STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525541	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holton Manor	645 N Church St Elkhorn, WI 53121

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that residents with pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 2 (R37, R7) of 4 residents reviewed for pressure injuries.*R37 admitted to the facility with a stage IV pressure injury that had an abscess of bursa for wound management. R37 proceeded to develop two new pressure injuries while at the facility.*R7 did not have a comprehensive assessment of their right buttock pressure injury from 4/2/2026, when discovered, until 4/14/2026.Findings include:The facility Policy titled Pressure Injury Prevention and Management copyright 2026, documents: Policy: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries.Policy Explanation and Compliance Guidelines:2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate.3. Assessment of Pressure Injury [NAME]. Licensed nurses will conduct a pressure injury risk assessment. on all residents upon admission/re-admission, weekly x (times) four weeks, then quarterly or whenever the condition changes significantly.c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. Findings should include type of wound, wound measurements (measured upon discovery and at least weekly thereafter), other wound characteristics (color, exudate, odor, pain, tissue type in wound bed), and treatment and interventions implemented.d. Assessments of pressure injuries will be performed by a licensed nurse, and documented in the resident progress notes. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS.4. Interventions for Prevention and to Promote Healinga. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions.b. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics).c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to:i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.);ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination;iii. Provide appropriate, pressure-redistributing, support surfaces;iv. Provide non-irritating surfaces; ande. The goals and preferences of the resident and/or authorized representative will be included in the plan of care.f. Interventions will be documented in the care plan and communicated to all relevant staff.1.) R37 was admitted to the facility on [DATE] with pertinent diagnoses that include abscess of bursa on right hip (a serious, rare condition where the fluid-filled sac becomes infected, causing intense pain, swelling, (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Actual harm Residents Affected - Few	redness, and fever), cutaneous abscess of right hip (a painful, pus-filled lump under the skin, typically caused by a bacterial infection entering through a small cut or follicle), paraplegia (a form of paralysis affecting the lower half of the body, including both legs and sometimes the abdomen), and acquired absence of left leg below knee (refers to the surgical or traumatic amputation of the left leg below the knee joint).R37's Quarterly Minimum Data Set (MDS) with an assessment reference date of 2/25/2026, documents a Brief Interview for Mental Status (BIMS) score of 15, indicating that R37 is cognitively intact. R37 was coded to understand others and makes self understood. The MDS documents that R37 was assessed to have no behaviors exhibited during the look back period, which includes rejection of care. R37 has a catheter for elimination of bladder and is incontinent of bowel. The MDS documents that R37 was assessed as at risk of developing pressure injuries.R37's Braden Scale for Predicting Pressure Score Risk evaluation completed 11/20/2025, after R37 admitted to the facility documented that R37 was assessed as at risk with a score of 15. Surveyor noted R37 admitted with a stage IV pressure injury. R37's care plan, with start date of 11/18/2025, documents: R37 is at risk for skin breakdown, pressure injury, skin tears R/T (related to) impaired mobility, thin fragile skin, Abscess of bursa, right hip, Paraplegia, Peripheral vascular disease, Morbid (severe) obesity, moisture to folds, bowel incontinence, suprapubic catheter. R37 prefers to direct R37's own cares. R37's goal is documented as risk for skin breakdown will be minimized as evidenced by less than 1 pressure ulcers by next review with staff monitoring, education, encouragement, and approaches with a target date of 05/25/2026 .Pertinent Approach(s) include:-R37 prefers to determine how long R37 is in bed and how long R37 is in their electric WC, Start Date 03/04/2026-Ensure alternating air mattress is in place and functioning Every Shift, Start Date 11/20/2025-Foam Heel boot right foot when in bed due to paraplegia Every Shift, Start Date 11/20/2025-Roho cushion in wc (wheelchair) at all times, Start Date 11/18/2025-Chart episodes or refusals to reposition under OTHER tab, Start Date 11/18/2025-Assist to turn and reposition in bed frequently. Start Date 11/18/2025-Assist to make small frequent position changes while in chair. Start Date 11/18/2025-Educate on the risks vs (versus) benefits of staying in bed vs getting up for offloading and position changes to prevent breakdown if indicated. Start Date 11/18/2025-Avoid shearing resident's skin during positioning, transferring, and turning. Start Date 11/18/2025-Keep clean and dry as possible. Minimize skin exposure to moisture. Start Date 11/18/2025-Assess resident for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible. Start Date 11/18/2025.R37's care plan, with start date of 11/18/2025, documents: R37 has wounds to right hip/buttock, left anterior upper thigh, back of left thigh upon admission. R37's goal was for R37 will show S/S (signs/symptoms) of stabilizing, healing, and risks for further breakdown will be reduced with staff monitoring, education, and approaches by next review has a target date of 05/25/2026.Pertinent Approach(s) include:-Wound care to right hip/buttock: **Wound VAC on HOLD* Cleanse wound with wound cleanser, pat dry, gently pack with VASHE soaked kerlix (ensure to wring out so gauze is only damp, apply alginate, cover super absorbent pad and secure with paper tape daily and PRN (as needed), Start Date 04/21/2026-Alternating air mattress is in place, Start Date 11/20/2025-Use off loading boot to relieve pressure on the heel. Start Date 11/18/2025-Provide incontinence care after each incontinent episode. Start Date 11/18/2025-Use Pressure relieving cushion for pressure reduction when resident is in chair. Start Date 11/18/2025-Instruct resident to reposition self frequently when resident is in bed. Start Date 11/18/2025-Turn and reposition frequently Q (per) shift. Start Date 11/18/2025-Keep resident off area as much as possible. Start Date 11/18/2025-Assess the pressure ulcer for stage, size (length, width, and depth), presence/absence of granulation tissue and epithelization, and condition of surrounding skin weekly by wound nurse. Start Date 11/18/2025-Conduct a systematic skin inspection weekly. Report any signs of any further skin breakdown (sore, tender, red, or broken areas). Start Date 11/18/2025-Keep linens clean, dry, and wrinkle free. Start Date 11/18/2025-Keep clean and dry as possible. Minimize skin exposure to moisture. Start Date 11/18/2025R37's physician order, dated 11/25/2025, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	documents monitor skin peri (around) wound vac for skin breakdown and s/s of infection Q shift. report changes to wound NP (Nurse Practitioner), Every Shift. R37's progress note, written by Registered Nurse (RN)-M, dated 11/18/2025, documents: Skin assessment - resident has several bruises, redness to several areas and scarring. Right front - bruising to right antecubital space, top of RFA (right forearm), top of right shoulder which is faint. PICC RUE (right upper extremity). Redness to under right axilla, under abdominal fold/crease, under right groin, scar (divet) by right knee. Right bottom of foot discolored area. Left front - Left axilla redness, left elbow 2 bruised areas, left inner forearm has 2 little red spots or bumps, left upper knee with scar, left inner thigh wound 2 cm x 1cm, left puncture wound with discoloration below thigh wound, left below knee amputation scar. Back - top of right shoulder scar past sx (surgery), right back leg oval shaped raised area, red skin very dry, 2 blister like areas left buttock and slit area covered by tegaderm.Surveyor noted only one measurement for R37's left inner thigh wound was included and no assessment information, including measurements or a wound bed description, was documented including the stage iv pressure injury resident admitted with.R37's progress note, written by previous Assistant Director of Nursing (ADON)-K, dated 11/19/2025, documents: Skin assessment: pink scar tissue noted to right shin -states this was from a scrape from her w/c (wheelchair)- now resolved, large callous noted to bottom of right heel, left anterior thigh: 0.5cm x 0.5cm x 0.5cm depth, 100% dry smooth pink tissue, pt (patient) states this is from a previous surgery, back of left inner thigh: 1cm x 0.5cm (50% scar tissue/50% pink tissue) scant amount of serous drainage noted, 1cm x 1cm blister below this area noted, skin prep applied and foam dressing to pink/scarred area -per patient, redness noted to bilat (bilateral) axilla and groin/[NAME] - per pt uses miconazole cream to these areas - areas cleansed with soap and water and cream applied, mepilex removed from coccyx, no redness or open areas to coccyx, bruise/greenish noted to right shoulder and outer aspect of right elbow, right buttock: x2 scabs both 1cm x 1cm, Right hip wound: 5cm x 8cm x 12cm at deepest point, slough visible at base, 80% granulated, large amount of serosanguinous drainage noted, slight malodor - resolved after cleaning wound, packed with Vashe soaked gauze and covered with ABDs and tape per patient, orders obtained for all of the above per Physician Assistant (PA)-J will add to wound rounds.R37's note from previous ADON-K to PA-J, dated 11/19/2025, documents: They were packing the large area on right hip Vashe moistened gauze roll and covering with ABDs (abdominal pads) and medipore tape. And for left ant (anterior) thigh: hydrogel and gauze with tape, back of left thigh. with blister below/skin prep applied f/b (followed by) foam border PA-J responded to message what was etiology of the hip wound? Those sound good to continue.R37's progress note, written by previous ADON-K, dated 11/25/2025, documents: Writer completed wound rounds with PA-J, left upper anterior thigh assessed: 3.5cm x 0.5cm, pt states this is from a previous surgery- dry pink tissue noted - cont. (continue) with hydrogel to this area, back of left thigh: 1.7cm x 1,6cm x<0.1cm and dry pink tissue/scar tissue - may cleanse with Vashe and apply foam dressing per pt preference, Right hip ulcer: 3.5cm x 11.3cm x 10.5cm at deepest point, edges irregular, peri wound is irritated from tape - skin prep applied, NOR for wound vac with black foam to be changed 3x/(times per) week and PRN, pt in agreement with this tx (treatment), Vac applied, pt tol (tolerated) well, no s/s of infection noted, pt has air mattress, education provided on being cautious with transfers etc, shifting weight to left side instead of right side where the wound is, okay to use beezy board with therapy per PA-J therapy team updated.R37's progress note, written by previous ADON-K, dated 1/6/2026, documents: Writer completed wound rounds with PA-J, wound to right hip/buttock assessed: 2.5cm x 8.4cm x 7.9cm, wound bed= 100% granulated tissue, no bone/facia etc. palpable, wound (previous bridged area from wound vac site): 2cm x 2.9cm x 0.2cm and is 100% granular with central ecchymottic tissue - NOR (new order received) for xeroform to this area, new linear DTI(deep tissue injury)/ecchymotic tissue above large ulcer and proximal to the previous area of skin break down above old vac site: 1.9cm x 1.7cm, pt states she does not know how this happened, appears to be from pressure, electric w/c has metal pieces with padding that this could likely be from, Additional new OA (open area), very (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	superficial likely from tape: 1.5cm x 1.2cm- clean pink non-granular tissue base - NOR for xeroform and foam dressing to this area. education provided to pt on importance of repositioning and not sitting up in her w/c for extended amounts of time, pt states she often sits in chair from when she gets up until 10pm, Dressing change (Vashe) for large hip ulcer changed to once/day per patient request as she states BID (twice daily) is not sustainable, education provided, unable to place wound vac as planned d/t (due to) surrounding tissue/skin breakdown, pt has air mattress, pressure relief cushion and takes protein shakes.R37's progress note written on 02/03/2026, at 10:17 AM, documents: Wound improving, air mattress and pressure reduction interventions in place. Refusing protein supplements but resident buys own high protein food items and is very aware of interventions to assist with wound healing. Wound is improving, no s/s of infection noted. No pain noted, tolerating wound vac without issues.On 11/25/2025, R37 was seen by PA-J for initial evaluation after admitting to facility. R37's progress note documents: Evaluation of right hip postoperative wound as well as left medial thigh wound. R37 is seen today for wound care initial evaluation. Patient is a T9 paraplegic with a complex past medical history, most recently hospitalized due to right hip cutaneous abscess related to a pressure wound infection. She states that recently she had developed a pressure wound related to her hospital bed which became secondarily infected. She was hospitalized on [DATE] underwent surgical debridement resulting in a large postoperative wound. She has been discharged on IV antibiotics including vancomycin and meropenem. There was discussion about initiation of a wound VAC however this was not started prior to her discharge. In addition she has a left medial thigh wound as well as a left anterior lateral thigh healing wound. She denies any fevers or chills. She has a right arm PICC line in place. She denies any other complaints at this point in time.Interventions in place are documented as: Heel offloading with heel offloading boots or pillows as tolerated by patient. Turn and reposition every 2-3 hours with assistance as needed. Dietary collaboration, PT/OT (physical therapy/occupational therapy) collaboration.Wound #1Type: Full-thickness surgical wound; Site: Right lateral hip; Dimensions: 3.5 x 11.3 x 10.5 cm; Wound bed: Appears red and pink tissue with muscle and fascia noted to the wound bed deep, no bone exposed, no obvious slough or necrotic tissue apparent; Drainage: Moderate sanguinous; Periwound: Moist but intact; Status: Present on arrival, improved.Plan: Given depth, location, and size with the amount of drainage she is having she is a candidate for negative pressure wound therapy. Apparently this had been discussed prior to her even leaving the hospital but was not initiated. Patient has had wound vacs in the past for a left thigh wound as well. She is agreeable with starting today. Wound VAC was applied, see below. This will be changed 3 days/week with pressure set at 125 mmHg.Wounds #2 and #3 were assessed as partial thickness abrasions that were present on arrival.Surveyor noted R37 was seen 12/2/2025 by PA-J with assessments and treatments. Surveyor noted that at the time, the abrasions are deemed healed and R37's stage IV pressure injury was assessed weekly and treated appropriately by PA-J.On 12/9/2025, R37 was seen by PA-J and the progress note documents: R37 seen today for wound care follow-up. Events noted, VAC has been able to stay in place over the weekend with good suction. Continues to have issues with incontinence to the perineum area and the backside and has been trying to have the draw sheet and Chux changed out regularly. Denies any fevers or chills.A new wound is added to the evaluation. Type: partial-thickness pressure related unstageablel Site: right lateral hip/thigh; Dimension: 2.2 x 2.0 x UTD (unable to determine) cm; Wound bed: 50% slough 50% pink tissue; Drainage: small serosanguineous; Periwound: macerated edges with poorly defined edges; Status: stablePlan: Continue Medihoney with foam border. This is related to maceration from incontinence as well as pressure related from the bridging from the VAC device. Attention is being made to avoid these areas with continuation of the VAC device for the surgical wound.On 12/16/2025, R37 is seen by PA-J and the partial thickness pressure related unstageable remains to the right lateral hip/thigh. The new dimensions are 1.8 x 1.7 x UTD cm with same characteristics from 12/9/2025. The status is stable and the treatment remains the same.On 12/23/2025, R37 was seen by PA-J and wound type is changed to partial-thickness pressure related now able to classify as (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	stage III post debridement to the right lateral hip/thigh. The assessment documents: Dimension: 2.4 x 2.9 x 0.2 cm post debridement; Wound bed: prior to debridement 100% slough which was necrotic appearing, post debridement 90% pink tissue, 10% scattered ecchymotic tissue; Drainage: small serosanguineous; Periwound: macerated edges with poorly defined edges be defined post debridement; Status: stalled.Plan: Site was debrided today. Post debridement, adjust to silver alginate with foam border changing 3 times weekly and as needed.On 12/30/2025, R37 is seen by PA-J and the wound type remains partial-thickness pressure related now able to classify as stage III to the right lateral hip/thigh. The assessment documents: Dimension: 3.7 x 2.7 x 0.2 cm post debridement; Wound bed: 60% granular with 40% slough post aggressive scrubbing of the wound; Drainage: small serosanguineous; Periwound: macerated edges with well defined edges; Status: improved; Plan: will adjust to hydrafera blue followed by foam border changing 3x per week and as needed. Continue offloading the site.On 1/6/2026, R37 was seen by PA-J the partial-thickness pressure related now able to classify as stage III to the right lateral hip/thigh remains. The assessment documents: Dimension: 2.0 x 2.9 x 0.2 cm; Wound bed: 100% granular with central area approximately half centimeter area of ecchymotic changes similar to prior; Drainage: small serosanguineous; Periwound: macerated edges with well defined edges; Status: stable; Plan: will adjust to Xeroform gauze followed by foam border changing 3x per week and as needed. Continue offloading the site.A new DTI (deep tissue injury) superior to the pressure wound was added to the 1/6/2026 assessment. The assessment documents: Dimension: linear DTI measuring 1.9 x 1.7 ; Wound bed: 100% ecchymotic linear; Drainage: none; Periwound: dry and fragile; Status: new; Plan: skin-prep to the site and will be covered by foam border given the location related to the adjacent pressure wound continue offloading.On 1/13/2026, R37 is seen by PA-J the partial-thickness pressure related now able to classify as stage III to the right lateral hip/thigh remains. The assessment documents: Dimension: 2.4 x 2.5 x 0.2 cm; Wound bed: 100% granular with no further ecchymotic changes; Drainage: small serosanguineous; Periwound: no further maceration of the edges; Status: stable; Plan: will apply collagen powder to the wound bed followed by foam border changing 3x per week and as needed. Continue offloading the site.The DTI superior to the pressure wound is assessed as: Dimension: linear DTI measuring 2.6 x 2.5 cm; Wound bed: 100% slough; Drainage: small serosanguineous; Periwound: poorly defined edges, mild maceration; Status: stable; Plan: will adjust to Xeroform gauze followed by foam border. Will change 3 times per week as needed.On 01/20/2026, at 02:40 PM, R37's progress note documents: Writer completed wound assessment on pt. DTI to right buttock is 100% resolved. wound superior to vac site while pt side laying position: 2.5cm x 3cm with Ecchymotic center 0.5cm x 0.25cm - cont. (continue) with collagen to this area.On 1/27/26, R37 is seen by PA-J the partial-thickness pressure related now able to classify as stage III to the right lateral hip/thigh remains. The assessment documents: Dimension: 2.0 x 3.1 x 0.2 cm; Wound bed: 100% granular; Drainage: small to moderate serosanguineous; Periwound: no maceration of the edges; Status: stable; Plan: will apply collagen powder to the wound bed followed by foam border changing 3x per week and as needed. Continue offloading the site.The DTI superior to the pressure wound is assessed as: Dimension: closed; Wound bed: 100% epithelialized; Status: resolved; Plan: will leave the area open to air but obviously continue to protect as this is being closed with the VAC apron.On 2/3/26, R37 is seen by PA-J the pressure wound to the right lateral hip remains. The assessment documents: Dimension: 1.9 x 2.1 x 0.1 cm; Wound bed: 100% granular; Drainage: moderate, described as sanguineous; Periwound: no maceration, dry and intact; Status: improved; Plan: collagen matrix to the wound bed with calcium alginate overlying, foam border dressing, change three times per week.On 2/10/26, R37 is seen by PA-J the pressure wound stage III superior medial to hip wound remains. The assessment documents: Dimension: 1.5 x 1.5 x 0.1 cm; Wound bed: 100% granular; Drainage: moderate serous drainage; Periwound: no maceration or erythema; Status: improved; Plan: will continue with collagen to the wound bed with calcium alginate overlying for drainage control followed by foam border changing three days per week.On 2/17/26, R37 is seen by PA-J the pressure (stage III) to the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	right lateral hip remains. The assessment documents: Dimension: 1.0 x 1.8 x 0.2 cm; Wound bed: 100% granular; Drainage: scant serosanguinous; Periwound: no maceration or erythema; Status: improved; Plan: collagen with calcium alginate and foam border; dressing changes three days per week.On 2/24/26, R37 is seen by PA-J the pressure ulcer, stage III medial to stage IV surgical wound remains. The assessment documents: Dimension: 1.0 x 1.9 x 0.1 cm; Wound bed: 100% granular; Drainage: scant, serosanguinous; Periwound: no erythema; Status: stable; Plan: collagen with foam border, dressing change three days per week.On 3/3/26, R37 is seen by PA-J the pressure (stage III) lateral to stage IV surgical wound remains. The assessment documents: Dimension: 0.6 x 1.6 x 0.1 cm; Wound bed: 50% epithelialized, 50% granular; Drainage: scant sanguinous; Periwound: no erythema, no maceration; Status: improved; Plan: collagen; foam border; dressing change 3 times per week.On 3/10/26, R37 is seen by PA-J the pressure ulcer (stage III) lateral hip right remains. The assessment documents: Dimension: 0.4 x 0.8 x <0.1 cm; Wound bed: 75% epithelialized, 25% granular; Drainage: none; Periwound: dry intact; Status: improved; Plan: collagen with foam border dressing; change 3 days per week.On 3/17/26, R37 is seen by PA-J the stage III pressure wound medial to stage IV hip wound is deemed healed. The assessment documents: Dimension: closed; Wound bed: 100% epithelialized; Drainage: none; Periwound: intact; Status: resolved; Plan: discontinue active wound dressing; monitor for skin integrity.Surveyor noted R37 continues to be seen by PA-J for the stage IV surgical wound and no additional wounds were present.On 05/05/2026, at 12:44 PM, Surveyor interviewed PA-J regarding R37's wound care. PA-J stated that the previous ADON-K assessed the stage IV surgical wound upon R37 admitting and reached out to PA-J for orders on treatment. PA-J started R37 on the wound VAC after the initial evaluation. Surveyor asked how the two new wounds started and was told the first was from the wound VAC bridging. The second was from R37's power wheelchair, PA-J showed Surveyor a hard edge next to the seat cushion in the wheelchair. PA-J stated that R37 is actively trying to get a consult for the initial stage IV wound to be closed up surgically, R37 is on a waiting list. On 05/06/2026, at 11:38 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and asked if facility knew R37 was at risk for pressure injuries as R37 admitted with one, what was being done to prevent more pressure injuries while R37 resided in the facility. NHA-A stated will look at everything for R37 and get back to Surveyor. On 05/06/2026, at 2:00 PM, Surveyor followed up with NHA-A and was told Licensed Practical Nurse (LPN)-L was printing information now. Surveyor stated would review what was given, however the concern is what was done to prevent two new pressure injuries from starting.On 05/06/2026, at 2:39 PM, LPN-L told Surveyor R37 has an air mattress and takes a multivitamin. R37 was provided a bigger roho cushion for R37's wheelchair.Surveyor noted these interventions were on R37's care plan, yet two new pressure injuries developed. Surveyor noted R37 was admitted for care of the stage IV pressure injury, the risk of additional skin breakdown was known. R37's physician order, dated 11/25/2025, documents monitor skin peri (around) wound vac for skin breakdown and s/s of infection Q shift. report changes to wound NP (Nurse Practitioner), Every Shift. Surveyor noted the first wound started due to the bridging of the wound vac. Surveyor received additional information on 5/14/2026, Surveyor reviewed the information, which included the same Wound Care Assessments done weekly by Wound PA-J and facility wound care documentation by previous ADON-K. No new details were provided to prove the pressure injury development was unavoidable. Both pressure injuries developed in the facility. One was due to the wound vac bridging and there was an order in place to monitor skin peri (around) wound vac for skin breakdown. The other was suspected from R37's wheel chair rubbing and a new cushion was deemed necessary after the wound developed. Proper monitoring by the facility could have had the potential to prevent these new pressure injuries from developing. No additional information was provided. 2.) R7 was admitted to the facility on [DATE] with pertinent diagnoses that include systolic and diastolic heart failure with respiratory failure (both types of heart failure, sometimes occurring together, cause substantial lung dysfunction, decreased oxygenation, and increased mortality risk. Both can cause acute respiratory failure by creating high pulmonary (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holton Manor	645 N Church St Elkhorn, WI 53121

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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 0686 Level of Harm - Actual harm Residents Affected - Few	pressures that lead to pulmonary edema and congestion.), dysphagia (difficulty swallowing), and gastrostomy (a surgically created opening in the abdomen that connects to the stomach, often for the purpose of feeding or administering medication).R7's 5 day Minimum Data Set (MDS) with an assessment reference date of 4/25/2026, documents a Brief Interview for Mental Status (BIMS) score of 15, indicating that R7 is cognitively intact. R7 was coded to understand others and make self understood. The MDS documents that R7 was assessed to have no behaviors exhibited during the look back period, which includes rejection of care. The MDS documents that R37 is at risk of developing pressure injuries.R7's Braden Scale for Predicting Pressure Score Risk evaluation completed 3/18/2026 after R7 admitted to the facility documented that R7 was assessed as moderate risk with a score of 14.R7's care plan, with start date of 4/02/2026, documents: R7 is at risk for skin breakdown, pressure injury, skin tears r/t (related to) impaired mobility, thin fragile skin, recent CABG, foley, bed bound, g-tube, necrotic tissue in mouth d/t (due to) intubation. R7 prefers to spend most of her time in bed and needs encouragement to get up for position change. Folds and groin have redness. R7's goal is R7's risk for skin breakdown will be minimized as evidenced by less than 1 pressure ulcers by next review with staff monitoring, education, encouragement, and approaches and has a target date of 7/21/2026.Pertinent Approach(s) include:-Make sure bilateral heels are clean and intact, apply skin prep twice a day. Start date 4/7/2026.-Avoid shearing resident's skin during positioning, transferring, and turning. Start date 4/2/2026.-Chart episodes or refusals to reposition under OTHER tab, Start Date 4/2/2026-Educate on the risks vs (Versus) benefits of staying in bed vs getting up for offloading and position changes to prevent breakdown if indicated. Start Date 4/2/2026-Encourage & assist to make small frequent position changes while in chair. Start Date: 4/2/2026-Encourage & assist to turn and reposition in bed frequently. Start Date 4/2/2026-Float heels to reduce the risk of pressure and friction, Start Date 4/2/2026R7's care plan, with start date of 4/15/2026, documents: Problem: R7 has a pressure ulcer to R (right) buttock. R7's goal is R7 will show no S/S (signs/symptoms) of infection to wound and risks for further breakdown will be reduced with staff monitoring, education, and approaches by next review and has a target date of 05/29/2026 .Pertinent Approach(s) include:-Use off loading boots or pillows to relieve pressure on the heels. Document refusals, Start Date 04/21/2026-Alternating air mattress in place for pressure relief and off loading, Start Date 04/21/2026-Use Pressure relieving cushion for pressure reduction when resident is in chair. Start Date 04/21/2026-Turn and reposition frequently Q shift. Start Date 04/21/2026-Pressure sore to R buttock: Cleanse with normal saline, pat dry, apply Triad paste BID (Twice A Day), Start Date 04/21/2026-Keep resident off area as much as possible. Start Date 04/21/2026-Keep linens clean, dry, and wrinkle free. Start Date 04/21/2026-Instruct resident to reposition self frequently when resident is in bed. Start Date 04/21/2026R7's physician order documents: Ensure alternating air mattress is in place and functioning properly for pressure relief and off loading, every shift.R7's 4/2/2026 physician order documents: Assist with repositioning and floating heels in bed frequently. HOB > 30 degrees at all times.R7's 4/2/2026 physician order documents: Heel boots on at all times while in bed d/t (due to) DTI (deep tissue injury), risk for skin breakdown.Surveyor noted R7 admitted to the facility on [DATE], R7 readmitted to the hospital from [DATE] to 4/2/2026. On 3/29/2026 while in the hospital there was a skin assessment that documented no skin issues for R7.R7's progress note dated 04/02/2026, written at 07:20 PM, documents: Skin assessment.Resident has 2 deep tissue injury's noted - 1 to each heel. Left heel 0.4x 0.4 - right heel 0.5 x 0.2 - no drainage, dark tissue, DTI (deep tissue injury). Education done with daughter and resident on importance of using heel boots, states understanding. Stage II pressure ulcer noted to left buttock, 3cm x 3cm x 0.1 - 100% pink wound bed, non granulation, no drainage noted. No pain or s/s (signs/symptoms) of infection noted. New order for TRIAD paste BID until resolved. Message left to request air mattress d/t (due to) current pressure ulcers and high risk for skin breakdown.Surveyor noted Nursing Home Administrator (NHA)-A verified the air mattress was delivered 4/3/2026 for R7. Surveyor noted the stage II pressure ulcer was on the right buttock

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review. the facility did not ensure each resident received adequate supervision to prevent accidents for 1 (R16) of 2 residents reviewed for accidents.* R16 was not provided with the prescribed therapeutic diet and choked on food. R16 was sent to the hospital with a diagnosis of aspiration pneumonia (lung infection caused by inhaling a foreign material such as food). R16 was to be supervised intermittently while eating. R16 was observed not being intermittently supervised while eating and was left alone in the dining room for 20 minutes with no facility staff during noon meal on 5/4/2026 and 13 minutes at breakfast meal on 5/5/2026.Findings include:The facility policy titled, Therapeutic Diet Orders with no initiated, reviewed, or revised date documents: Policy: The facility provides all residents with foods in appropriate form and/or appropriate nutritive content as prescribed by a physician, and/ or assessed by the interdisciplinary team (IDT) to support the resident's treatment/ plan of care, in accordance with his/ her goals and preferences.Policy Explanation and Compliance Guidelines: 2. Therapeutic diet, including mechanically altered diets where appropriate, will be based on the resident's individual needs as determined by the resident's assessment.3. Therapeutic diets are provided only when ordered by the attending physician or a registered/ licensed dietician who has been delegated to write orders to the extent allowed by state law. Should the attending physician delegate the prescribing therapeutic diets, he or she will supervise the dietitian and remain responsible for the resident's care.4. The reason for a therapeutic diet is to be documented in the medical record and/ or indicated on the resident's comprehensive plan of care. All diet orders are to be communicated to the dietary department in accordance with facility procedures.5. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form.The facility policy titled, Foreign Body Airway Obstruction Management (Choking) with no initiated, reviewed, or revised date documents: Policy: It is the policy of this facility to ensure that residents will be effectively managed if a foreign body airway obstruction (FBAO) occurs. Policy Explanation: Foreign bodies can cause mild or severe airway obstruction and can affect anyone. Residents with impaired swallowing, neurological disorders or dental issues are at increased risk for foreign body airway obstruction.Compliance Guidelines:2. Residents should be assessed to determine if they are at higher risk for foreign body obstruction/ choking episodes and care planned accordingly. Consult the speech pathologist as needed.7. The facility will ensure that residents who have impaired swallowing issues are on an altered diet and receiving the appropriate diet.10. Document the event and response to the interventions implemented.R16 was admitted to the facility on [DATE] with diagnoses that include spastic hemiplegia affecting the right dominant side, dysphagia, traumatic brain injury (TBI), unspecified psychosis, vascular dementia with agitation and behavioral disturbance, and persistent affective mood disorder. R16's Quarterly Minimum Data Set (MDS) dated [DATE] indicated R16 was assessed to have moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 9. The MDs documents that R16 was assessed as needing supervision with eating.R16's Nutritional Status Care Area Assessment (CAA) dated 9/10/2025 documents: (R16) at facility for long term placement with a history of dysphagia. Diet is Dysphagia 3 (soft, moist foods that require minimal chewing), soft to chew, mechanical soft foods with nectar thick liquids. (R16) can feed self but needs supervision. (R16) uses adaptive equipment with meals to assist with feeding self. R16's at risk for aspiration due to dysphagia with poor positioning care plan dated as started on 11/10/2020 documents: R16 frequently chooses not to follow speech therapist (ST) recommendations such as educated to take small bites and R16 will put large bites into mouth on purpose. R16 becomes agitated with eating with small spoons and demands to have a fork for independence. R16 can become agitated at meals if R16 feels as if staff is looming over him and with education given. R16 has the following interventions initiated: - Diet as ordered per medical doctor (MD).- Monitor for signs/ (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	symptoms of aspiration pneumonia.- Monitor need for changing diet consistency to increase ease of eating.- Observe resident closely for signs of difficulty swallowing and/or aspiration.- Obtain dietary consultation, flow recommendations.- Offer available substitutes if resident has problems with the food being served.- Provide assistance with meals such as set-up help, cueing, supervision.- Speech therapy consult, follow recommendations.- Thicken all liquids before serving.- Use aspiration precautions.R16's alteration in nutritional status care plan dated as started on 11/5/2020 documents: R16 requires Dysphagia 3 diet easy to chew, and mechanical soft foods with nectar thick liquids per MD orders. R16 has history of aspiration pneumonia. Dysphagia- oropharyngeal phase, TBI, and dementia. R16 at times will become agitated with small utensils and throw them on the floor. R16 will demand to use regular sized utensils at times.R16 has the following interventions initiated: - Dietician consult as needed (start: 1/24/2022)- Monitor for any chewing/ swallowing problems and report to nursing.- Set up and assist all meals as needed.- (R16) requires set up all meals, eat slowly, encourage to stay upright for 30 minutes after eating. (Start: 3/4/2022)- Dysphagia 3- Easy chew with nectar liquids. (Start date: 11/5/2020, edited 7/7/2022)- Intermittent supervision with eating. Encourage to eat slowly. Assist with setting up tray, encourage small bites alternating solids and liquids frequently. Encourage use of small spoon, may have a regular fork with foam grip. (Start: 7/8/2022, edited: 6/10/2025)On 5/4/2026, at 11:40 AM, Surveyor interviewed Family Member-N who stated R16 had a choking episode at supper a couple months ago and had to be sent to the hospital. Family Member-N stated R16 has a tendency to eat very fast and will choke on food so R16 has to be supervised frequently and told to slow down while eating.R16's progress note dated 3/1/2026, at 5:28 PM, written by Licensed Practical Nurse (LPN)-O documented: R16 was eating in dining room and started to throw up a lot of phlegm. LPN-O noted food on the floor R16 coughed up. R16 continues to cough up phlegm and at this time is able to say a few words. R16's coloring in face is improving. Vital signs: blood pressure- 116/80, oxygenation- 91% room air, pulse-98, respirations- 17, temperature-98.4 degrees Fahrenheit. Orders received to send R16 to emergency room for further evaluation.R16's hospital after visit discharge note dated 3/1/26 documents: Diagnosis- Aspiration PNA (pneumonia).R16's progress note dated 3/1/2026, at 9:05 PM, written by LPN-O documented: R16 returned back to facility with diagnosis of aspiration pneumonia. Orders received for doxycycline (antibiotic) 100mg- 1 tab twice a day for 5 days. R16's at risk for aspiration care plan was revised with the following interventions:- ST (speech therapy) guidelines: supervision with eating. Encourage (R16) to eat slowly, assist with tray set up, use [sic] table close to trunk, encourage small bites alternating solids and liquids frequently. Encourage use of small spoon, uses sip cup and remind to clear throat and to stop to breath. (start: 3/4/2026)- Speech to evaluate.- DIET: mechanical soft with nectar liquids (start: 4/17/2026)- R16's legal guardian/ power of attorney (POA) desires to bring foods from home. POA has been educated on recommended diet and risk/benefit. R16's POA understands but preference is to bring upgraded foods and diet deviation form signed. Family must supervise closely if they give R16 regular foods. Staff will continue with diet as recommended/ ordered. R16's nutritional status care plan was revised with the following interventions:- Remind to go slow, stop, breath, clear throat 3 times throughout the meal. Place utensils near left side. Keep table close to trunk, supervise (Start: 3/4/2026)- Provide adaptive equipment with all meals to aid with independence. Inner lip plate, mat, covered cups, small spoon. (start: 4/17/2026)- Provide small spoon at meals to assure [sic] (R16) takes small bites. Give education if refusing to use small spoon and covered cups.- (R16's) POA prefers to bring in foods from home with visits. Diet deviation form signed and educated on risk/ benefit. (start 4/20/2026)Surveyor reviewed R16's certified nursing aide (CNA) care card and noted the following intervention started on 3/4/2026:-Problem category-Nutritional status- remind to go slow, stop, breath, clear throat three times throughout the mean. Place utensils near left side. Keep table close to trunk, supervise.Surveyor noted no interventions were in place on the CNA care card prior to 3/4/2026 and was unable to locate a therapeutic diet order on the care card to notify CNA's what R16's diet is supposed to be.On 5/4/2026, at 12:30 PM, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor observed R16 sitting in the dining room at R16's table waiting for lunch to be served. On 5/4/2026, at 12:43 PM R16 received a meal tray and was noted to be moving R16's food around with a fork.On 5/4/2026, at 1:00 PM Surveyor overheard a CNA state R16 will probably not eat because R16 had a late lunch. Surveyor noted nursing staff leave dining room and noted R16 was left in the dining room with no supervision from facility staff. R16 was noted to start eating R16's lunch. R16 was noted to have a neck tilt to the left side and upper body was tilted and slumped over R16 left side. On 5/4/2026, at 1:27 PM Surveyor noted facility staff come into the dining room and asked if R16 was finished with lunch and cleaned up R16's dining spot. Surveyor noted that R16 was not being supervised while eating on 5/4/2026 from 1:00 PM to 1:27 PM.On 5/5/2026, at 9:19 AM, Surveyor observed R16 brought to dining area for breakfast. Surveyor observed 1 CNA in the dining room assisting another resident to eat and the CNA's back was facing R16. R16 started to eat breakfast. Surveyor noted the CNA did not turn to look at R16 while R16 was eating.On 5/5/2026, at 9:32 AM, another CNA came into the dining room and sat at the table next to R16 to assist another resident with breakfast. Surveyor noted that R16 did not get supervision with breakfast meal for 13 minutes or from 9:19 AM to 9:23 AM. On 5/5/2026, at 2:18 PM, Surveyor interviewed ST-P who stated R16's diet is International Dysphagia Diet Standardization Initiative (IDDSI) level 6 (soft and bite sized- moist, tender, and soft foods that do not require a knife to cut). ST-P stated R16 needs supervision during meals due to R16 having frequent episodes of coughing while eating because R16 tends to put a lot of food in R16's mouth at once. R16 will not eat if someone is sitting close to R16 or tells R16 how to eat, but staff should be close by R16 and within eyesight of R16. Staff should be facing R16 because of how R16 leans to the left side and staff should not have their back to R16 when supervising R16 to eat. ST-P stated R16 must always be supervised while eating due to recent episodes of R16 unable to clear the food out of his mouth and having to be sent to hospital for evaluation. On 5/5/2026, at 3:22 PM, Surveyor interviewed LPN-O who stated LPN-O was called to the dining room on 3/1/2026, due to R16 choking and coughing a lot. LPN-O stated by the time LPN-O got to the dining room, R16 had cleared what was causing R16 to cough. LPN-O saw floor on the floor and R16 was coughing up a lot of phlegm. LPN-O stated at that time R16's face was red and breathing easier. LPN-O received an order to send R16 to hospital for further evaluation and R16 came back later that night with an order for antibiotics due to aspiration pneumonia. LPN-O stated R16 should be supervised or have eyes on R16 while eating. LPN-O stated was passing medications at the time and was not in the dining area during R16's incident on 3/1/2026. On 5/6/2026, at 12:09 PM, Surveyor interviewed CNA-S who stated the meal that night was a taco dish. CNA-S was assisting another resident with eating and a family member of another resident alerted CNA-S that something was wrong with R16. CNA-S went to R16 and noted R16 to be a little purple in the face and was coughing/ vomiting food out. CNA-S noted there were shreds of lettuce and R16 was not supposed to get lettuce. CNA-S called LPN-O and R16 was assessed and sent to the hospital. CNA-S stated R16 received the supper meal tray, and no one checked the tray before R16 started to eat from it. CNA-S stated when a resident is supervised during meal, the resident has to be checked on to make sure the resident is eating ok and does not need any assistance. CNA-S stated R16 does not like to be watched when eating but still have to check to make sure R16 is ok.On 5/6/2026, at 12:23 PM, Surveyor interviewed Cook/ CNA-R who was working as a CNA on 3/1/2026. Cook/CNA-R was assisting another resident with eating in the dining area and heard CNA-S ask for help. Cook/CNA-R stated R16 received shredded lettuce and was not supposed to due to the therapeutic diet R16 is on. Cook/CNA-R stated the meal slips are color coded according to what diet the resident is to get. R16 has a yellow slip and documents the diet R16 is to have which is mechanical soft and documents foods R16 is not to get. Cook/CNA-R believes the cook that night on 3/1/2026 just did not look at R16's slip and feels that is why R16 received the wrong diet, and no one caught it. Cook/CNA-R stated R16 is not very complainant with R16's diet and R16's family brings R16 regular foods, but staff needs to supervise R16 to make sure eating ok and not putting too much into R16's mouth.On 5/6/2026, at 12:41 PM, Surveyor interviewed dietary supervisor-T who recalled (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	being notified R16 was provided with the wrong therapeutic diet on 3/1/2026 and received shredded lettuce, had an episode of choking or coughing the food up and was sent out to the hospital for further evaluation. Dietary supervisor-T spoke with the cook on duty during evening meal and the cook stated not sure what happened, just made a mistake and probably did not read the ticket close enough. Dietary supervisor-T stated meal tickets are color coded according to what diet a resident should get and listed on the tickets what the resident cannot have. R16 should not have received shredded lettuce. On 5/6/2026, at 1:30 PM, Surveyor was provided with an infection tracker document for R16 for the antibiotic R16 was prescribes for diagnoses of aspiration pneumonia from 3/1/2026. Surveyor asked NHA-A if there was an investigation or root cause completed for R16's choking incident on 3/1/2026. NHA-A stated there was not because R16's issue is not new and interventions are implemented for R16.Surveyor notified NHA-A that R16 was provided with the wrong diet on 3/1/2026 and received shredded lettuce and that it was what R16 choked on. NHA-A stated NHA-A was not aware of R16 receiving the wrong diet and receiving shredded lettuce. Surveyor shared concerns with NHA-A of Surveyors observations on 5/4/2026 R16 was not supervised during noon meal for 20 minutes and not supervised for breakfast meal on 5/5/2025 for 13 minutes. NHA-A replied staff should check on periodically and does not need to be watched all the time. Surveyor informed NHA-A per ST-P staff should be in eyesight of and facing R16 and not be left alone when eating food. NHA-A stated that it was not relayed to NHA-A and will clarify R16's interventions and revise the care plan. Surveyor informed NHA-A that R16 was not supervised per R16's care plan during breakfast and noon meals, R16 was provided with a wrong diet on 3/1/2026 resulting in R16 having to go to the emergency room for evaluation and was diagnosed with aspiration pneumonia and required an antibiotic. NHA-A understood Surveyors' concerns and would be looking into the concerns.No additional information was provided at the time of write up.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an effective infection prevention and control program or sanitary environment to help prevent the development and transmission of communicable diseases and infections potentially affecting 53 of 53 residents and 1 (R23) of 2 residents reviewed with indwelling urinary catheters. *The facility did not have a system for identifying potential infections utilizing a line list of symptomatic residents and did not report monthly infections with the calculations of rates of infection. Respiratory outbreaks did not have a summary to show an investigation of the source of transmission and the control of the infection. The facility did not use the data collected on infections to apply corrective action. *Linens were not handled in a sanitary manner to prevent the spread of infection. *The facility did not review policies and procedures on an annual basis, and the facility pneumococcal vaccine policy did not have the current immunizations documented. *R23's indwelling urinary catheter bag was observed on 5/4/2026 and 5/6/2026 to be on the floor with no barrier. Findings include: The facility policy and procedure titled Infection Control Policy, undated, documents: Policy Guidelines: Standard Precautions are used for all patient care. They're based on a risk assessment and make use of common sense practices and personal protective equipment use that protect healthcare providers from infection and prevent the spread of infection from patient to patient. 3. All residents will be assessed by licensed personal [sic] on a continuous basis for early detection, intervention and treatment of any infection or possible infection. Such determination is based on several factors. This includes, but is not limited to: A. Date of Event: The date of event is defined as the date when the first clinical evidence (signs/symptoms) appeared or the date the specimen used to make or confirm the diagnosis was collected, whichever comes first. The infection control nurse complies [sic] monthly infection control information in the Infection Control Log. Including, but not limited to: A. Resident name B. Room number and unit in facility C. Date of onset D. Site E. Infection type F. Culture collected G. Organism if applicable H. Antibiotic prescribed I. Definition of infection met J. Nosocomial K. Date resolved L. Isolation is [sic] applicable Infection control logs will be complied [sic] monthly and reviewed at least quarterly with the Medical Director and Quality Assurance Committee to identify trends, patterns, and will implement corrective actions. The infection control nurse will monitor the 24-hour board daily and review the line list as needed. In the absence of the infection control nurse the DON or floor RN will review the 24-hour board and update the list. Each infection type will be recorded individually as a percent and monthly to identify rate of infections in those areas. 1.) On 5/5/2026, Surveyor reviewed the facility Infection Prevention and Control Program. The facility provided line lists and monthly infection data from December 2024 through May 2026. Surveyor noted from December 2024 through December 2025, a monthly Infection Summary was handwritten providing the number of each type of infection per unit and staff with a corrective action taken or a preventive (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	measure taken. From January 2026 through April 2026, no Infection Summary was included. The monthly Infection Summaries did not have rates of infection calculated. Surveyor identified a COVID-19 outbreak in December 2024/January 2025, a COVID-19 outbreak in April 2025, a COVID-19 outbreak in August 2025, and an Influenza A outbreak in December 2025/January 2026. These outbreaks were identified by Surveyor by looking at the line lists provided. No outbreak summaries were provided and there was not a separate line list for the individual outbreaks. 2.) The facility policy and procedure titled Laundry dated 2025 documents: 1. Aligning with principles of standard precautions, staff should consider all previously worn clothing and used linens as potentially contaminated. 2. The facility's laundry area will provide hand washing facilities and products as well as PPE. (personal protective equipment) On 5/5/2026 at 11:30 AM, Surveyor observed the laundry room, including the dirty room for incoming dirty laundry. Laundry Aide (LA)-D was in the laundry room and escorted Surveyor through the laundry process. LA-D stated dirty linens and resident personal laundry are taken from resident rooms and put in hampers in a closet on each unit. LA-D stated either laundry staff or Certified Nursing Assistants (CNAs) bring the dirty laundry to the dirty area of the laundry and separate the items into the appropriate bins for laundering. Surveyor observed the dirty area of the laundry and did not see any gowns for staff members to wear while sorting the laundry. Surveyor asked LA-D if LA-D sorts any of the dirty linens or dirty personal resident laundry. LA-D stated yes. Surveyor asked LA-D what protective equipment LA-D wore when sorting dirty laundry. LA-D stated LA-D wears gloves when sorting clothing. Surveyor asked LA-D if LA-D ever wears a gown when sorting dirty laundry. LA-D stated no, well maybe if the laundry is wet or excessively soiled. Surveyor asked LA-D if LA-D wears a gown when placing dirty laundry into the washer. LA-D stated no. Surveyor asked LA-D if any of the CNAs wore gowns when sorting the laundry. LA-D stated the CNAs could wear a gown if they wanted to, but that was up to them. Surveyor observed LA-D to be in the clean area of the laundry holding a freshly laundered blanket. LA-D was holding the blanket so the blanket was up against LA-D's clothing. In an interview on 5/6/2026 at 8:49 AM, Surveyor asked CNA-G how dirty laundry was handled. CNA-G stated the dirty linen goes into a hamper in the soiled linen closet and then the laundry personnel come and get the dirty linens and take it to the laundry room. Surveyor asked CNA-G if CNA-G ever has to take dirty laundry to the laundry room and sort any clothes. CNA-G stated at the end of the day when the laundry staff are gone, the CNAs will take the soiled linen bags and sort them in the sorting area of the laundry. Surveyor asked CNA-G if CNA-G wore any PPE when sorting the laundry. CNA-G stated just gloves. Surveyor asked CNA-G if CNA-G ever wore a gown when sorting dirty laundry. CNA-G stated no, unless the linens are wet or something. 3.) The facility policy and procedure titled Policy and Procedure for Pneumococcal Vaccine, undated, documents the pneumococcal vaccines Prevnar 13 and Pneumovax 23 administration schedule. The policy does not address the most current pneumococcal vaccines and is outdated. No date of implementation or review was on the policy. The facility Infection Control Policy was undated, did not have a date of implementation, and did not have a review or updated date. On 5/6/2026 at 10:05 AM, Surveyor met with Interim Director of Nursing (IDON)-B who was the facility Infection Preventionist (IP). IDON-B had been employed at the facility since 4/1/2026 and had no recent background working in nursing homes. IDON-B stated NHA-A had been helping IDON-B go over all the IP duties and expectations and still has a lot to learn. Surveyor reviewed with IDON-B the line lists and monthly Infection Summary sheets that had been provided. Surveyor shared the concern (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the monthly rates of infection had not been calculated to show tracking and trending was done to focus educational opportunities for staff. Surveyor shared the respiratory outbreaks Surveyor had noted from the line lists did not have separate line lists or any outbreak summaries to show how the outbreak occurred or who was affected by the outbreak. Surveyor shared the concern the line lists only included those residents that had been prescribed an antibiotic and did not include symptom surveillance. Surveyor shared the concern the pneumococcal vaccination policy was not dated and did not contain current immunizations. Surveyor asked IDON-B if policies were reviewed annually. IDON-B stated they should be but had not been in the facility long enough to know if that had been happening. IDON-B stated the pneumococcal vaccination policy was definitely outdated and provided Surveyor with an algorithm for all current pneumococcal vaccines that IDON-B uses for all newly admitted residents to make sure they are up to date on their immunizations. Surveyor shared the concern the two policies, Infection Control Policy and Policy and Procedure for Pneumococcal Vaccine were not dated when they were implemented or reviewed. Surveyor shared with IDON-B the observation of the laundry sorting room where no gowns were available for staff to put on when sorting dirty laundry and the conversation with LA-D about not wearing gowns when sorting dirty laundry and the observation of LA-D holding a clean blanket up against LA-D's clothing. IDON-B and Surveyor informed Nursing Home Administrator (NHA)-A of the above findings. No additional information was provided. 4.) The facility policy titled Catheter Care with no initiated, reviewed, or revised date documents: Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. 20. Document care and report any concerns noted to the nurse on duty. R23 was admitted to the facility on [DATE] and has diagnoses that include hemiplegia and hemiparesis following stroke affecting the right dominant side, aphasia, chronic kidney disease stage 3, obstructive and reflex uropathy, major depressive disorder, benign prostatic hyperplasia with lower urinary tract symptoms, . and gross hematuria. R23's admission Minimum Data Set (MDS) dated [DATE] indicated R23 has intact cognition with a Brief Interview for Mental Status (BIMS) score of 15. The MDS documents that R23 was admitted with an indwelling foley catheter and was assessed to need assistance with 1 staff member for activities of daily living (ADL's). R23's Indwelling urinary catheter related to obstructive and reflux uropathy care plan was initiated on 4/16/2026 documents the following interventions:- Assess drainage. Record amount, type, color, odor. Observe for leakage and keep closed system as much as possible to reduce risk of infection.- Assist with tubing management to reduce risk of tripping.- Enhanced barrier precautions.- Foley Catheter 22 French (F, size of tubing), 10cc balloon)- Monitor for signs/symptoms of urinary tract infection (UTI) such as pain, burning with urination, new frequency or urgency, fecer, change in urine character, altered mental status. Report abnormal findings to medical doctor (MD). Follow Mcgreers. R23's refusal care plan related to refusing showers, foley cares, and ADLs at times. R23 can become combative with cares was initiated on 4/20/2026 and documents the following interventions:- Allow (R23) to choose options.- Assess (R23's) noncompliance (e.g. expectations, cognitive status, motivation, lack of understanding). - Encourage (R23) to express concerns about showering. Clarify (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	misunderstandings.- Give (R23) choices when possible.- Reiterate the purpose and advantages of showering for (R23) such as minimizing risk of breakdown and good hygiene.- Respect (R23's) right to refuse showers and re-approach at a later time. On 5/4/2026, at 9:46 AM, Surveyor observed R23 lying in bed watching TV. Surveyor observed R23's foley catheter bag hanging on the right side of R23's bed and the bottom half of the catheter was lying on the floor without a protective barrier. R23 stated has had the catheter for about a year since R23's stroke and was not able to urinate without the catheter. R23 stated facility staff take care of R23's catheter, but that R23 does not know what to do or how to care for the catheter and stated R23 does not touch the catheter at all. On 5/6/2026, at 8:07 AM, Surveyor observed R23 lying on the bed sideways with R23's back against the wall. Surveyor observed R23's catheter bag lying directly on the ground underneath where R23 was sitting on the bed, without a protective barrier. R23 was not aware how the catheter got under the bed on the floor. R23 was not sure when the catheter was last checked on or emptied. On 5/6/2026, at 8:23 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-Q who stated R23 tends to be fidgety and mess with the catheter bag. Surveyor asked if any interventions have been implemented to prevent R23 from messing with the catheter bag or prevent the catheter bag from ending up on the ground. CNA-Q stated she was not sure and stated that CNA-Q checks on R23 every couple hours to make sure R23 is okay and if R23's catheter bag has to be emptied. CNA-Q checked on R23 earlier in the morning and R23's catheter bag was hanging on the right side of the bed. On 5/6/2026, at 8:30 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-L who stated catheter bags should be kept off the floor and/or have a protective barrier to prevent the risk of possible infection. Surveyor shared observations of R23's catheter bag on the floor without a protective barrier. LPN-L stated R23 can be very restless and mess with the catheter bag. Surveyor asked if that was the case what is the process to prevent R23 from messing with the catheter bag. LPN-L stated revisions would be made to R23's care plan and assess why and when R23 tends to mess with R23's catheter bag and see if interventions can be implemented to prevent R23 from messing with the catheter bag and prevent the catheter bag ending up on the floor. Surveyor shared was not able to see revisions to the care plan implemented to indicate to staff R23 plays with the catheter bag or gets restless. LPN-L stated would look into the concerns. On 5/6/2026, at 8:54 AM, Surveyor shared observations of R23's catheter bag lying on the ground without a protective barrier on 5/4/2026 and 5/6/2026 with Nursing Home Administrator (NHA)-A. Surveyor shared concerns staff indicated R23 was restless at times and messed with R23's catheter bag, but no care plan revisions were implemented to indicate R23's behavior with being restless or messing with R23's catheter bag to prevent R23 from messing with the catheter bag and ending up on the ground without a protective barrier. No additional information was provided.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility did not ensure a staff person designated as the Infection Preventionist (IP) completed specialized training in infection prevention and control. This practice had the potential to affect all 53 residents residing in the facility.The Interim Director of Nursing (IDON)-B was the facility's designated IP. IDON-B did not complete specialized infection prevention and control training. The facility also failed to designate an alternate qualified resource to oversee or the infection prevention and control program (IPCP) responsibilities of the facility. Findings include:The facility policy titled Infection Preventionist with no initiated, reviewed, or revised date documents: Policy: The facility will employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program. Policy Explanation and Compliance Guidelines:1. The facility will designate a qualified individual as IP whose primary role is to coordinate and be actively accountable for the facility's IPCP to include the antibiotic stewardship program.2. The facility will ensure the IP is qualified by education, training, experience or certification.4. The IP will have the knowledge to perform the role and remain current with infection prevention and control (IPC) issues and be aware of national organizations' guidelines, as well as those from national/state/local public health authorities.10. The IP must receive specialized IPC training beyond initial professional training or education. Specialized training should include the following topics:a. IPCP overviewb. IP rolec. Infection surveillanced. Outbreaks .h. Water managementi. Linen management .n. Antibiotic stewardship .11. responsibilities of the IP include .:a. Develop and implement ongoing (IPCP) to prevent, recognize, and control the onset and spread of infections in order to provide a safe, sanitary, and comfortable environment.b. Establish facility wide systems for the prevention, identification, reporting, investigation and control of infections and communicable diseases of residents, staff, and visitors.c. Develop and implement written policies and procedures in accordance with current standards of practice and recognized guidelines for infection prevention and control.d. Oversight of and ensuring the requirements are met for the facility's antibiotic stewardship program.e. Oversight if resident care activities .f. Review and/or revise the facility's (IPCP), its standards, policies, and procedures annually and as needed for changes to the facility assessment to ensure they are effective and in accordance with current standards of practice for preventing and controlling infections.g. Review/ revise and approve infection preventions and control training topics and content and ensure facility staff are training on IPCP.12. The IP will participate on and is part of the quality assessment and assurance committee (QAA) and will report regularly on the IPCP activities.On 5/5/2026, at 10:17 AM, Surveyor interviewed IDON-B about the IP role. IDON-B stated IDON-B was hired on 4/1/2026 to be the assistant DON but the previous DON no longer is employed with the facility since 4/24/2026 and IDON-B took over for DON until a permanent replacement is found. IDON-B's certification as an infection preventionist is currently being completed. Surveyor asked if she had previously served as an IP or had similar experience. IDON-B informed Surveyor that IDON-B had not previously worked in the IP role or had any similar experience. Surveyor asked if there was a resource or staff overseeing the IPCP program while IDON-B is getting certification. IDON-B stated IDON-B was not sure who IDON-B would go to if there were questions or concerns and would look into it.Surveyor noted that IDON-B was working in the IP role at the facility but did not obtain specialized IPC training beyond initial professional training or education prior to assuming the role.On 5/5/2026, at 3:01 PM Surveyor asked Nursing Home Administrator (NHA)-A what plan was put in place for the facility's IP and IPCP when the previous DON left the facility. NHA-A stated the previous DON was the IP and oversaw the IPCP and was working with IDON-B. NHA-A stated NHA-A would have to ask corporate if there is anyone to oversee the facility's IPCP with IDON-B. NHA-A stated there was an employee in the facility that has their certification, but that employee is not currently overseeing the IPCP or assisting IDON-B and was not in the IPCP role. The (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility Assessment's dated as reviewed on 2/28/2026 did not identify the role for the Infection Preventionist (IP) position and the IP role was not included in the facility's staffing hours listed in the Facility Assessment. Surveyor noted that the facility assessment did not list the amount of time required to fulfill the IP role, did not determine the resources the facility needs for its IPCP, and ensure that those resources were provided for the IP to be effective.On 5/6/2026, at 1:20 PM, NHA-A stated there is a resource at the corporate level with IP certification, however that resource would not be in the facility overseeing the IPCP with IDON-B. Surveyor shared concern the facility does not have a designated and qualified IP for the IPCP. On 5/8/26, NHA-A provided the state agency via email a statement that documented: Infection preventionist is not qualified because she is enrolled in but not completed with certification course. For qualifications, the federal regulation states: The facility must designate one or more individual(s) as the infection preventionist(s) (IPs) who are responsible for the facility's IPCP. The IP must: (1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; (2) Be qualified by education, training, experience or certification; (3) Work at least part-time at the facility; and (4) Have completed specialized training in infection prevention and control. IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals, if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. The person designated as our IP is a RN and has taken a few IP related courses, as shown in attachment, prior to assuming the role. She is enrolled in the certification course but not completed it yet. We do have an RN who is certified in IP to assist as needed which was shared with surveyors. Both work on-site, full time, and one does attend QA. Surveyor noted that when interviewed, NHA-A stated there was another RN on staff that help the IP certification, however the RN does not serve as the IP for the facility. Surveyor noted that when interviewed, NHA-A was asked if any other staff member or corporate staff could serve as the IP to assist IDON-B as IDON-B obtained her IP certification. NHA-A stated that at the time, the facility did not have other staff member or corporate staff that could serve as the IP while IDON-B obtained her certification. On 5/19/26 at 2:00 PM, Surveyor spoke with NHA-A regarding IDON-B's experience and certifications. NHA-A informed Surveyor that NHA-A believed IDON-B had sufficient courses taken to serve as the facility's IP and stated that a corporate staff member whom was certified could serve as the facility's IP only if required. Surveyor requested from NHA-A and experience or courses completed by IDON-B that documented her experience to serve as the facility's IP. On 5/19/26 at 2:20 PM, NHA-A emailed Surveyor a copy of courses completed by IDON-B. The courses included: Antibiotic Stewardship- completed 3/29/26Bloodborne Pathogens- completed 3/28/26Hand Hygiene- completed 3/28/26Infection Prevention and Control for All Staff- completed 3/29/26Personal Protective Equipment (PPE)- completed 3/29/26Surveyor noted that the courses documented as completed did not include any specialized IPC training beyond initial professional training or education prior to IDON-B assuming the infection preventionist role. The courses provided did not include courses in: Infection prevention and control program overview, the infection preventionist's role, Infection surveillance, outbreaks, Principles of standard precautions (e.g., content on hand hygiene, personal protective equipment, injection safety, respiratory hygiene and cough etiquette, environmental cleaning and disinfection, and reprocessing reusable resident care equipment), Principles of transmission-based precautions, Resident care activities (e.g., use and care of indwelling urinary and central venous catheters, wound management, and point-of-care blood testing), Water management, Linen management, Preventing respiratory infections (e.g., influenza, pneumonia), Tuberculosis prevention, Occupational health considerations (e.g., employee vaccinations, exposure control plan, and work exclusions), Quality assurance and performance improvement, Antibiotic stewardship, and care transitions. No additional information was provided.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not submit for the completion of a level 2 Preadmission Screening (PASARR) for 1 (R10) of 2 sampled residents with a mental disorder and intellectual disability to see if an individual requires such level of services or whether the individual requires specialized services. * R10 did not have a completed Level 2 PASARR screen for developmental disability or to see if R10 required specialized services. Findings include:The facility policy titled Resident Assessment- Coordination with PASSARR Program with no initiated, reviewed or revised date documents: Policy: This facility coordinates with the preadmission screening and resident review (PASSARR) program under Medicaid to ensure individuals with mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: ii. Positive Level 1 Screen-necessitates a PASSARR Level 2 evaluation prior to admission.b. PASSARR Level 2- A comprehensive evaluation by the appropriate state- designated authority . that determines whether the individual had Mental disorder, intellectual disability, or related conditions, determines the appropriate setting for the individual, and recommends any specialized services and/ or rehabilitative services the individual needs.3. A record of the pre-screening shall be maintained in the resident's medical record.6. The admissions nurse shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority.7. Recommendations, such as any specialized services, from PASSARR level 2 determination and/ or PASSAR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care. R10 was admitted to the facility on [DATE] with diagnoses that include spastic quadriplegic cerebral palsy, epilepsy, hydrocephalus with history of a ventriculoperitoneal shunt (drains excess cerebrospinal fluid from the brain), bipolar disorder, major depressive disorder and anxiety disorder.R10's admission Minimum Data Set (MDS) dated [DATE] indicated R10 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 3. On 5/4/2026, Surveyor reviewed R10's medical record was able to located R10's PASSAR level 1, which documented that R10 required a level 2 PASSAR screening. Surveyor was unable to locate R10's PASSAR level 2. Surveyor requested from the facility R10's PASSAR level 2.On 5/6/2026, at 1:32 PM, Nursing Home Administrator (NHA)-A informed Surveyor that NHA-A was not able to locate R10's PASSAR level 2. NHA-A stated the previous admissions staff kept everything in a folder; however, no one could locate that folder. NHA-A reached out to get a copy of what was submitted. Surveyor shared the concern that R10's PASSAR level 2 was not available for Surveyor to review or to verify that a PASSAR Level 2 screening was completed. NHA-A understood the concern and would notify Surveyor if the facility was able to locate R10's PASSAR level 2 screen. On 5/8/2026, at 1:11 PM, Surveyor received an email from NHA-A with an attachment documenting R10's PASSARR level 2 was completed. On 5/11/2026, at 9:20 AM, Surveyor reviewed the document but could not locate a date the PASSAR level 2 was completed. Surveyor emailed NHA-A confirming the receipt of R10's PASSAR level 2 screen and asked if NHA-A could provide a date the PASSAR level 2 was submitted for R10, as Surveyor was attempting to verify if R10's PASSAR level 2 screen was completed in a timely manner after R10's PASSAR Level 1 screen was completed.On 5/12/2026, at 8:19 AM, Surveyor received an email from NHA-A that documented NHA-A was not able to determine the date R10's PASSAR level 2 was submitted.On 5/14/2026, at 12:47 PM, Surveyor emailed NHA-A asking if NHA-A could provide a date the PASSAR level 2 was submitted for R10, as Surveyor was attempting to verify if R10's PASSAR level 2 screen was completed in a timely manner after R10's PASSAR Level 1 screen was completed.No response was received.No additional information was provided.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, record review and interview, the facility did not ensure 1 (R5 and R10) of 1 sampled residents received the necessary care and services to ensure that a resident's abilities in activities of daily living (ADLs) do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable, including receiving ADL assistance to maintain grooming. * R5 requires staff assistance with ADLs and was not shaven for a couple days.Findings include:1.) R5's Quarterly Minimum Data Set (MDS) assessment completed 2/2/26 documents that R5 was assessed to have a Brief Interview of Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The MDS documents that R5 was assessed to require partial to moderate staff assistance for and personal hygiene. R5's Certified Nursing Assistant (CNA) Plan of Care documents: Start date of 9/9/2024- Provide 1 assist with dressing/grooming.R5's Comprehensive Care Plan ADL's Function, started 9/6/2024, documents: R5 is at risk for self-care deficit and needs assistance with ADL's related to impaired mobility, Congestive Heart Failure exacerbation, oxygen at bedtime, hard of hearing, confusion, and situation confusion with delusions at times. The Goal Date is 5/4/26, needs will be met without distress by staff monitoring, education, encouragement, staff approaches daily. And Intervention, dated 9/6/24, is to Provide 1 staff assist for dressing/grooming.On 5/04/2026 at 9:43 AM, Surveyor observed, and interviewed, R5 in their room. R5 was sitting in their lounge chair watching TV. R5 had noticeable facial hair and did not know why they were not shaved. R5 stated they have a razor and is unsure why they were not shaved. On 5/05/2026, at 9:12 AM, Surveyor observed, and interviewed, R5 in their room. R5 had facial hair and did not get shaved. R5 did not know why they did not get shaved.On 5/05/2026, at 9:27 AM, Surveyor interviewed CNA-H. CNA-H stated they did not offer, or ask, to shave R5. CNA-H stated CNA-H did not shave R5 because R5 did not ask. On 5/05/2026, at 9:27 AM, Surveyor interviewed CNA Supervisor-C. CNA Supervisor-C would expect staff to ask residents if they want to be shaved.On 5/6/26, at 10:45 AM, Surveyor informed Nursing Home Administrator (NHA) -A that R5 was not shaved and that staff did not ask R5 if he wanted to be shaved. No additional information was provided as to why the facility did not ensure that R5 received the necessary care and services to ensure that R5's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable, including receiving ADL assistance to maintain grooming.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility did not ensure 1 (R10) of 1 sampled residents who are unable to carry out activities of daily living (ADL) receives the necessary services to maintain good grooming and personal hygiene. * R10 requires total staff assistance with ADLs, and was observed to have significant discharge matter coming from both eyes. Facility staff did not clean R10's eyes to ensure R10 maintained good personal hygiene. Findings include:1.) R10 was admitted to the facility on [DATE] and has diagnoses that include spastic quadriplegic cerebral palsy, epilepsy, hydrocephalus, mild cognitive impairment, dysphagia, aphasia, anxiety disorder, major depressive disorder and bipolar disorder. R10's Quarterly Minimum Data Set (MDS) dated [DATE] indicated R10 has a severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 3. The MDS documents that R10 was assessed as being dependent on staff for activities of daily living (ADLs). R10's upper and lower limbs are contracted and R10 is unable to use R10's hands or feet.R10's care plan documents that R10 is dependent on staff for ADLs such as grooming, bathing and personal hygiene. On 4/24/2026, at 12:43 PM, in the progress notes nursing documented: (R10's) right eye lid noted to be slightly red with slight clear, crusting drainage. (R10) denies pain, itching, blurriness and sclera is clear. Nurse Practitioner (NP) saw (R10), order to wash both eyes with small amount of baby shampoo on a washcloth twice a day for 7 days.On 4/26/2026, at 5:40 PM, in the progress notes nursing documented (R10's) right eye continues to drain along with the left eye. A sty is forming on the right eye lid. (R10's) upper lid is red and slightly red on the lower lid. Orders received for artificial tears four times a day and warm compressed to right eye three times a day.R10 has the following physician orders:1. Erythromycin Ointment 5mg/gram (0.5%)- Apply small amount to both eyes four timed a day for 10 days for viral conjunctivitis (Start: 5/2/2026 - 5/12/2026)2. Warm compress to right eye three times a day until cleared (Start: 4/26/2026)On 5/5/2026, at 8:09 AM, Surveyor observed R10 lying in bed. R10 observed R10's right eye to have light yellow stringy drainage covering R10's right eye. Surveyor observed a sty to R10's right upper, inner eye lid. Surveyor asked if anyone washed R10's eyes or put a warm compress on R10's eyes; R10 replied no. Surveyor asked if R10 received ointment in both eyes yet and R10 replied no.On 5/5/2026, at 11:16 AM, Surveyor showed Interim Director of Nursing (IDON)-B R10's right and left eye with drainage over the whole right eye and a bit on the left eye. Surveyor shared with IDON-B R10 stated no one has cleaned R10's eyes, applied warm compress, or administered R10's erythromycin per R10 yet. IDON-B stated they would follow up with staff. On 5/6/2026, at 9:18 AM, Surveyor shared observations with Nursing Home Administrator (NHA)- A of R10's right and left eyes having drainage on 5/5/2026 and R10 stated did not get eyes cleaned, warm compress applied or administered erythromycin ointment per physician orders. NHA-A was made aware by IDON-B of Surveyors concern and noted R10's erythromycin ointment was administered per physician order, however R10's eyes should have been cleaned up to ensure R10's personal hygiene. No additional information was provided.

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	525541	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holton Manor	645 N Church St Elkhorn, WI 53121

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure 2 (R10 and R23) of 8 sampled residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion.* R10 was observed not having rolled up washcloths in both hands to prevent further decrease in range of motion and was not wearing shoes when up in R10's wheelchair per care plan.* R23 was observed not wearing R23's right ankle foot orthotic (AFO) to prevent further decrease in range of motion.Findings include:The facility policy titled Use of Assistive Devices with no initiated, reviewed or revised date documents: Policy: The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function, dignity, and quality of life. Policy Explanation and Compliance Guidelines: 2. The use of assistive devices will be based on the resident's comprehensive assessment, in accordance with the resident's plan of care.3. The facility will provide assistive devices, as indicated, for residents who need them. Nursing, dietary, social services, and therapy departments will work together to ensure availability of devices, such as for ordering and/or replacement.6. Direct care staff will be trained on the use of the devices as needed to carry out their roles and responsibilities regarding the device. Training will also include when to refer to other departments for . or problems with the device.7. A nurse with responsibility for the resident will monitor the consistent use of the device and safety in the use of the device. Refusals of use, or problems with the device, will be documented in the medical record. Modifications to the plan of care will be made as needed.1.) R10 was admitted to the facility on [DATE] and has diagnoses that include spastic quadriplegic cerebral palsy, epilepsy, hydrocephalus, mild cognitive impairment, dysphagia, aphasia, anxiety disorder, major depressive disorder. and bipolar disorder.R10's quarterly Minimum Data Set (MDS) dated [DATE] indicated R10 has a severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 3. The MDS documents that R10 was assessed as being dependent on 1-2 staff for activities of daily living (ADLs) and that R10's upper and lower limbs are contracted with R10 unable to use R10's hands or feet.R10's Restorative: Active and Passive range of motion (ROM) to maintain current range of motion to upper and lower extremities due to being admitted with contractures . care plan was initiated on 7/28/2025 with the following interventions: -Perform active ROM to bilateral upper and lower extremities with dressing two times a day, 7 days a week. use palm protectors on in the AM and of at night. (edited 10/23/2025)R10's ADLs functional status/ rehabilitation potential- R10 has self-care deficit and needs total assistance with all ADL's related to immobility, cognitive deficit, epilepsy, aphasia, contractures, tremors, spastic quadriparesis, and spasmodic torticollis care plan was initiated on 7/28/2026 with the following interventions: -Shoes on feet when up in wheelchair. (created: 1/7/2026)R10's Certified Nursing Aide (CNA) care card has the following CNA approaches/ (tasks) documented: - Use palm protectors on in the AM, of at night. (start: 7/28/2025)- Shoes on feet when up in wheelchair. (start: 1/6/2026)- Rolled wash cloths in both palms. [NAME] (put on) with AM cares after hands washed and dried and off with PM cares- wash/dry and lotion hands prior to bed. Change daily. (start: 3/8/2026)Surveyor noted R10 had a care plan to have both palm guards to both hands and rolled up washcloths in both palms to be put on in the morning and taken off at night.On 5/4/2026, at 12:26 PM, Surveyor observed R10 in the bedroom sitting in the wheelchair. R10 did not have shoes on both feet per R10's plan of care. On 5/5/2026, at 8:09 AM, Surveyor observed R10 in the bedroom sitting in the wheelchair. R10 did not have shoes on both feet and R10's right foot was crossed over R10's left foot. R10 did not have palm guards or rolled up washcloths in R10's right or left hands per R10's plan of care.Surveyor observed 3 pictures on R10's wall above R10's bed. The pictures demonstrated how R10 should be positioned in R10's wheelchair. Surveyor observed R10 wearing palm guards in the right and left hands. Surveyor (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could not locate a date for which the pictures were taken or hung up.On 5/5/2026, at 11:16 AM, Surveyor observed R10 lying in bed. R10 did not have palm guards or wash clothes in R10's right or left hands, per R10's plan of care. On 5/5/2026, at 2:17 PM, Surveyor interviewed Physical Therapy Assistant (PTA)-U and Certified Occupational Therapy Assistant (COTA)-V. PTA-U stated R10 had palm guards at first, then R10's power of attorney (POA) wanted rolled up washcloths instead of the palm guards. PTA-U stated R10 should wear shoes on right and left feet to prevent foot drop from occurring in R10's feet.Surveyor asked how changes to the care plan would get relayed to nursing staff. PTA-U stated the care plan would be revised either by the nursing staff or during morning stand-up and by therapy verbally telling nursing staff changes and then nursing staff would relay it during shift report. Surveyor asked if R10's care plan should have been revised when R10's POA requested R10 to have washcloths instead of palm guards. PTA-U stated the care plan should reflect what the resident currently should have in place.On 5/6/2026, at 8:23 AM, CNA-Q who stated R10 should have rolled up washcloths in both hands and was not sure if R10 ever had palm guards that CNA-Q could recall. CNA-Q stated R10 doesn't refuse cares or treatments, and if a resident refuses care or treatments CNAs are to notify the nurse, and the nurse would take care of it. CNA-Q was not sure if a note was written or if anyone got contacted regarding R10's refusal of cares or treatments. CNA-Q stated nursing staff notify CNAs of any changes, sometimes changes will be on the care cards, but mostly passed along verbally any changes. CNA-Q stated R10 should have shoes on both feet when up in the wheelchair. On 5/6/2026, at 8:54 AM, Surveyor informed Nursing Home Administrator (NHA)-A of the observations of R10 not having rolled washcloths in both hands and shoes not on both feet per R10's care plan. Surveyor shared concern R10's care plan and CNA care card did not reflect what R10 currently should have in place to prevent contractures from worsening and R10's care plan document R10 should wear right and left hand palm guards and rolled up washcloths. NHA-A acknowledged concerns. No additional information was provided.2.) R23 was admitted to the facility on [DATE] and has diagnoses that include hemiplegia and hemiparesis following stroke affecting the right dominant side, aphasia, . and major depressive disorder.R23's admission Minimum Data Set (MDS) dated [DATE] indicated R23 has intact cognition with a Brief Interview for Mental Status (BIMS) score of 15. The MDS documents that R23 was assessed as requiring maximal assistance with 1-2 staff for activities of daily living (ADLs). R23 was noted to have impairments to the right upper and right lower extremity due to history of having a stroke. R23's ADLs functional status/ rehabilitation potential- limited in ability to transfer self-related to impaired mobility requiring 2 persons assist, gait belt, and AFO (ankle foot orthodic) to right foot when transferring due to weakness and deconditioning post hospitalization care plan was initiated on 4/16/2026 with the following interventions: - Instruct in use of assistive devices.- Monitor skin under AFO for signs/symptoms of breakdown.Surveyor noted R23's use of an AFO is not documented on how often or when R23's AFO should be put on.R23's physician order documents: AFO to right foot due to foot drop, monitor skin for breakdown every shift: Day shift, Second shift, and Third shift. (Start: 4/17/2026)On 5/4/2026, at 9:49 AM, Surveyor observed R23 lying in bed watching TV. Surveyor observed R23's right foot to be turned inward. R23 stated R23 is not really able to move the right side of R23's body. Surveyor observed a black AFO foot brace with Velcro straps on R23's recliner chair at the end of R23's bed. Surveyor asked if R23 was supposed to have the brace on. R23 stated that R23 was unsure if the AFO is supposed to have it on and the brace just sits on the chair.On 5/4/2026, at 3:56 PM, Surveyor observed R23 lying in bed watching TV and R23's black foot AFO brace was on R23's reclining chair and R23 was not wearing it per R23's plan of care. On 5/5/2026, at 8:05 AM, Surveyor observed R23 lying in bed. Surveyor noted R23's right AFO brace sitting on R23's recliner. R23 stated R23 has not had the brace on at all that R23 can remember. Surveyor noted that R23 was not wearing the AFO per R23's plan of care. On 5/5/2026, at 10:31 AM, Surveyor observed R23 lying in bed sleeping and R23's right AFO brace was sitting on R23's recliner chair. Surveyor noted that R23 was not wearing the AFO per R23's plan of care. On 5/5/2026, at 2:06 PM, Surveyor observed R23 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sitting up on the side of the bed, anti-slip socks were on both feet and R23's right AFO was sitting on R23's recliner chair. Surveyor noted that R23 was not wearing the AFO per R23's plan of care. On 5/5/2026, at 2:17 PM, Surveyor interviewed Physical Therapy Assistant (PTA)-U who stated R23 is to wear the right AFO brace at all times when in bed and when out of bed due to R23 having Right foot drop and the AFO was used to prevent further decline. Surveyor informed PTA -U that Surveyor has not observed R23 with Right AFO on R23's right foot on 5/4/2026 and 5/5/2026. PTA-U stated the therapy department does not monitor R23's right AFO and orthopedic doctor would monitor R23's right AFO.PTA-U stated R23 came form either the hospital or another facility with the Right AFO and PTA-U stated therapy continued the orders of R23 wearing the right AFO at all times, but ultimately R23 would have to see orthopedic doctor for further direction on when exactly R23 should wear the right AFO. PTA-U was not sure if R23 has been seen by an orthopedic doctor since being admitted to the facility.On 5/5/2026, at 3:00 PM, PTA-U shared information with Surveyor regarding having heard R23's right AFO is broken and that is why R23 is not wearing the right AFO. Surveyor asked to see documentation, however PTA-U stated it was all verbally passed along. PTA-U would look into if R23 has an orthopedic appointment for an AFO replacement and will get back to Surveyor. On 5/6/2026, at 8:07 AM, Surveyor observed R23 sitting on the side of the bed eating breakfast. Surveyor observed R23 to be wearing R23's right AFO. Surveyor asked if staff put R23's right AFO this morning. R23 could not recall when he got the AFO put on. Surveyor asked R23 if the AFO was comfortable or fit properly and if R23 heard anything about the AFO being broken. R23 stated the AFO felt fine and is not aware of the AFO being broken. R23 did not recall going to an orthopedic appointment since being admitted to the facility.On 5/6/2026, at 8:23 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-Q who stated R23 should wear the right AFO at all times is what she was told. CNA-Q has not heard anything about R23's right AFO being broken. CNA-Q stated R23 will refuse to wear the right AFO at times but usually will wear it part of the day most of the time. CNA-Q stated when R23 refuses the AFO nursing is made aware and will reapproach R23 later and ask if R23 wants the AFO on. On 5/6/2026, at 8:29 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-L who stated from what LPN-L understood, R23 is to wear the right AFO during transfers to help with stability. LPN-L was not aware of R23's right AFO being broken and not being able to use it. Surveyor shared concern regarding R23's care plan does not indicate exactly when and how often R23 should wear R23's right AFO and per physician order R23's AFO is to be worn at all times. Surveyor shared concern R23 was observed not wearing R23's right AFO on 5/4/2026 or 5/5/2026 and has not seen an orthopedic doctor regarding R23's AFO follow up. LPN-L stated LPN-L would look into concerns.On 5/6/2026, at 8:54 AM, Surveyor informed Nursing Home Administrator (NHA)-A that facility staff was not aware of when or how often R23 was to wear R23's right AFO and there was confusion on whether R23's right AFO was broken or not. NHA-A stated when R23 was admitted to the facility NHA-A recalled R23's family stating something about the AFO being broken and was trying to get R23's previous facility to pay for it, however NHA-A does not know what happened or if anything was done about R23's right AFO.Surveyor shared observations of R23 not wearing the right AFO on 5/4/2026, and 5/5/2026 per R23's physician's order and plan of care. Surveyor shared concern R23's care plan does not indicate when or how often or if R23 refuses to wear R23's right AFO. Surveyor also shared therapy department shared they do not monitor R23's AFO and R23 would have to see an orthopedic doctor for R23's maintenance of the right AFO and Surveyor did not find any evidence R23 is being evaluated and treated by an orthopedic doctor for R23's right AFO. NHA- understood the concerns and would look into what is happening with the use of R23's right AFO. No additional information was provided.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents with a gastrostomy tube received the appropriate treatment to prevent complications of enteral feeding for 1 (R7) of 1 resident with a gastrostomy tube.R7's gastrostomy tube was not checked for placement prior to the attempt to administer medication which had the potential of causing water and medication to enter the abdominal cavity rather than the stomach.Findings include:The facility policy and procedure titled Verifying Placement of Feeding Tube from dated 2025 documents: 1. Before beginning a feeding, flushing the tube, or administering a medication via the feeding tube, proper placement and functioning will be verified. 4. Procedure for verifying placement of feeding tubes: . c. Verify tube placement: i. For gastrostomy tubes, check that the enteral retention device is properly approximated to the abdominal wall by gently tugging on the tube and taking note of the marking on the tube. Notify supervisor and/or physician of abnormal findings, OR ii. Measure length of tube from insertion site to tip upon new admission to facility or with a new/change in the tube and record the length. Check and record the length of the tube prior to feeding as per facility policy. Notify supervisor and/or practitioner if abnormal finding. iv. If unable to confirm placement, notify supervisor and/or physician. Consider alternative verification methods such as x-ray. Do not proceed with feeding, flush, or medication administration until tube placement is verified. v. If performed in the facility, measure the pH of the gastric secretions: 1) Draw back on syringe to slowly obtain 5-10 mL of aspirate, and empty into a clean medicine cup. 2) Dip the pH strip into the aspirate in the medicine cup. 3) Compare the color of the strip with color on chart as per manufacturer's instructions. (Note: Gastric fluid usually has a pH of 5 or less). d. If performing the pH measurement, flush feeding tube with 30 mL of water after residual measurements to maintain tube patency.R7 was admitted to the facility on [DATE] after hospitalization for a coronary artery bypass graft (CABG) surgery with traumatic intubation resulting in necrotic tissue in the mouth. R7 had placement of a percutaneous endoscopic gastrostomy (PEG) tube for R7 to receive all nutritional needs.R7's Tube Feeding Care Plan initiated 4/2/2026 has interventions:-Check gastric residuals if clinical assessment reveals R7 is not tolerating enteral feedings, the marked position of the tube has changed, the appearance and pH of aspirate suggests the tube is misplaced, or as ordered-Check placement and patency of feeding tube before each feeding or medication administration.-Check placement and patency of feeding tube every shift and before med pass.On 5/6/2026 at 1:05 PM, Surveyor observed Licensed Practical Nurse (LPN)-F prepare a medication to administer to R7. LPN-F donned a gown and gloves after hand hygiene was completed. LPN-F placed a stethoscope to R7's abdomen and listened to all four quadrants of R7's abdomen. Surveyor observed a gauze drain sponge around the base of the PEG tube obstructing the view of the entry of the PEG tube into the abdomen or of how the PEG tube was affixed to R7's abdomen. LPN-F did not remove the drain sponge at any time during the procedure. LPN-F connected an empty syringe barrel to R7's PEG tube, opened the valve and clamp, and placed approximately 30 mL of water into the barrel of the syringe. LPN-F did not check the PEG tube under the drain sponge to assess the entry point of the PEG tube, measure the length of the PEG tube from the abdomen to the end of the PEG tube, or attempt to aspirate stomach contents to verify placement of the PEG tube. The water LPN-F placed in the syringe barrel did not go into R7's PEG tube due to obstruction in the tube. LPN-F contacted LPN-E to assist with trying to unclog R7's PEG tube. They were unsuccessful at that time.Surveyor did not observe any physical markings on R7's PEG tube. In an interview on 5/6/2026 at 9:05 AM, Surveyor asked LPN-E how LPN-E checks for PEG tube placement before giving a medication or feeding. LPN-E stated LPN-E was not sure and would have to look it up. LPN-E went to the computer and looked online for how to check PEG tube placement. LPN-E stated you would pull back on the syringe to see if there are stomach contents.In an interview (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 5/6/2026 at 1:05 PM, Surveyor asked interim Director of Nursing (IDON)-B what the facility protocol was for checking placement of a PEG tube prior to administering medication or tube feeding. IDON-B attempted to pull up the facility policy on the computer. Surveyor shared with IDON-B that Surveyor had the policy already and wanted to know IDON-B's expectation of staff when performing that task. IDON-B stated IDON-B did not know what the protocol was for checking placement; it is something that is new to IDON-B. Surveyor shared with IDON-B the concern placement of R7's PEG tube was not completed prior to attempting to administer medication by either observation of the tube base markings or aspiration of stomach contents.On 5/6/2026 at 3:23 PM, Surveyor informed Nursing Home Administrator (NHA)-A and Nurse Clinical Officer (NCO)-I that R7's PEG tube placement was not checked prior to attempting to administer medication per R7's plan of care. NCO-I stated their policy is to go by the markings on the tube and the length of the tube. Surveyor shared the concern there was nothing in R7's medical record that documented the measurement of R7's PEG tube for staff to know the appropriate length or if there was a change in the length of the tube. Surveyor also informed NCO-I that Surveyor did not observe any physical markings on R7's PEG tube for staff to use a reference point for placement. On 5/12/26, the facility provided additional information that included the facility's policy on verifying placement of a feeding tube with the steps they follow along with R7's physician order which states in the special instructions how to verify placement of R7's PEG tube. The policy that was provided, titled Verifying Placement of Feeding Tube documents: For gastrostomy tubes, check that the enteral retention device is properly approximated to the abdominal wall by gently tugging on the tube and taking note of the marking on the tube. Notify supervisor and/or physician of abnormal findings, ORMeasure length of tube from insertion site to tip upon new admission to facility or with a new/change in the tube and record the length. Check and record the length of the tube prior to feeding as per facility policy. Notify supervisor and/or practitioner if abnormal finding.The physician's order for R7 that was provided documents: Special Instructions- First check that g-tube is properly approximated to abdominal wall by gently tugging or taking note of the marking on the tube. You may measure it as well. Surveyor noted that with the additional information, the facility did not provide documentation that explained why LPN-F was observed aspirating for stomach contents to check R7's tube placement or how facility staff would measure R'7s feeding tube if the tube had no visible markings on it when Surveyor observed it. No additional information was provided.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review the facility did not ensure posted nurse staffing data included the total actual hours worked by registered nurses (RN), licensed practical nurses (LPN's), and certified nurse aides (CNAs) each shift. * The facility did not document the number and actual hours worked for licensed and unlicensed nursing staff directly responsible for resident care per shift.This deficient practice has the potential to affect all 53 residents residing in the facility.Findings include:On 5/4/2026, at 3:58 PM, Surveyor observed the nurse staff posting located to the right of the main entrance door. Surveyor noted the postings documented the total RN hours, total LPN hours, total medication tech (MT) hours and total CNA hours for the whole day. Surveyor noted the nursing staff hours were not broken up to indicate what licensed and unlicensed staff worked each shift.Surveyor requested to review nurse postings for last 30 days (4/1/2026 - 5/4/2026). Surveyor noted nurse posting from the last 30 days did not indicate what licensed and unlicensed staff worked each shift.On 5/6/2026, at 1:20 PM, Surveyor informed Nursing Home Administrator (NHA)-A the nurse staff postings did not include what licensed and unlicensed staff worked each shift. NHA-A stated the facility only ever documented the hours per day for nurse postings and not each shift. Surveyor informed NHA-A that the nurse postings should document the hours for licensed and unlicensed nursing directly responsible for resident care per shift. No additional information was provided.