STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525532	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - St Croix Falls	750 E Louisiana St St Croix Falls, WI 54024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 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 1 (R13) of 12 resident's right to be informed of, and participate in, his or her treatment was honored. The facility offered R13 the Respiratory Syncytial Virus (RSV) Vaccine but did not administer the vaccine when R13 indicated her preference for receiving it. Findings include: The facility policy, titled Resident Rights - Self Determination dated 4/20/20 with a revision date of January 2025, indicates, in part: Purpose: To ensure that each resident has the opportunity to exercise their autonomy regarding those things that are important in their life which includes interests and preferences. Procedure: Residents have the right to actively participate in planning their care, making informed decisions about their treatment, and being fully aware of their care options. Residents will be informed of available services and care options and will have the right to select those services that best meet their needs. The facility will accommodate to the extent possible, resident preferences. The facility policy, titled Resident Rights, dated June 2002 with a revision date of January 2025, indicates, in part: Purpose: . The facility is committed to. each resident by honoring their individual goals, preferences, and choices. and their right to make decisions regarding their care and well-being. Procedure: Resident rights include: . Planning and Implementing Care. Self-Determination. The facility will support residents in exercising their rights to autonomy and choice, allowing them to decide, to the fullest extent possible, how they wish to. receive care. The facility policy, titled Management of RSV, dated 12/2024, indicates, in part: Policy: It is the policy of this facility to ensure that proper and appropriate infection control principles are utilized to help decrease the risk of transmission and respiratory syncytial virus (RSV). Definition: Respiratory syncytial virus (RSV) refers to a common respiratory virus that usually causes mild, cold-like symptoms. It can be dangerous for adults 65 years and older. those with weakened immune systems. Policy Explanation: Respiratory syncytial virus (RSV) is a highly contagious respiratory virus that can affect any age but is a greater risk for children and older adults. It is easily spread through the air on infected respiratory droplets or through direct contact. For older adults, serious complication like pneumonia. can occur. Compliance Guidelines: . 6. The facility may offer the RSV vaccine to residents aged 75 and older and residents 60-74 at increased risk of severe RSV. R13 was admitted to the facility on [DATE] with diagnoses that include multiple sclerosis, pneumonitis (inflammation of the lungs) due to inhalation of other solids and liquids, and personal history of Covid-19. R13's Acknowledgement of Receipt of Vaccine Information Sheet indicates the following, in part: I understand that Dove Health Care - St. Croix Falls recommends that I receive the vaccines to protect myself, other residents, and others in the facility and surrounding community. Dove has provided information on the risks and benefits of each vaccine listed. I have checked YES or NO to identify which vaccines I would like to receive. R13 placed a check mark in the box for Yes I want this for the Respiratory Syncytial Virus Vaccine. R13 signed and dated this form on 10/8/24. Surveyor reviewed R13's electronic health record (EHR) and could find no evidence that R13 received the RSV vaccine per her preference. On 9/17/25 at 10:23 AM, Surveyor interviewed IP AA (Infection Preventionist) and asked her if R13 received the RSV vaccine per her preference. IP AA stated that R13 did not receive the RSV vaccine, and that the facility would have to call the pharmacy in order to obtain it because they don't have that vaccine in house. Surveyor asked IP AA if R13 should have received the RSV vaccine if she wanted it. IP AA stated yes, R13 should have received the RSV vaccine if she wanted it. The facility failed to ensure that R13 was provided the RSV vaccine per her preference.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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 0578 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 the resident's right to request, refuse, and/or discontinue treatment and to formulate an advanced directive for 2 of 12 residents (R27 and R32) R27 and R32's charts did not contain current copies of their advanced directive and/or did not contain evidence of advanced care planning, other than code status, for a time when they are not able to make their own healthcare decisions. Evidenced by: The facility policy titled, Advance Directives, revision date 7/10/24, indicates, in part: Policy: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate advance directive. Definitions: Advanced directive is a written instruction, such as a living will or durable power of attorney for health care. relating to the provision of health care when the individual is incapacitated. Policy Explanation and Compliance Guidelines: 1. On admission, the facility will determine if the resident has executed an advanced directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information.about the right to refuse medical or surgical treatment and formulate an advance directive. 3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff.7. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives. Example 1 R27 was admitted to the facility on [DATE]. On 9/16/25 at 9:19AM during the record review portion of the initial pool process, surveyor was unable to locate a copy of R27's advanced directive/POAHC (Power of Attorney for HealthCare) in his electronic medical record. On 9/16/25 at 3:15PM Surveyor interviewed Social Services Director C (SSD) and requested information regarding advanced directive/living will documentation for R27. SSD C indicated R27 did not have one on file. Surveyor asked SSD C if a copy of the HCPOA should be on file at the facility, or if they do not have one, should it be documented that the resident was offered assistance in completing one and their preference. SSD C indicated, yes. SSD C indicated she would look for any documentation about offering assistance, if they refused, and if anyone reapproached if they wanted more time to decide. On 9/16/25 3:52PM Surveyor interviewed SSD C who indicated she was unable to find anything for R27 related to his HCPOA/living will. Surveyor asked SSD C if someone should have ensured a HCPOA/living will was on file for R27 or documented discussions/assistance offered to R27 regarding completing a HCPOA/living will. SSD C indicated, yes. Example 2 R32 was admitted to the facility on [DATE]. On 9/16/25 at 8:18AM during the record review portion of the initial pool process, surveyor was unable to locate a copy of R32's advanced directive/POAHC (Power of Attorney for HealthCare) in his electronic medical record. On 9/16/25 at 3:15PM Surveyor interviewed Social Services Director C (SSD) and requested information regarding advanced directive/living will documentation for R32. SSD C indicated R32 did not have one on file. Surveyor asked SSD C if a copy of the HCPOA should be on file at the facility, or if they do not have one, should it be documented that the resident was offered assistance in completing one and their preference. SSD C indicated, yes. SSD C indicated she would look for any documentation about offering assistance, if they refused, and if anyone reapproached if they wanted more time to decide. On 9/16/25 at 3:56PM SSD C brought in documentation regarding HCPOA/living will for R32. The document dated 4/25/25 and titled, Social Service Evaluation (Q) Care Conference Progress Note . indicates, in part: Section G. Advance Care Planning.2.No POA (Power of Attorney) paperwork on file, resident is interested in completing the documents. On 9/17/25 at 8:47AM Surveyor interviewed SSD C, reviewed the information from the document dated 4/25/25 and titled, Social Service Evaluation (Q) Care Conference Progress Note ., Section G. Advance Care Planning.above. Surveyor asked SSD C, with the note stating R32 was interested in completing the documents, should assistance have been given and documented. SSD C indicated, absolutely.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not document a thorough investigation and did not resolve grievances as outlined in the facility policy for 2 of 12 Residents (R32 and R20) reviewed for grievances. R32 voiced a concern to a staff member and the facility failed to follow their grievance policy by thoroughly investigating, following up, and documenting the concern. R20 voiced a grievance regarding wound care and the facility did not follow the grievance process. Evidenced by: The facility policy, “Grievance Policy,” revision date 11/2019, indicates, in part: Policy Statement: …grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their long-term care facility stay. The facility will ensure prompt resolution to all grievances, keeping the Resident and Resident Representative informed throughout the investigation and resolution process. The Facility grievance process will be overseen by a designated Grievance Official who will be responsible for receiving and tracking grievances through their conclusion, lead necessary investigations…communicate with residents throughout the process to resolution…Objective of Grievance Policy: The objective of the grievance policy is to ensure the Facility makes prompt efforts to resolve grievances a resident may have. The facility policy, “Grievance Procedure,” revised date 11/2023, indicates, in part: Purpose: To ensure that each Resident or Resident Representative has the right to voice grievances regarding treatment, care, management of funds, lost clothing or violation of rights and to ensure that the Facility makes prompt efforts to resolve these grievances. Procedure: …5. The facility has identified a grievance official who is responsible for: a) Overseeing the grievance process b) Receiving and tracking grievances through their conclusion c) Leading any necessary investigations by the facility…e) Issuing written grievance decisions to the Resident or Resident Representative as requested…7. As necessary, the Facility will take immediate action to prevent further potential violation of Resident rights while the alleged violation is being investigated…9. Facility will immediately initiate an investigation by acknowledging receipt of the grievance. Assurance will be given that the incident or series of incidents will be investigated. 10. The investigation report should include, as each may apply: a. The date and time the incident took place; [sic] b. The date and time the grievance was received; c. A summary statement of the Resident’s grievance; d. The steps taken to investigate the grievance…e. A statement as to whether the grievance was confirmed or not confirmed f. Any corrective action taken or to be taken by the Facility as a result of the grievance will be in accordance with Facility policies and Federal and State regulations. g. The date written decision was determined…12. The investigation should be completed within fifteen (15) working days of the receipt of the grievance unless otherwise directed and/or approved by administration. 13. The Resident or Resident Representative will be informed of the conclusion of the investigation and will be given a written summary upon request… Example 1 (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R32 was admitted to the facility on [DATE] with diagnoses that include, in part: Acute and Chronic Respiratory Failure with Hypoxia; Difficulty in Walking; Muscle Weakness; Pain in Left Hip; Trochanteric Bursitis, Right Hip (an inflammation of the bursa, a fluid-filled sac, located on the outer side of the hip) … R32’s most recent Minimum Data Set (MDS), 8/8/25, indicates R32 has a Brief Interview for Mental Status (BIMS) score of 12, indicating R32 has a moderate cognitive impairment. R32’s Kardex indicates, in part: Mobility/Transfer/Bed Mobility: …Transfer: 2 assist full mechanical lift… R32’s Kardex does not address Locomotion on the unit. R32’s Comprehensive Care Plan includes, in part: .Focus: I have an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) activity intolerance, fatigue, pain. Date initiated: 7/13/23. Revision on: 1/31/24…Interventions: Transfer: 2 assist full mechanical lift. Date Initiated: 1/12/24. Revision on: 9/16/25. Surveyors were unable to find information regarding locomotion on the unit noted on the comprehensive care plan. 9/15/2025 3:58PM Surveyor interviewed R32 as part of the initial screening process. R32 indicated sometimes when he goes to the dining room, he requests help, and he is told he can do it himself. R32 states sometimes he can but doesn’t always feel up to it and sometimes when he carries his cup with him, he can’t do it himself. R32’s progress notes, include, in part: 9/14/25 1:22PM…Behavior: Resident was yelling out while rolling himself down the (hallway number) hallway. Nurse was going to resident to assist him with a ride in his wheelchair to his room. Resident began to cry i can’t wait until Monday to report not being helped. Resident was upset he couldn't find a ride from the dining room to his room. Resident had a cup in his hand making it hard to roll himself back to his room with 1 hand. Nurse explained to resident that during lunch, people have to pass trays and assist others with feeding. Resident was not understanding. Interventions Attempted: Nurse gave resident a ride back to his room…Resident greatly appreciative. Effectiveness of Interventions: effective. Author: Registered Nurse (RN) D (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/25 at approximately 10:39AM, Surveyor interviewed Certified Nursing Assistant L (CNA) and asked how she knows how the residents she cares for move on the unit. CNA L indicated they have a Kardex in their room and it is updated on Monday, Wednesday, Friday, and as needed. Surveyor asked CNA L how R32 moves on the unit. CNA L indicated she knows he is dependent in the hall. Surveyor asked CNA L if R32 has ever told her he isn’t being helped. CNA L indicated he’s asked me if he is being ignored, and she tells him no and explains if she was helping another person. CNA L indicated if you explain it to him, he is usually pretty understanding. CNA L indicated he has never told her “Flat out” that people haven’t helped him. Surveyor requested CNA L review the Kardex in R32’s room with her. Surveyor asked CNA L if she could locate information on how R32 moves around in the hall. CNA L indicated she could not locate the information and that the Kardex is what she uses to know how to care for her residents. Surveyor asked CNA L how she knows that R32 needs assistance moving in his wheelchair on the unit. CNA L indicated from the nurses, other aides, and from doing a lot of her training on the hall. On 9/17/25 at approximately 10:00AM Surveyor interviewed RN D (Registered Nurse) and asked what the expectation is if a resident voices a concern. RN D indicated, typically they will make note of it and report it to the case managers. We now have a policy where we have to reach out to the Nursing Home Administrator (NHA) or Director of Nursing (DON), but I know that the case manager also reaches out to them. RN D indicated, depending on the concern we will go talk to the resident, get their side, and see what is going on. Surveyor reviewed with RN D the note above from 9/14/25 1:22PM (authored by RN D) for R32 regarding him stating he doesn't get help and couldn’t wait until Monday to report it. Surveyor asked RN D if R32 had told her if he had asked for help that day. RN D indicated, he just made the comment that he can’t ever get any help, which is typical of him if he can’t get it right away. Surveyor asked RN D if she reported to anyone R32’s concern with not getting help. RN D indicated she did not, she just did the behavior note since he was on behavior charting. Surveyor asked RN D if she feels this should have been reported as a grievance. RN D indicated, now that I’m thinking about it yes. In the moment, it is such a common thing for him to say he doesn’t get help, that it didn’t register to file one. Surveyor asked RN D if this is something R32 says all the time at what point would she say it should be looked into given he continues to say he isn’t receiving help. RN D indicated, I don’t really have an answer, sooner rather than later. On 9/17/25 at 10:55AM Surveyor interviewed Nursing Home Administrator A (NHA) and asked if he was the grievance officer. NHA A indicated he was. Surveyor reviewed the note from 9/14/25 regarding R32 reporting to RN D that he is not getting help and the interview with RN D indicating he states this frequently. Surveyor asked NHA A if there should have been a grievance completed given R32’s concern. NHA A indicated, yes. Example 2 R20 was admitted to the facility 3/2/23 with diagnosis of Diabetes Mellitus Type II with foot ulcer, and personal history of diabetic foot ulcer. On 9/18/25 at 7:34 AM During an interview R20 indicated she did not want NP Z (Nurse Practitioner) debriding her foot wound, stating “It’s worse, and then it starts to make my leg start to hurt. ” R20 indicated she reported to the NHA A and one of the nurses her concern about her wound. R20 told NP Z that she didn’t like her and didn’t want her to touch her foot anymore. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	0n 9/18/25 at 9:49 AM AA K (Administrative Assistant) indicated that R20 had voiced a concern about not wanting to see NP Z anymore. AA K indicated R20’s concern is a grievance, and it should be investigated. AA K stated that she reported R20’s voiced concern to NHA A. On 9/18/25 at 10:01 AM NHA A indicated he was aware of R20’s voiced concern. NHA A (Nursing Home Administrator) indicated when a resident voices a concern. Staff should follow the facility grievance policy. (It is important to note that R20 voiced a grievance to facility staff, and they did not fill out a grievance form and follow up on the concern per facility policy.)

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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. (continued on next page)

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F 0609 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 all alleged violations involving injuries of unknown origin are reported immediately to the administrator of the facility and to other officials, including to the State Agency, in accordance with State law for 1 of 12 residents (R1) reviewed for abuse.R1 was noted to have an area of swelling to right hip and dark purple bruising to right shoulder and arm. The origin of this injury was unknown and was not reported to the Nursing Home Administrator (NHA) or the State Agency (SA). Evidenced by:The facility's Resident Abuse, Neglect, Misappropriation of Property, and Exploitation Prevention Program policy, dated 10/2023, states, in part: .Definitions: . Injuries of unknown source an injury should be classified as an injury of unknown source when all of the following are met: the source of the injury was not observed by any person; and the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.7. Reporting/Response: .All staff/covered individuals are required to immediately report all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property to the administrator, State Survey Agency, and local law enforcement, without fear of retaliation or reprisal. In addition, facility must report alleged violations related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source and misappropriation of resident property and report the results of all investigation to the State Survey Agency, and other proper officials (e.g. local law enforcement and adult protective services) within the prescribed time frame. This required reporting is the responsibility of the Administrator or designee.R1 was admitted to the facility on [DATE] and has diagnoses that include Cerebral infarction due to thrombosis of left middle cerebral artery (a stroke caused by blockage in a major blood vessel in the brain); Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side (paralysis or weakness on the right side of the body following stroke); difficulty in walking; unsteadiness on feet.R1's Minimum Data Set (MDS), dated [DATE], indicates a Brief Interview of Mental Status (BIMS) score of 8, indicating moderate cognitive impairment.R1's progress notes include:*3/8/25: This nurse called into resident's room for assessment by CNA (Certified Nursing Assistant) because resident was complaining of increased pain, difficulty ambulating, an area of swelling noted on right hip and dark purple bruising on the front of right shoulder and arm.*3/8/25: Resident is at hospital.has a hematoma (a localized collection of blood outside the blood vessels that causes swelling and bruising) and a pneumothorax (a condition where air enters the space between the lung and chest wall, causing the lung to collapse; may occur without obvious cause or may be result of chest injury) with a chest tube (a tube inserted into the space between the lung and chest wall to drain fluid, air, or pus).On 9/16/25 at 3:46 PM, Surveyor interviewed RNNM J (Registered Nurse / Nurse Manager) and asked about the procedure when a resident is noted to have swelling and bruising. RNNM J stated an assessment would be done and if the facility does not know how it occurred there will be an investigation and documentation on a risk management. Surveyor reviewed R1's progress note from 3/8/25. RNNM J stated there should be risk management, but did not see any in R1's chart.On 9/16/25 at 4:21 PM, Surveyor interviewed DON B (Director of Nursing) about the procedure when a resident is noted to have swelling and bruising. DON B stated complete an assessment, notify the provider, investigate the root cause. DON B stated this would be documented in risk management. Surveyor asked if there was risk management for R1 for the bruising and swelling noted on 3/8/25. DON B stated no and would have expected there to be an investigation; this would be an injury of unknown source that would need to be reported to NHA and SA, but it was not reported.On 9/17/25 at 4:05 PM, Surveyor interviewed NHA A (Nursing Home Administrator) who stated that R1's swelling and bruising would be considered an injury of unknown origin and should have been reported.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that each resident receives adequate supervision and assistive devices to prevent accidents in 2 of 2 (R6 and R17) residents reviewed for falls. R17 was assessed and care planned for 2-person assist with an EZ stand to meet her needs for transfers. CNA E (Certified Nursing Assistant) did not follow manufacturer’s recommendations for the EZ stand lift and did not fasten the harness’ safety strap around R17’s waist. R17 had a change in plane when she was lowered to the floor. R6 has diagnoses repeated falls, has been assessed by the facility to be at risk for falling, and has experienced multiple falls since admission. Surveyor observed R6 without his care planned intervention in place related to fall prevention. This is evidenced by: Facility policy, titled Safe Resident Handling/Transfers, revised 1/2025, states in part…the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Compliance Guidelines, states in part…14. Resident lifting and transferring will be performed according to the residents’ individual plan of care. 15. Staff will perform mechanical lifts/transfers according to the manufacturer’s instructions for use of the device. EZ way Smart Stand Operator’s Instructions with a revision date of 5/9/2025, states, in part; …Safety Notes …Do not modify harness design in any way. …Transferring the patient: …1) Position the harness around the upper body of the patient so the sides of the harness are between the patient’s torso and arm, resting 2-3 inches below the underarm. 2) For the safety of the patient, securely fasten the safety strap around the patient’s torso. 3) Secure the buckle and pull the strap to tighten. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy, titled Fall Prevention Program, reviewed on 8/24, 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… Some interventions may include, but not limited to encourage resident to wear shoes or slippers with nonslip soles when ambulating… Each resident’s risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. Interventions will be monitored for effectiveness. The care plan will be revised as needed. When a resident experiences a fall, the facility will: assess the resident, complete post fall assessment, complete an incident report, notify the provider and resident/resident representative, review care plan and update as needed, document all assessments/observations and actions, obtain witness statements in the case of injury, neuro checks will be completed for any unwitnessed fall or witnessed fall where resident hit their head… staff to alert provider of any abnormal findings from the neuro checks… Review each fall/fall investigation during the next morning meeting/clinical meeting with the interdisciplinary team. Actions may include review investigation and determination of potential root cause of fall, review of fall risk care plan and update, additional revisions to the care plan, education of staff to as any care plan revisions as needed, scheduling care conferences, verification of timely notification of provider and responsible party. Example 1 R17 admitted to the facility on [DATE]. Her diagnoses include arthropathy (any kind of disease or disorder affecting a joint), morbid obesity, polyneuropathy (a condition where multiple peripheral nerves throughout the body become damaged or diseased), unilateral primary osteoarthritis right knee (joint condition that causes pain, stiffness and loss of movement), edema (swelling), and history of right humerus (upper arm) fracture. R17’s MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 7/21/25 indicates R17 was cognitively intact with a BIMS (Brief Interview for Mental Status) of 15 out of 15. R17’s Comprehensive Care Plan date initiated 4/2/24, target date 10/23/25, indicates R17 requires two assist, with mechanical sit to stand, and XL harness for transfers. R17’s Facility Fall Report, dated 9/12/25, includes the following: Date and Time occurred-9/12/25 9:00 PM. Incident Location: Activity Room (it should be noted that the fall occurred in R17’s room.) Initial Report: Fall was reported to RN D (Registered Nurse) that R17 had fall in evening of 9/12/25 from lift. Writer was notified and investigation initiated. Incident was witnessed. Immediate action taken: Description: Investigation completed. RN D completed skin assessment and initiated clinical follow up forms. DON, admin, on call provider updated. Resident not taken to hospital. Other information: Resident was unwilling to allow staff to reposition her properly. She would not have been lowered to the floor if she would have let us touch her legs. Power was out, backup generator functioning to red outlets. Bed was stuck in raised position and staff were unable to transfer her back to bed from commode. Statements: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA E (Certified Nursing Assistant): …in part, CNA E states that resident had requested to go on the commode, she transferred very well and safely. R17 began saying she was tired and “get me to the bed.” At this point CNA E walkied (Walkie Talkie) for second staff member. R17 began saying “no, no, no put me back on the commode”, and started to let go of the lift. Resident was beginning to slide through the straps and CNA E stated she got behind her and assisted her slowly to the ground sliding to the floor with her legs and body. Resident did not fall out of the Hoyer but did remark in having R (right) shoulder pain. CNA G: Called for fall, resident was reportedly standing in EZ stand. Reports resident did not fall from Hoyer sling. Was positioned on her back onto sling. Resident was out of it, received pain meds and within 30 min (minutes) back to normal. May have pinched her arm in the sling as she was asked to give herself a hug but was out of it and staff had to watch arm and body positioning. CNA F: …in part, [CNA E] called for help with getting resident off commode. When she went into help [CNA E] started moving her and asked her to put the bed down. Was unable to as power was out. [CNA E] told her to get the w/c (wheelchair) or commode to put under her. Resident was squatting too much and fell. On 9/17/25 at10:41 AM, CNA E indicated R17 was moved to her commode with EZ stand. She was ready to go back. Once standing she wanted to go back to the commode, but she was too low and couldn’t get her back on the commode. R17 was screaming take me back to the commode. CNA E reported the sling on her arm had come off. Surveyor asked if the sling had come off the machine, CNA E stated no; the clip was off. She stood behind R17, and she slid her down onto the floor. Called the nurse and any help we could get. Now use the Hoyer to transfer. We put her back to bed from the ground with the Hoyer. On 9/17/25 at 11:02 AM Surveyor interviewed CNA F. Surveyor asked CNA F what happened during fall with R17. CNA F reported that she told CNA E that she had to go to the bathroom and then she could help transfer R17. CNA E asked me to help but started before me. When CNA F returned CNA E was pulling her away from the commode and was stuck on the wheel of her electric wheelchair. R17 was yelling to go back to the commode. R17 started to squat down, and she tried to get the commode underneath her, but she was slowly going down. Surveyor asked CNA F how R17 could be sitting on the floor with the sling still on. CNA F reported that she didn’t think that CNA E had the harness clipped. R17 was holding onto the sides of the lift until she couldn’t hold anymore and then she let go and lowered to the floor. Surveyor asked CNA F what the policy is for lifting with the EZ stand. CNA F stated that R17 was a 2 assist for transfers. The information is on a board in the back of the staff office, or a Kardex on her door. On 9/17/25 at 2:10 PM Surveyor interviewed CNA G. CNA G reported that she had put R17 on the commode with another staff member earlier. She was called into the room for a fall R17 was sitting on the floor and her back was resting on CNA E’s legs. EZ stand was in the highest position and not lowered down. Surveyor asked CNA G how the EZ stand could be at its highest position and the patient is on the floor. “R17 doesn’t like to be strapped into the belt.” Surveyor asked how the harness was used without it being clipped shut. CNA G responded that R17 doesn’t like the sling to be buckled. The loops are hooked to the actual machine. She has it hanging there (the buckle) with her arms over the straps. CNA G reports she has been doing this for 2 years. CNA G stated R17 is very particular. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/25 at 7:32 AM Surveyor interviewed CNA H. Surveyor asked if you are transferring with an EZ stand how many staff do you have. CNA H stated EZ stand is 1 unless care planned for 2. On 9/18/25 at 7:47 AM Surveyor interviewed CNA I. Surveyor asked if you are transferring with an EZ stand how many staff do you have. CNA, I reported usually 1 unless care planned, then 2. On 9/18/25 at 9:46 AM Surveyor interviewed RN D (Registered Nurse). Surveyor asked should the buckle on the EZ stand harness be clipped during the transfer. RN D responded absolutely. On 9/18/25 Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if she would expect her staff to follow the care plan for each resident. DON B replied yes. Surveyor asked if R17 should have had two staff with her transfer. DON B replied yes. Surveyor asked DON B if the belt on the harness should have been clipped. DON B stated yes. DON B provided fall and sling sizing education that was completed on 9/16/25. (Education was started after the survey team entered the building.) Example 2 R6 admitted to the facility on [DATE] with the following diagnoses: Parkinsonism (clinical syndrome characterized by tremor, bradykinesia, rigidity, and postural instability), peripheral vascular disease (narrowed or blocked blood vessels in the limbs), unspecified dementia, repeated falls, hemiplegia (the complete paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body), and cerebral infarction (stroke). R6’s fall risk assessment, dated 4/17/25, indicates he is at risk for falls with a score of 16. R6’s Comprehensive Care Plan, effective 11/20/23, includes: 4/29/25 Wear grippers without shoes, as my current ones are rubbing on my toe. 6/16/25 Wear grippers without shoe, as my current ones are rubbing on my toe. R6’s Nurse Notes, dated 6/12/25, include: Nurse was called to the … restroom for an unwitnessed fall. Resident was found sitting on his buttocks in front of the sink, with back against the wall. He states that he needed to use the bathroom, and his common bathroom was locked. So, he transferred himself to this bathroom and fell. He denied hitting his head. Denies any pain. States his neighbor had the bathroom door locked and he needed to go so he transferred himself. States he lost his balance and fell. Assessed body alignment and for pain. Vitals assessed and WNL (within normal limits). Assisted resident into his wheelchair and back to room. Assisted with toileting and ensured his bathroom door was unlocked. Educated him on the importance of calling before transferring to prevent falls in the future. Nurse Practitioner at facility and aware of fall. Nurse Manager alerted of incident. Neurological checks initiated. Interventions discussed and put in place. R6’s Nurse Note, dated 7/30/25, includes: … was called to resident's room by CNA (Certified Nursing Assistant) via walkie (Walkie Talkie). Writer walked into resident's room and found resident on his back near his wheelchair. Resident was holding his head up and writer assessed resident and found no injury. Resident states, I slid out of my chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6’s Comprehensive Care Plan, effective 11/20/23, includes: 8/28/25 Wear gripper socks at all times, no shoes . R6’s Kardex, reviewed and updated 9/15/25, includes: wear gripper socks at all times. No shoes. On 9/17/25 at 8:00 AM Surveyor observed R6 in the dining room with regular socks on. R6 indicated in an interview that a staff member assisted him in getting ready for the day. On 9/17/25 at 9:00 AM during an interview R6 indicated he has fallen a couple times, and he has a wound on his toe that was caused by his shoes. R6 showed Surveyor the shoes he said cause the wound on his toe. On 9/17/25 at 10:14 AM during an interview CNA O (Certified Nursing Assistant) indicated she was unsure if R6 was a fall risk. CNA O and Surveyor reviewed R6’s Kardex that hung in his bathroom. On 9/17/25 at 10:15 AM Surveyor asked CNA O if R6 should have nonskid footwear on? CNA O stated, “I tried to put your shoes on this morning, and you refused.” R6 indicated his shoes hurt his feet. Surveyor and CNA O reviewed R6’s Kardex noting it states “wear gripper socks at all times. No shoes. Surveyor observed CNA O exchange R6’s socks for gripper socks/nonskid footwear. CNA O indicated the gripper socks are for fall prevention, and he can’t have the shoes due to his wound. On 9/17/25 at 2:09 PM NHA A (Nursing Home Administrator) and Surveyor reviewed R6’s Comprehensive Care Plan, 2 falls, and Kardex. NHA A indicated R6 is a fall risk and has a pressure injury on his toe caused by his shoes. Surveyor shared observation with NHA A of R6 having on regular socks. NHA A stated, “He should have gripper socks on.” On 9/18/25 at 9:22 AM [NAME] President of Clinical Operations N indicated R6 should have gripper socks on at all times.

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation and interview, the facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 47 residents who reside in the facility. Surveyor observed staff in the food preparation area without donning hair restraints. Surveyor observed frozen drips on the ceiling inside of the facility's freezer and on and inside of boxes of food that were no longer sealed by the manufacturer. Surveyor observed a stored mixer to be stored unclean. Surveyor observed [NAME] Y with his personal beverage on the food preparation counter. Surveyor observed opened boxes of juice without an open date. Evidenced by: Example 1 Facility policy, titled Dietary Employee Personal Hygiene, effective 4/2025, includes: Hair Restraints: All dietary staff must wear hair restraints, hairnet, hat, and/or beard restraint to prevent hair from contacting food. Head coverings must be clean. On 9/16/25 at 11:50 AM Surveyor observed [NAME] R in the kitchen, in the food preparation area, without a beard restraint and with a baseball cap. Surveyor also observed [NAME] Q serving lunch with a stocking cap on. During an interview [NAME] Q indicated he wears the stocking cap everywhere as he is a snowboarder and a skateboarder. Surveyor asked [NAME] Q if he has a hat that is designated just to the facility's kitchen. [NAME] Q indicated he doesn't, but he would get one. On 9/16/25 at 12:13 PM Dietary Manager P indicated NHA A (Nursing Home Administrator) told her that the men did not need beard restraints, and she was not sure which food code the facility uses as a standard of practice. Dietary Manager P indicated both [NAME] R and [NAME] Q wear their hats to the facility and to home when they leave. Dietary Manager P indicated she was unsure how often the hats are laundered or where exactly [NAME] Q and [NAME] R are wearing the hats outside of the facility. On 9/16/25 at 12:15 PM NHA A (Nursing Home Administrator) indicated staff with facial hair need hair covered and there are beard restraints available for their use. NHA A indicated the facility should designate hats for [NAME] R and [NAME] Q to keep in the facility's kitchen. Then they can wear their personal hat to the kitchen and their designated hat in the kitchen while working. Example 2 On 9/15/25 at 1:12 PM Surveyor observed the facility's mixer to be stored with all of the pieces inside the bowl. When Surveyor looked up inside of the undercarriage, Surveyor observed splatters of orange and white food substance. During an interview, Dietary Manager P indicated the mixer is unclean and she would clean it right away. On 9/15/25 at 1:40 PM NHA A indicated kitchen equipment should be stored clean. Example 3 Facility policy, titled Dietary Employee Personal Hygiene, effective 4/2025, includes: Eating and drinking is not permitted in food service or preparation areas. On 9/15/25 at 1:12 PM Surveyor observed [NAME] Y ‘s half drank can of diet Pepsi on the food preparation table along with food items that would be used to prepare resident meals. During an interview [NAME] Y and Dietary Manager P indicated staff food and beverages should be kept separate from resident food and beverages. On 9/15/25 at 1:40 PM NHA A indicated staff should keep resident food or beverages and personal food or beverages separated. Example 4 On 9/15/25 at 1:12 PM during initial tour of the facility's kitchen, Surveyor observed frozen drips on the ceiling inside of the facility's walk-in freezer. Surveyor also observed opened, unsealed boxes of vegetables underneath the frozen drips. Surveyor observed the boxes to have ice buildup on and inside of the box flaps. During an interview, Dietary Manager P indicated there is potential for the food inside of the boxes to be contaminated due to the dripping. On 9/15/25 at 1:40 PM NHA A indicated there is potential for food to become contaminated if there is dripping condensation in and on the boxes and ice built up on and in the boxes. Example 5 On 9/15/25 at 1:12 PM Surveyor observed two containers of juice in the facility's juice machine to be opened and undated. Surveyor asked Dietary Manager P when the juices were opened, and she indicated she was unsure. During an interview Dietary Manager P indicated all food and beverages that are opened should be labeled and dated with an open date or a use by date. On 9/15/25 at 1:40 PM NHA A indicated all food, and drinks should be labeled with an open date or used by date when it is opened.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interview and record review, the facility has not established an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This has the potential to affect all 47 residents (R) in the facility. The facility failed to test staff who displayed COVID-19 and norovirus symptoms. The facility failed to ensure staff wore appropriate PPE (personal protective equipment) while handling soiled linens and laundry. This is evidenced by: The facility policy, titled, Covid-19 Prevention, Response and Reporting, dated 1/2025, includes in part: Policy: It is the policy of this facility to ensure that appropriate interventions are implemented to prevent the spread of Covid-19 and promptly respond to any suspected or confirmed Covid-19 infections. Policy Explanation and Compliance Guidelines: . 2. Staff will be alert to signs of Covid-19. a. Fever or chills, b. Cough, c. Shortness of breath or difficulty breathing, d. Fatigue, e. Muscle or body aches, f. Headache, g. new loss of taste or smell, h. Sore throat, i. Congestion or runny nose, j. Nausea or vomiting, k. diarrhea. 4. The facility will establish a process to identify and manage individuals with suspected or confirmed SARS-CoV-2 infection to include: . b. Establishing a process to make everyone entering the facility aware of the recommended actions to prevent transmission to others if they have any of the following. criteria: . ii. Symptoms of Covid-19. 5. The facility will instruct Healthcare Personnel (HCP) to report any of the above criteria to the Infection Preventionist or designee for proper management. 28. The Infection Preventionist, or designee, will monitor and track Covid-19 related information to include, but not limited to a. The number of residents and staff who exhibit signs and symptoms of Covid-19. The facility policy, titled, Infection Prevention and Control Program, dated 1/2025, includes in part: Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Definitions: Staff includes all facility staff (direct and indirect care functions) . who provide care and services to residents on behalf of the facility. Policy Explanation and Compliance Guidelines: 1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious disease. staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases. 2. All staff are responsible for following policies and procedures related to the program. 9. Covid-19 Testing: a. Anyone with even mild symptoms of Covid-19. should receive a viral test for SARS-CoV-2 as soon as possible. The facility policy, titled Personal Protective Equipment, dated 12/2024, states, in part: Policy: This facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff. Definitions: Personal Protective Equipment or PPE, refers to a variety of barriers used alone or in combination to protect. skin and clothing from contact with infectious agents. It includes gloves, gowns. Policy Explanation and Compliance Guidelines: 1. All staff who have contact with residents and/or their environment must wear personal protective equipment as appropriate. in which exposure to blood, bodily fluids, or potentially infectious material is likely. 2. PPE will be utilized as part of standard precautions regardless of a resident's suspected or confirmed infection status. 4. Indications/considerations for PPE use: a. Gloves: i. Wear gloves when direct contact with blood, body fluids. is anticipated. b. Gowns: i. Wear gowns to protect arms, exposed body areas, and clothing from contamination with blood, body fluids, and other potentially infectious material. Example 1 On 9/18/25, Surveyor reviewed the Infection Control line list for the facility, which indicated, in part, the following for SM X (staff member): -Last date worked of 4/5/25. -Symptom onset date 4/6/25. -Symptoms including headache, sore throat, cold symptoms. -Comment section: blank (No indication that a Covid-19 test was performed). -Return to work date of 4/7/25. Example 2 On 9/18/25, Surveyor reviewed the Infection Control line list for the facility, which indicated, in part, the following for SM W: -Last date worked of 4/9/25. -Symptom onset date 4/14/25. -Symptoms including vomiting. -Comment section: blank (No indication that a Covid-19 or norovirus test was performed). -Return to work date of 4/15/25. Example 3 On 9/18/25, Surveyor reviewed the Infection Control line list for the facility, which indicated, in part, the following for SM U: -Last date worked of 4/13/25. -Symptom onset date 4/15/25. -Symptoms including vomiting, diarrhea. -Comment section: blank (No indication that a Covid-19 or norovirus test was performed). -Return to work date of 4/17/25. Example 4 On 9/18/25, Surveyor reviewed the Infection Control line list for the facility, which indicated, in part, the following for SM V: -Last date worked of 5/26/25. -Symptom onset date

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure they followed standards of practice for an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use for 1 (R44) of 5 residents reviewed for antibiotic stewardship.R44 was diagnosed with an acute urinary tract infection. The physician ordered the antibiotic ciprofloxacin (Cipro) 500 milligram (mg) tablet. There was no susceptibility testing done to ensure that R44's antibiotic treatment would be effective.Evidenced by:The facility's Antimicrobial Stewardship Procedure policy, dated March 2012, with last revision date of March 2024, states, in part: Policy: To ensure judicious use of antibiotics, optimize clinical outcomes while minimizing unintended consequences of antimicrobial use including toxicity, to prevent the development of pathogenic organisms. and the emergence of resistance. Procedure: 1. Antibiotic Decision Making. c. The medical provider utilizing their medical judgment and the clinical picture determines the correct treatment plan for the individual resident condition. 2. Basic Premises for all Common Infections in Long Term Care. a. Antibiotic treatment will be determined by the medical provider based on individual resident condition and clinical practice standards. These standards require the practitioner to evaluate symptoms and using their medical judgement. 3. Antimicrobial/Antibiotic orders: . e. The infection Preventionist or designee reviews any antibiotic orders entered in the electronic medical record. This review will include but not be limited to: i. Obtaining further documentation for the necessity of the treatment plan will be obtained from the medical provider as necessary. The facility's Infection Prevention and Control Program policy, dated 1/2025, states, in part: Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines . 1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious disease. 6. Antibiotic Stewardship: a. An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program. b. Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program.R44 was admitted to the facility on [DATE] with diagnoses that include chronic kidney disease, Type 2 diabetes mellitus, and urge incontinence. On 8/8/25 the facility Infection Surveillance Monthly Report indicates that R44 was experiencing pain, itching or burning in the vagina. On 8/10/25 R44 was seen in the Emergency Department (ED). R44's hospital encounter summary indicates, in part: . urinary tract infection presenting with concern for urinary tract infection with dysuria and discomfort in the area of the perineum. Patient notes that she was recently treated for urinary tract infection while she was on the antibiotics did seem as if the symptoms improved but noted that they seem to return shortly after she completed the antibiotics. R44's urinalysis results indicate, in part: . occult blood in the urine 1+. [NAME] Blood Cells (WBC) > 100. Bacteria moderate. R44 was diagnosed with an Acute urinary tract infection and ordered a 5-day course of the antibiotic ciprofloxacin (Cipro) 500 mg tablet to be taken twice daily. On 9/18/25 at 10:00 AM, Surveyor interviewed VPCO N (Vice President of Clinical Operations) about antibiotic stewardship. Surveyor asked VPCO N if there was a culture and sensitivity test completed for R44. VPCO N stated that she was looking for a culture and sensitivity in R44's electronic health record but was unable to find one. VPCO N stated of course there should have been a culture and sensitivity completed to ensure R44 was prescribed the correct antibiotic.