to swallow any liquids or solid foods for lunch. Resident did have family present, and they were able to get him to open his eyes and talk a little with them. After lunch and visiting with his nieces, resident was taken back to his room. Describe current condition and your current assessment: Writer observed resident's condition and asked if he felt ok, to which he replied yes. Writer notified the DON (Director of Nursing) of resident's condition, and a little while later when the Provider was here, writer asked her to take a look at the resident [NAME][sic], after describing his condition.Provider and Family notification and responses: Provider ordered some lab work to be performed the next morning.New orders or interventions put into place: CBC (Complete Blood Count) with diff (differential), CMP (Complete Metabolic Panel) labs ordered.(It is important to note that this nurse's note was written on 10/7/25 at 2:57 PM, there is no comprehensive RN assessment, vital signs or documentation of what was communicated to the Physician, there is no physician note regarding this interaction.) 10/6/25 at 4:42 PM Vital signs are documented as: BP (Blood Pressure) 152/74, Temperature 98.4, Pulse 53, Respirations 18, Oxygen level 75 % on room air

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident receives adequate supervision to prevent accidents for 2 of 3 residents (R1 and R3) reviewed for falls. R1 had 7 unwitnessed falls while self-transferring. The facility failed to complete adequate assessments, conduct root cause analyses, and implement interventions to address the unsafe self-transferring. R1 was found to have a subdural hematoma (a collection of blood that accumulates between the brain and the inner layer of the skull). R3 was admitted to the facility on [DATE] and identified at risk for falls. R3 has had 8 falls since the time of admission to current. The facility failed to identify root causes of the falls, identify trends, and update care plan. This is evidenced by: The facility policy Fall Prevention Program, dated 2/28/25, includes: 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. The facility utilizes a standardized risk assessment for determining a resident's fall risk. The risk assessment categorizes residents according to low, moderate, or high risk. The nurse will refer to the facility's High Risk or Low/Moderate Risk protocols when determining primary interventions. Low/Moderate Risk Protocols: a. Implement universal environmental interventions that decrease the risk of resident falling, including, but not limited to: i. A clear pathway to the bathroom and bedroom doors. ii. Bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed. iii. Call light and frequently used items are within reach. iv. Adequate lighting. v. Wheelchairs and assistive devices are in good repair. b. Implement routine rounding. c. Monitor for changes in resident's cognition, gait, ability to rise/sit, and balance. d. Encourage residents to wear shoes or slippers with non-slip soles when ambulating. e. Ensure eye glasses, if applicable, are clean and the resident wears them when ambulating. f. Monitor vital signs in accordance with facility policy. g. Complete a fall risk assessment every 90 days and as indicated when the resident's condition changes. High Risk Protocols: a. The resident will be placed on the facility's Fall Prevention Program. i. Indicate fall risk on care plan. b. Implement interventions from Low/Moderate Risk Protocols. c. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. d. Provide additional interventions as directed by the resident's assessment, including but not limited to: i. Assistive devices ii. Increased frequency of rounds iii. Sitter, if indicated iv. Medication regimen review v. Low bed vi. Alternate call system access vii. Scheduled ambulation or toileting assistance viii. Family/caregiver or resident education ix. Therapy services referral. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility policy Fall Risk Assessment, dated 9/25, includes: It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents. The risk assessment will be completed by the nurse or designee upon admission, quarterly, or when a significant change is identified. The risk assessment will contain the following components: a. Identify environmental hazards and individual risks, including the need for supervision b. Evaluate and analyze hazards and risks. An At Risk for Falls care plan will be completed for each resident to address each item identified on the risk assessment and will be updated accordingly. The At Risk for Falls care plan will include interventions, including adequate supervision, consistent with a resident's needs, goals, and current standards of practice in order to reduce the risk of an accident. Monitor the effectiveness of the care plan interventions, and modify the intervention as necessary, in accordance with current standards of practice. The facility policy Head Injury, dated 2/28/25, includes: It is the policy of this facility to report head injuries to the physician and implement interventions to prevent further injury. Assess resident following a known, suspected, or verbalized head injury. The assessment shall include, at a minimum: a. Vital signs. b. General condition and appearance. c. Neurological evaluation for changes in: i. Physical functioning ii. Behavior iii. Cognition iv. Level of consciousness v. Dizziness vi. Nausea vii. Irritability viii. Slurred speech or slow to answer questions d. Evaluation of head, eyes, ears, and nose for significant changes in vision, hearing, smell, or bleeding. e. Any injuries to head, neck, eyes, or face, including lacerations, abrasions, or bruising. f. Pain assessment. Perform neuro checks (Neurological assessment) as indicated or as specified by the physician. Continue monitoring for 72 hours following the incident or until the resident is asymptomatic for a period of time specified by the physician. Notify family and document all assessments, actions, and notifications. The facility policy Comprehensive Care Plans, dated 2/28/25, includes: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. f. Resident specific interventions that reflect the resident's needs. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. On 10/14/25 at 12:33 PM, Surveyor interviewed DON B (Director of Nursing) regarding the facility's neurological assessment sheets. DON B indicated the facility uses a form titled Vital Signs and Neuro Checks. DON B indicated the timing of vital signs and neuro checks are listed on the sheet. DON B indicated vital signs and neuro checks are completed as follows: every 15 minutes four times, every 30 minutes twice, every hour twice, every shift eight times for a total of 72 hours post fall. Example 1: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	R1 admitted to the facility on [DATE] with diagnoses including lymphedema (a condition in which excess lymph fluid accumulates in the tissues causing swelling), atrial fibrillation (a heart rhythm disorder where the upper chambers of the heart beat irregularly and rapidly, out of sync with the lower chambers), repeated falls, difficulty in walking, and cognitive communication deficit. R1's Brief Interview for Mental Status, dated 9/26/25, had a score of 9, indicating R1 is moderately cognitively impaired. R1's physician orders active as of 10/6/25, include: Warfarin Sodium Oral Tablet 2 MG (anticoagulant, a medication that prevents blood clots from forming, also known as blood thinners) by mouth one time a day every Tue (Tuesday), Thu (Thursday), Sat (Saturday) for A-fib (Atrial Fibrillation). OT (Occupational Therapy) Evaluation and treatment 3-5x week (3-5 times a week) for 41 days order date 9/10/25. Resident to have lymphedema treatments from PT/OT (Physical Therapy/Occupational Therapy) order date 9/2/25. R1's comprehensive care plan, printed on 10/14/25, includes:Focus: ADL (date initiated 8/13/25)Goal: Will be more independent in bathing, dressing, grooming, bed mobility, transfers and ambulation/locomotion by discharge date . Interventions/Tasks: Ambulation – Independent with 2 wheeled walker. Locomotion – Independent with 2 wheeled walker. Transfers – Independent with 2 wheel walker. Focus: The resident is at risk for falls r/t (Related To) BLE (Bilateral Lower Extremity) edema (Swelling), and weakness (date initiated 3/24/25)Goal: The resident will be free of falls through the review date. Interventions/Tasks: Anticipate and meet the resident's needs (date initiated 3/24/25). Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance (date initiated 3/24/25). Follow facility fall protocol (date initiated 4/17/25). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/14/25 at 12:33 PM, Surveyor interviewed DON B (Director of Nursing) regarding falls. DON B indicated if a resident has an unwitnessed fall, the staff should treat that fall as if the resident received a head injury. DON B indicated staff should immediately complete a thorough assessment of the resident to include, but not limited to, vital signs, neurological assessment (pupil size and reaction to light), hand grasps, facial symmetry, speech, pain, range of motion to extremities, full skin check, anything that might be a change from the resident's baseline status and to ask the resident what they were doing or how they fell. DON B indicate the assessment should be documented in the resident's medical record. DON B indicated the staff are responsible to complete an incident report, make proper notifications to family and providers, to document the complete assessment, start the vital signs and neuro checks sheet, and complete the post fall assessments. DON B indicated a resident who has fallen will be monitored, evaluated, and documented on every shift for 72 hours. DON B indicated the interdisciplinary team (IDT) reviews all falls and will make a note in the resident's medical record regarding that meeting. DON B indicated the following disciplines are in the fall meetings: therapy, MDS (Minimum Data Set) nurse, dietary, social services, DON B, and NHA A (Nursing Home Administrator). DON B indicated new interventions to prevent falls would be added to the resident's comprehensive care plan. DON B indicated LPN J (Licensed Practical Nurse) is responsible for updating the care plans with new interventions. DON B indicated the interventions on the comprehensive care plan flows into the CNAs' (Certified Nursing Assistants) Kardex so all staff would be aware of the resident's fall prevention interventions. DON B indicated the comprehensive care plan is updated with fall prevention interventions immediately or as soon as possible after a resident has a fall. Event 1R1's fall incident report dated 6/23/25 at 7:15 AM, includes: Incident Description: Nursing Description: cna (Certified Nursing Assistant) had found resident kneeling by the doorway of his room. Resident Description: slipped on his grippy socks and fell. Was this incident witnessed: N (No)Immediate Action Taken: Description: no first aid was needed. assisted back into his recliner using the hoyer lift. Injuries Observed at Time of Incident: No injuries observed at time of incident.Mental Status: Oriented to Person, Oriented to Place, Oriented to Situation, Oriented to TimePredisposing Environmental Factors: NonePredisposing Physiological Factors: ConfusedPredisposing Physiological Factors: Vision ImpairmentPredisposing Situation Factors: None R1's Vital Signs and Neuro Checks sheet dated 6/23/25, includes: Blank sections for Day 2 Shift #2 and Day 3 Shift #2. On 10/14/25 at 12:33 PM, Surveyor interviewed DON B regarding R1's 6/23/25 fall. DON B indicated R1 did not have a full assessment immediately following his fall. DON B indicated R1's comprehensive care plan was not reviewed and was not updated with a new intervention to prevent further falls. DON B indicated the facility did not complete a post fall assessment for R1. DON B indicated the post fall vital signs and neuro checks was not completed fully. Event 2 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's fall incident report dated 7/27/25 at 6:00 AM, includes: Incident Description: Nursing Description: Writer noticed first thing this morning that resident had skin tears and bruising on LUE (Left Upper extremity) and bruising on RUE (Right Upper Extremity) and asked resident what happened. Resident stated that he fell during the night. Writer asked if resident reported the fall to the Nurse, and he stated No. Writer then asked why not, and resident replied: I was mad that someone was knocking on my door stating 'Help me, help me', so I got up and fell while trying to get to my walker. Was this incident witnessed: N (No)Immediate Action Taken Description: Writer took vital signs and assessed the wound right away and asked if resident had any other injuries or had pain and resident stated No.Mental Status: Orientation to Person, Orientation to Place, Orientation to Situation. Notes: resident has been getting more confused and forgetful lately. As well as having temper outbursts. Injuries: Abrasion Forearm left, Abrasion Forearm RightPredisposing Environmental Factors: NonePredisposing Physiological Factors: Confused, Impaired Memory. Predisposing Situation Factors: NoneOther Info: Resident was hearing things and was confused and got up to get to his walker, and fell before he got to it. Resident failed to report fall to staff right away due to being angry per his statement to writer. R1's Vital Signs and Neuro Checks sheet, dated 7/27/25, includes: Blank section for Day 2 shift #2. R1's Post Fall assessment dated [DATE] includes: Date and time fall occurred: 7/27/25Location where fall occurred: resident's bathroomWhat was the resident doing prior to the fall, if known? Stated he fell during the night and did not report to amWhere was the resident? resident's roomWas the resident incontinent? YesWhen was the last time the resident was toileted/changed? Resident toileted self duing the nightWas the call light within reach? YesWas the call light activated? NoDescribe environment/surroundings (was w/c (wheelchair) nearby, bedside table etc): bedside table by reclinerDid the resident sustain an injury? If yes, describe: yes bruising and a skin tearDate and time family notified: 7/27/25 10:00 AMFall interventions currently in use (prior to fall): call light in reach and grippy socks on; resident was not using walkerFall history: 3 or more falls in last 6 monthsUnderlying Diseases or Conditions: Psychiatric or cognitive conditions, Cardiac diagnosis or pacemaker, Orthopedic/joint/arthritisMedications: Choose any of the following that predisposes the member to falling: (The following are checked) Psychotropics, Diuretics, Antihypertensives, Functional Status: Observe mobility, standing and sitting balance. Any problems noted? Yes. Does the resident use any assistive devices/adaptive equipment? Yes. Is the resident continent of bladder? No. Describe any variances from above questions: resident frequently does not ask for assistance; is supposed to use walker but forgets frequently; therapy evaluation for increased edemaReview of Post Fall Findings1. Summarize the post-fall findings: resident continues to have poor safety awareness2. Describe new fall prevention interventions to be implemented as a result of the assessment: staff continue to ask resident if he needs assistance and checks on resident frequently3. List suggestions of referrals to be made as a result of the fall: Blank4. Root Cause: Blank Of note, the post fall assessment was completed on 8/15/25 for the fall that occurred on 7/27/25. That is 19 days after R1's fall. Of note, the post fall assessment dated [DATE] for the fall that occurred on 7/27/25 mentions therapy evaluation for increased edema. The first orders after R1's 7/27/25 fall are dated 9/2/25 for R1 to have lymphedema treatments from PT/OT (Physical Therapy/Occupational Therapy). This is 37 days after R1's fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/14/25 at 12:33 PM, Surveyor interviewed DON B regarding R1's 7/27/25 fall. DON B indicated R1 did not have a full assessment immediately following staff notification of R1's fall. DON B indicated R1's comprehensive care plan was not reviewed and was not updated with a new intervention to prevent further falls. DON B indicated the facility did not complete a post fall assessment for R1 timely. DON B indicated the post fall vital signs and neuro checks was not completed fully. DON B indicated an IDT review was not completed. DON B indicated R1's walker not being near R1 was the root cause for this fall. DON B indicated the root cause of this fall was reviewed by the interdisciplinary team on 8/20/25. (Of note, this is 24 days after the fall.) Event 3 R1's Risk for Falls assessment, dated 8/3/25, includes:Score: 6Category: Low RiskReason for Assessment: Recent fallsLOC (Level of Consciousness)/Mental Status: Alert –(oriented x3)Falls: 1-2 falls in past 3 monthsAmbulation/Elimination Status: Ambulatory/ContinentGait Balance: Gait/Balance normal. Requires use of assistive devices (i.e., cane, w/c (wheelchair) walker, furniture) Summary of findings Narrative Summary: Res (R1) is at high risk for falls. Res has had 2 falls this past week, poor safety awareness, and resistant to staff assistance. R1's fall incident report, dated 8/3/25 at 11:20 AM, includes:Incident Description: Nursing Description: Res (R1) was yelling help. Writer entered res room and found res sitting on the floor in the doorway of his bathroom. Res was sitting up with legs straight out facing his bed. Resident Description: Res states, I was walking out of the bathroom and lost my balance. I guess I should keep my w/c (wheelchair) by my recliner instead of across the room.Was this incident witnessed: N (No)Immediate Action Taken Description: Writer assessed res and assisted CNA (Certified Nursing assistant) with using hoyer lift to transfer res off floor and into hi [sic] recliner. Mental Status: Oriented to Person, Oriented to Place, Oriented to TimeNotes: Res does have periods of confusion at times. No confusion noted at this time. Predisposing Environmental Factors: BlankPredisposing Physiological Factors: BlankPredisposing Situation Factors: BlankOther info: Res was ambulating without his walker. On 10/14/25 at 12:33 PM, Surveyor interviewed DON B regarding R1's 8/3/25 fall. Surveyor asked DON B what the nurse meant when she documented Writer assessed res? DON B indicated she did not know what type of assessment or what was included in the nurse's assessment. DON B indicated R1 did not have a full assessment immediately after falling. DON B indicated R1's comprehensive care plan was not reviewed and was not updated with a new intervention to prevent further falls. DON B indicated the facility did not complete a post fall assessment for R1. DON B indicated an IDT review was not completed. DON B indicated R1's walker not being near R1 was the root cause for this fall. DON B indicated the root cause of this fall was reviewed by the interdisciplinary team on 8/20/25. (Of note, this is 17 days after the fall.) DON B indicated the root cause of the 8/3/25 and 7/27/25 falls were the same. Surveyor asked DON B, if an IDT review, intervention, and care plan update after R1's 7/27/25 fall could have prevented the fall on 8/3/25 since they both had the same root cause. DON B did not provide a response. Event 4 (continued on next page)

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	525531	A. Building B. Wing	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Christian Home LLC	452 Fox Lake Road Waupun, WI 53963

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's fall incident reported, dated 8/14/25 at 16:30 (4:30PM), includes: Incident Description: Nursing Description: this incident was not witnessed resident was yelling loudly help. I went into residents room to find him sitting on the floor half into the shower legs straight out in front of him. Hes [sic] yelling to get him up he is not hurt. Hoyer and 2 staff members used to get him up. I can see he was trying to remove the elevated toilet chair as he is refusing to use it. It was half way pulled out from the toilet. Resident Description: lost his footing and fell. Reports he is not hurt.Was this incident witnessed: N (No)Immediate Action Taken Description: Resident gotten up off the floor with 2 assist and hoyer. Skin check done with no open areas or bruising at this time. ROM (Range of Motion) within residents normal. As soon as I finished skin check and vitals resident was off walking in the hallway. DON (Director of Nursing) and daughter [name] called. Mental Status: Oriented to Person, Oriented to Place, Orientated to Situation, Orientated to TimeNotes: called his daughter as soon as we got him up off the floorPredisposing Environmental Factors: Medical EquipmentPredisposing Physiological Factors: Gait ImbalancePredisposing Situation Factors: Ambulating without Assistance, Improper FootwearOther Info: resident reminded to use call light for assistance R1's Vital Signs and Neuro Checks sheet, dated 8/14/25, includes: Blank section for 1 hour #2. On 10/14/25 at 12:33 PM, Surveyor interviewed DON B regarding R1's 8/14/25 fall. DON B indicated R1's comprehensive care plan was not reviewed and was not updated with a new intervention to prevent further falls. DON B indicated the facility did not complete a post fall assessment for R1. DON B indicated the post fall vital signs and neuro checks were not completed fully. DON B indicated an IDT review was not done for this fall. R1's Risk for Falls assessment, dated 8/15/25, includes:Score: 21Category: High RiskReason for Assessment: Recent fallsLOC (Level of Consciousness)/Mental Status: Intermittent ConfusionFalls: 3 or more falls in past 3 monthsAmbulation/Elimination Status: Ambulatory/IncontinentGait Balance: Balance problem while standing. Balance problem while walking. Lower extremity weakness. Summary of findings Narrative Summary: resident at risk for falls; has had numerous falls in the past 2 months Event 5 R1's fall incident report, dated 9/17/25 at 11:40 AM, includes:Incident Description: Nursing Description: Writer had just walked past resident's room and saw him standing in the middle of the room with his walker. Writer walked down a few rooms with the med cart (Medication Cart), and heard a crash noise and resident was calling out for help. Writer ran to resident's room and found him on the floor. Writer asked other staff for help in getting resident up. Resident was gotten up off the floor with a hoyer sling and put into his wheelchair. Vitals were taken and resident was assessed for injuries, which he had none. Resident denied any pain as well. Resident Description: Resident stated he lost his balance and fell. Was this incident witnessed: N (No)Immediate Action Taken Description: resident up [sic] picked up off the floor with a hoyer sling and lift. Vitals were taken and resident was assessed for injuries, which he had none. Resident denies having any pain either. Mobility: Ambulating without assistanceMental Status: Oriented to Person, Oriented to PlaceNotes: resident is alert and oriented x2, forgetful and confused at timesPredisposing Environmental Factors: NonePredisposing Physiological Factors: Impaired MemoryPredisposing Situation Factors: Wanderer, Using Wheeled Walker (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/14/25 at 12:33 PM, Surveyor interviewed DON B regarding R1's 9/17/25 fall. Surveyor requested R1's Vital Signs and Neuro Checks sheet for the fall on 9/17/25. The facility was unable to provide the document. DON B indicated the post fall vital signs and neuro check were not completed for this fall. Surveyor asked DON B what the nurse assessed for when the nurse documented resident was assessed for injuries? DON B indicated she is unable to determine what the nurse assessed. DON B indicated R1 did not have a full assessment immediately following R1's fall. DON B indicated R1's comprehensive care plan was not reviewed and was not updated with a new intervention to prevent further falls. DON B indicated the facility did not complete a post fall assessment for R1. DON B indicated an IDT review was not completed. DON B indicated a root cause analysis was not completed. Event 6 R1's fall incident report, dated 9/28/25 at 6:15 PM, includes:Incident Description: Nursing Description: Staff in dining room heard someone yelling help. Staff immediately scattered to find where voice was coming from. Writer found resident sitting on buttocks in bathroom, alert, breathing and conscious. Resident Description: I went to the toilet, wiped and fell onto my butt. I'm fine, really. Was this incident witnessed: N (No)Immediate Action Taken Description: Checked for injuries, used hoyer lift per facility protocol, obtained vitals and back to chair. Mental Status: Oriented to Person, Oriented to Place, Oriented to Situation, Oriented to TimeNotes: softball sized bruise noted to right upper thigh proximal to buttocks. Predisposing Environmental Factors: NonePredisposing Physiological Factors: NonePredisposing Situation Factors: Using Walker On 10/14/25 at 12:33 PM, Surveyor interviewed DON B regarding R1's 9/28/25 fall. Surveyor asked DON B what the nurse assessed for when the nurse documented checked for injuries? DON B indicated she is unable to determine what the nurse assessed. DON B indicated R1 did not have a full assessment immediately following R1's fall. DON B indicated R1's comprehensive care plan was not reviewed and was not updated with a new intervention to prevent further falls. DON B indicated the facility did not complete a post fall assessment for R1. DON B indicated an IDT review was not completed. DON B indicated a root cause analysis was not completed. Event 7 R1's fall incident report, dated 9/29/25 at 3:15 PM, includes:Incident Description: Nursing Description: Staff overheard resident yelling loudly for help. Staff immediately went to room and found him on the floor. Resident laying under sink with feet pointing towards wall. Denies LOC (Loss of Consciousness), denies hitting head, stated he was using the circular towel holder to get up. [NAME] in bathroom, unknown which way it was facing. Resident has been on the toilet several times. Resident description: I was using this handle to get up. Was this incident witnessed: N (No)Immediate Action Taken Description: checked for injuries and got off floor with hoyer lift per facility protocol. Mental Status: Oriented to PersonPredisposing Environmental Factors: NonePredisposing Physiological Factors: ConfusedPredisposing Situation Factors: Using WalkerOther Info: Resident has been on toilet several times since the beginning of second shift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/14/25 at 12:33 PM, Surveyor interviewed DON B regarding R1's 9/28/25 fall. Surveyor asked DON B what the nurse assessed for when the nurse documented checked for injuries? DON B indicated she is unable to determine what the nurse assessed. DON B indicated R1 did not have a full assessment immediately following R1's fall. DON B indicated R1's comprehensive care plan was not reviewed and was not updated with a new intervention to prevent further falls. DON B indicated the facility did not complete a post fall assessment for R1. DON B indicated an IDT review was completed on 10/4/25. DON B indicated a root cause analysis was not completed. R1's nurse progress notes, dated 9/29/25 at 4:21 PM, includes: Resident unable to void for specimen, did bladder scan of over 1000 ml in bladder. Attempted to cath (catheterize) him sterile technique to get him to void, unable to see penis through foreskin even with manipulation. Another nurse also tried, unsuccessful. Writer also talked with NP (Nurse Practitioner) [name] with above. Resident continues with confusion and urgency. Talked to Daughter [name] with update to send out to ER (Emergency Room). R1's emergency room notes, dated 9/29/25 at 5:13 PM, include: Chief Complaint: Altered mental status. He also has urinary retention and on arrival bladder scan is showing 554 ml in the bladder. Patient denies any symptoms. No.abdominal pain except suprapubic pressure reported by patient. Physical Exam: General: He is not in acute distress. Has baseline dementia. He is awake and alert and answers simple questions. 9/30/25 at 11:07 AM, Patient CT (Medical imaging that create a detailed image of the body) head showed subacute subdural hematoma. On 10/13/25 at 1:30 PM, Surveyor interviewed CNA D (Certified Nursing Assistant) regarding fall interventions. Surveyor asked CNA D what interventions were in place for R1 related to falls. CNA D stated, We didn't do much, he was very independent, but maybe if he had used the call light he would not have fallen as much. On 10/14/25 at 9:07 AM, Surveyor interviewed CNA F regarding fall interventions. CNA F indicated if a resident is at risk for falls it would be on their Kardex. CNA F indicated fall interventions are also on the Kardex. On 10/14/25 at 7:48 AM, Surveyor interviewed LPN G regarding falls. LPN G indicated she looks at the CNAs' Kardex to see the residents at risk for falls and their interventions because the CNA Kardex is more focused and the information comes from the care plan. LPN G indicates the CNA Kardex gives a quick overview of the resident. LPN G indicated if a resident falls the nurse has to complete an overall head to toe assessment with vitals. LPN G indicated the nurse is looking for a change in condition, physical anomalies, internal/external rotation of legs, bleeding, neuro assessment including pupils, and range of motion. LPN G stated her entire assessment gets documented in the resident's medical record. LPN G indicated she would try to find a root cause of the resident's fall if she could and she would make recommendations to the DON about any interventions that may help prevent another fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/14/25 at 10:14 AM, Surveyor interviewed RN I (Registered Nurse) regarding falls. RN I indicated fall interventions are on the care plan. RN I indicated if a resident falls, a full assessment needs to be completed to include things such as pain, range of motion, skin checks, hand grasps, pupils, and cognition. RN I indicated an incident report has to be completed. RN I stated there are a couple of assessments that are triggered when an incident report is completed including the Post Fall Assessment. RN I indicated the incident report helps to identify the root cause and interventions should be put in place after a resident falls. RN I indicated the resident needs documented follow up every shift for 72 hours after a fall. On 10/14/25 at 1:46 PM, Surveyor interviewed LPN J regarding care plans. LPN J stated she is responsible for updating resident care plans when she completes the MDS (Minimum Data Set) assessment. LPN J indicated she also updates the care plans after the IDT meetings in the morning. LPN J indicated she does update care plans with fall interventions that were discussed in the morning IDT meeting. LPN J indicated the care plans should be updated as soon as possible with new information. Surveyor and LPN J reviewed R1's care plan together. LPN J indicated R1's care plan had not been updated related to any of his 7 documented falls. LPN J indicated if she does not attend the IDT meeting in the morning or is not made aware of new interventions she would not know the care plan needed to be updated. Surveyor asked what the process was for updating the care plans when LP

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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. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible, or resident preferences indicate otherwise for 1 of 3 residents (R2) reviewed for hydration. R2's fluid intakes were not monitored to ensure he was meeting his estimated daily fluid needs, resulting in R2 being hospitalized for dehydration. Evidenced by:The facility's policy titled Nutritional Management dated 2/2025 states in part .3. Evaluation/ analysis: a. The assessment shall clarify the resident's current nutritional status and individual risk factors for altered nutrition/ hydration. b. The dietician shall use the data gathered from the nutritional assessment to estimate the resident's calorie, nutrient, and fluid needs and whether intake is adequate to meet those needs.5. Monitoring. Revision: a. Monitoring of the resident's condition and care plan interventions will occur on an ongoing basis. According to the National Library of Medicine article titled Adult Dehydration dated 3/5/25 states in part .Dehydration in adults is a clinically significant condition caused by an imbalance between fluid intake and loss, often leading to disturbances in the balance of total body electrolytes. Dehydration is often precipitated by low fluid intake, increased fluid loss, or a combination of both of these factors. This is further influenced by factors such as age-related changes, chronic illness, and medication use.[2] The pathophysiological mechanisms include activation of the renin-angiotensin-aldosterone system, increased release of antidiuretic hormone (ADH), and stimulation of the sympathetic nervous system, all of which work to retain fluids and stabilize circulation. Clinically, dehydration presents with symptoms ranging from mild thirst and fatigue to severe complications such as confusion, hypotension, and multiple organ dysfunction.[3] Dehydration is a common cause of hospital admissions, contributing to significant morbidity and mortality while often complicating a range of medical conditions.[2] Dehydration is primarily diagnosed clinically, with laboratory investigations, including serum electrolytes, serum osmolality, and renal function tests, providing supportive information. Treatment focuses on correcting fluid and electrolyte imbalances through oral or intravenous (IV) rehydration while closely monitoring serum electrolytes and renal function.[4] Early symptoms may include increased thirst, dry mouth, weakness, and decreased urine output. As dehydration worsens, additional symptoms such as dizziness, muscle weakness, palpitations, confusion, and irritability may emerge. In severe cases, lethargy, seizures, and hypovolemic shock can occur. Laboratory testing is crucial in diagnosing dehydration and assessing electrolyte imbalances. Common findings include an elevated blood urea nitrogen (BUN) to creatinine ratio greater than 20:1, suggesting prerenal azotemia due to reduced renal perfusion. Adult Dehydration - StatPearls - NCBI BookshelfR2 admitted to the facility on [DATE] with diagnoses that include Parkinson's disease (a progressive movement disorder of the nervous system; it causes nerve cells to weaken, become damaged, and die, leading to symptoms that include problems with movement, tremor, stiffness, and impaired balance), anemia, hypo- osmolality (a state of low blood solute concentration, causes hyponatremia (low sodium) symptoms by leading water into the cells, causing them to swell) and hyponatremia, chronic kidney disease stage 3b (moderate to severe loss of kidney function), congestive heart failure (the heart cannot pump blood well enough to give the body a normal supply), and hypertension (high blood pressure).R2's most recent MDS (Minimum Data Set) dated 9/12/25 states that R2 has a BIMS (Brief Interview of Mental Status) of 10 out of 15, indicating that R2 has moderate cognitive impairment.R2's Medical Nutrition Therapy Assessment date 9/10/25 states in part .D. Risk Factors.4. Dehydration Risk: j. Laxatives.POC (Plan of Care) needs are determined by above Risk Factors- Risk Factors are addressed in POC. 6. Proceed with POC: a. Yes.9. Fluid Needs: cc (cubic centimeter)/ day.2350 cc fluids.R2's care plan dated 9/10/25 states in part . Focus: I have a dx (diagnosis) of CKD (chronic kidney disease): at risk for lab abnormalities and alteration in nutrition.Goal: Stabilize and/ or improve my bloodwork within an acceptable range. My meal intake will be >50% .Interventions/ Tasks: . Monitor my PO (oral) intake PRN (as needed) .Provide me with food/ beverage preferences as available.It is important to note that R2's care plan does not address R2's risk for dehydration.R2's fluid intake documentation is as follows:9/14/25: 820 cc9/15/25: 1020 cc9/16/25: 820 cc9/17/25: 690 cc9/18/25: 840 cc9/19/25: 840 cc9/20/25: 840 cc9/21/25:980 cc 9/22/25: 990 cc9/23/25: 1110 cc9/24/25: 1050 cc9/25/25: 1560 cc9/26/25: documentation indicates that resident not available and resident refused9/27/25: 1570 cc9/28/25: 2030 cc9/29/25: 1400 cc9/30/25: 980 cc10/1/25: 1810 cc10/2/25: 1850 cc10/3/25: 2430 cc (of