STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525547	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Glendale West	6263 N Green Bay Ave Glendale, WI 53209

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record, the facility did not ensure 1(R1) of 1 resident was assessed by the interdisciplinary team to determine it was clinically appropriate to self-administer medication.*On 11/11/25 Surveyor observed a medication cup marked with R1's first name & noon with two white tablets.Findings include:The facility's policy titled, Resident Self-Administration of Medication and dated 4/25 under policy documents It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safety. Under Policy Explanation and Compliance Guidelines documents 1. Each resident is offered the opportunity to self-administer medications during the routine assessment by the facility's interdisciplinary team. 2. Resident's preference will be documented on the appropriate form and placed in the medical record.R1's diagnoses includes hypertension, radiculopathy (1 or more nerve roots in spinal column become compressed or irritated) lumbar region, bilateral primary osteoarthritis of knee benign prostatic hyperplasia (enlarged prostate, obstructive & reflux uropathy (urine flows backward from bladder into ureters) and anxiety disorder (group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life). R1's quarterly MDS (minimum data set) with an assessment reference date of 9/8/25 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact.On 11/11/25, at 12:52 p.m., Surveyor observed R1 in bed on his back. Surveyor observed on the overbed table is a medication cup marked with R1's first name & noon with two white tablets. R1 informed Surveyor they said they are going to transfer him around 1:00 p.m. R1 informed Surveyor, Surveyor can watch the transfer but doesn't want Surveyor watching the shower. Surveyor informed R1 this is his right, and Surveyor will only observe his transfer. Surveyor then asked R1 about the two pills in the medication cup on the overbed table. R1 stated those are my Tylenol. R1 explained his lower half is frozen and stated sometimes I take the medication. I might take it after I get out of the shower.On 11/11/25 at 1:04 p.m. Surveyor observed Physical Therapy Assistant (PTA)-J transfer R1 from the bed into a shower chair using a gait belt. Surveyor observed Certified Nursing Assistant (CNA)-F was in R1's room at this time and at 1:08 p.m. CNA-G entered R1's room. PTA-J informed CNA-F & CNA-G he will be back when they are done. CNA-F wheeled R1 into the bathroom which contains a shower. As Surveyor was leaving R1's room, at 1:10 p.m., Surveyor observed the medication cup with 2 Tylenol tablets continues to be on R1's overbed table.On 11/11/25, at 1:16 p.m., Surveyor reviewed R1's November MAR (medication administration record) and noted an order date 9/2/25 which documents Acetaminophen 500 mg (milligrams). Give 1000 mg by mouth three times a day for back pain. Surveyor reviewed R1's medical record and was unable to locate a self-administration assessment for R1.On 11/11/25, at 1:41 p.m., Surveyor observed R1 sitting in a shower chair covered with a towel in R1's room. R1 informed Surveyor he is waiting to get back in bed. Surveyor observed on the overbed table the medication cup is tipped on the side and still contains two Tylenol tablets.On 11/11/25, at 1:44 p.m., Surveyor asked Licensed Practical Nurse (LPN)-I if she usually leaves R1's medication. LPN-I replied he can self-administer his medication. Surveyor asked LPN-I if she knew where Surveyor would be able to locate R1's self-administration medication assessment. LPN-I informed Surveyor she did not.On 11/11/25, at 1:47 p.m., Surveyor asked Director of Nursing (DON)-B where Surveyor would be able to locate self-administration medication assessments. Regional Registered Nurse (R)-M, who was in DON-B's office, informed Surveyor it's under the assessment section quarterly/annual assessment.R1's WI (Wisconsin) Admit/Readmit assessment dated [DATE] under the self-administration section for the question Does the resident desire to self-administer his/her own medications, no is answered.R1's WI (Wisconsin) Admit/Readmit assessment dated [DATE] under the self-administration section for the question Does the resident desire to self-administer his/her own medications, no is answered.Surveyor was unable to locate a self-administration for medication assessment for R1.On 11/11/25, at 2:12 p.m., Surveyor asked LPN-I how she knew R1 could self-administer his medication. LPN-I replied he can't I was wrong, sorry.On 11/11/25, at 3:05 p.m., during the end of the day meeting Surveyor informed Nursing Home Administrator (NHA)-A, DON-B, and Regional RN-M, of the observation of R1's Tylenol being left on the overbed table without a self-administration medication assessment.No additional information was proved to Surveyor as to why R1's medication was left on the overbed table

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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 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 Interview and record review, the facility did not ensure showers were provided for 3 out of 3 residents (R1, R2, and R3) dependent on staff for Activities of Daily Living (ADLs). Findings Include: The facility policy, entitled Activities of Daily Living (ADLs), dated 12/24, stated: The facility will comma based on the residence comprehensive assessment and consistent with the residents' needs and choices comma ensure a residence abilities in ADL's do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: - Bathing, dressing, grooming, and oral care. Policy Explanation and compliance Guidelines: - A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition grooming and personal and oral hygiene. - The facility will maintain individual objectives of the care plan and periodic review and evaluation. The facility policy, entitled Resident Showers, dated 6/25, stated: It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation, and help prevent skin issues as per current standards of practice Equipment and Supplies: - gloves - two washcloths - several towels - shower cap (if needed) - shower chair - bath blanket (if available) - resident's clothing Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Residents will be provided showers as per request or as per facility scheduled protocols and based upon resident safety partial baths may be given between regular shower schedules as per facility policy. - Help the residents sit on the shower chair. Use safety straps if necessary and available. The Facility Assessment for Glendale Care and Rehab, dated 10/17/25, documented: Purpose Statement: o The purpose of this assessment is to determine what resources are necessary to care for our residents competently during both day-to-day operations (including nights and weekends) and emergencies. Scope: o This assessment addresses the following elements: The facility's resident population. The facility's resources, including but not limited to: equipment (medical and non medical). Information about how we ensure adequate supplies and upkeep. o physical equipment each department manager, or designer, follows procedures for maintaining inventory, assessing the condition of all equipment and determining what equipment is needed. Preventive maintenance and/more cleaning schedules are in place according to manufacture recommendations. When equipment is needed, whether new or replacements, each department head follows procedures for obtaining purchase orders or capital expenditure authorizations for obtaining the needed equipment. 1.) R3 was admitted on [DATE] with diagnoses of Hemiplegia and Hemiparesis after intracerebral hemorrhage (Paralysis and weakness on one side of the body after a stroke that causes blood vessels in the brain to rupture and bleed into the brain tissue), epileptic seizures (repeated seizures), and Dementia (cognitive decline that severely impacts ADLs). R3's Quarterly Minimum Data Set (MDS) dated [DATE], indicated that R3 had Long-term and short-term memory problems, and severely impaired cognitive skills for daily decision making. R3 is completely dependent for all cares: transferring, bed mobility, eating, dressing, hygiene/showers, and transportation in a wheelchair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's annual MDS dated [DATE] indicated staff answered for R3's preferences for customary routines including bathing due to R3 not responding to questions related to R3's cognition. Staff answered for R3 to prefer a bath or sponge bath for bathing. Surveyor noted historically, R3's MDS including R3's 5 day admission MDS dated [DATE], section F which documented R3's preferences, Indicated that it was very important to R3 that R3 received and decided between Shower, tub bath, bed bath, or a sponge bath historically. R3's comprehensive care plan documented: - R3 has an ADL self care performance deficit r/t (related to) impaired mobility, weakness. Initiated 7/1/25 o BATHING/SHOWERING R3 is totally dependent on one staff to provide bathing/showering 2X/week and as necessary. Initiated 5/4/23, revised 7/1/25 Surveyor notes R3 has 2 care plans for falls, neither mention R3 as not being able to receive showers due to safety. - R3 is at risk for falls related to poor trunk control and total assistance with transfers. Initiated 7/1/25. - Potential/actual for falls, R3 is at risk for injury from falls WEAKNESS, unsteady gait, history of fall. Initiated 2/21/2020, revised 5/24/2022 R3's Physician orders documented: - Shower days: chart refusal and body check Every evening shift every Wednesday and Sunday for showers. Make sure hair is washed at least weekly. Every evening shift every Wednesday, Sunday. Start date 4/2/2025. R3's Care Card dated 11/6/25, indicates to Certified Nursing Assistants (CNAs) how to care for residents, documented: - R3 shower is on Sunday and Wednesday - Assist of 1, dependent for upper and lower body dressing/hygiene, wash hair at least weekly on shower days. - For transfers use Hoyer lift and Broda chair On 11/10/25, at 3:20 PM, Surveyor interviewed CNA-O regarding cares for R3. CNA-O stated CNA-O provides all cares to R3, including baths, washing up, oral care, lotion, check and changes for incontinence, and catheter care. CNA-O stated R3 only gets bed baths and it has been like that for a while now. CNA-O stated R3 has poor trunk control and cannot sit up in the shower chair, so for safety R3 gets bed baths only. CNA-O denied if any alternatives were provided for R3 in place of bed baths. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/11/25, at 10:45 AM, Surveyor interviewed Registered Nurse Unit Manager (RN UM)-N regarding R3 only getting bed baths. RN UM-N stated R3 only gets bed baths due to safety as R3 cannot sit up and has poor trunk control, and it has been like that since RN UM-N has worked at the facility. RN UM-N denied if any alternatives were provided for R3 in place of bed baths. On 11/11/25, at 11:01 AM, Surveyor interviewed Director Of Nursing (DON)-B regarding R3 only getting bed baths. DON-B stated R3 cannot sit up and for safety only bed baths are provided. DON-B stated there are multiple residents throughout the building who cannot get showers and only get bed baths for the same reason. DON-B stated the facility does not have shower cots and if they did the shower rooms are not big enough to accommodate the shower cot and the staff member assisting the shower. DON-B stated the facility had been planning on extending one of the shower rooms in the facility to make it big enough to accommodate the shower cot and staff. DON-B does not have a timeframe for which the shower room remodeling will occur. Surveyor asked DON-B if any bathing alternatives were provided for R3, DON-B stated no, only bed baths. Surveyor asked DON-B how CNAs would know that R3 can only have a bed bath, DON-B stated that on each resident's care card, under the shower section, it notes if the resident can have a shower or bed bath. DON-B stated DON-B would provide surveyor a copy, surveyor did not receive a copy of R3's care card that indicated that R3 only can get bed baths. Surveyor noted that the care card Surveyor obtained on the unit, did not indicate if R3 can gets a shower or bed bath. It only notes to bathe Wednesday and Sunday and wash hair at least weekly. Surveyor reviewed R3's bathing records from 5/22/25 – present, that indicated: - 5/22/25 – 5/31/25 R3 did not receive 1 of the scheduled bathings: o on Sunday 5/25/25. - June 2025, R3 did not receive 5 of the scheduled bathings: o 6/8/25 Sunday o 6/11/25 Wednesday o 6/18/25 Wednesday o 6/22/25 Sunday o 6/25/25 Wednesday o R3 went 7 days straight without bathing twice in the month of June. - July 2025, R3 did not receive 2 of the scheduled bathings: o 7/23/25 Wednesday o 7/27/25 Sunday o R3 went 9 days straight without bathing in the month of July (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- August 2025, R3 did not receive 3 of the scheduled bathings: o 8/3/25 Sunday o 8/6/25 Wednesday o 8/20/25 Wednesday o R3 went 10 days straight without bathing in the month of August - September 2025, R3 did not receive 1 of the bathings: o 9/3/25 Wednesday o R3 went 7 days straight without bathing in the month of September. 8/29/25-9/4/25 - October 2025, R3 did not receive 4 of the scheduled bathings: o 10/8/15 Wednesday o 10/19/25 Sunday o 10/22/25 Wednesday o 10/26/25 Sunday o R3 went 8 days straight without bathing in the month of October. - November 2025, R3 received all bathings thus far. Surveyor noted that all documentation of bathing is recorded as bed baths. On 11/12/25, at 9:30 AM, DON-B provided additional information regarding dates R3 received bathing. The sheets provided are titled, CNA walking shift reporting, documented: - 6/25/25, 2nd shift a y (indicating yes) is written at the top of the shower category and a line going straight down through each resident section. It is not documented what type of shower/bed bath/sponge bath was given. o The charting in the electronic medical recorded (EMR) for 6/25/25 on 2nd shift is recorded as N/A (not applicable) for bathing on this day for R3. - 6/20/25, 2nd shift a yes is written at the top of the shower category and a line going straight down through each resident section. It is not documented what type of shower/bed bath/sponge bath was given. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o The charting in the EMR for 6/20/25 on 2nd shift is recorded as N/A for bathing on this day for R3. - 9/19/25, 2nd shift a Y (indicting yes) is written in R3's shower category. It is not documented what type of shower/bed bath/sponge bath was given. o The charting in the EMR for 6/19/25 on 2nd shift is recorded as N/A for bathing on this day for R3. - 9/18/25, 2nd shift a Y (indicting yes) is written in R3's shower category. It is not documented what type of shower/bed bath/sponge bath was given. o There is no documentation for showering in EMR on this day. On 11/11/25, at 3:20 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A, DON-B, and Regional RN -N that R3 is only getting bed baths and has missing bathing days. No further information has been provided at this time by the facility for R3's missing scheduled shower dates, alternative shower/bath methods for R3, or when the remodeling of the shower room to accommodate a shower cot for R3 and other residents like R3. 2.) R1's diagnoses includes hypertension, radiculopathy (1 or more nerve roots in spinal column become compressed or irritated) lumbar region, bilateral primary osteoarthritis of knee, benign prostatic hyperplasia (enlarged prostate, obstructive & reflux uropathy (urine flows backward from bladder into ureters) and anxiety disorder (group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life). R1's ADL (activities daily living) self-care performance deficit care plan initiated 6/26/25 & revised 7/17/25 includes an intervention *BATHING/SHOWERING: The resident requires max (maximum) assist x1 (times one) staff to provide (shower) (twice weekly) and as necessary. Initiated 6/26/25 & revised on 9/2/25. R1's admission MDS (minimum data set) with an assessment reference date of 7/2/25 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. For the question how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath #1 very important is answered. R1's quarterly MDS with an assessment reference date of 9/8/25 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R1 is assessed as requiring substantial/maximal assistance for shower/bathe self. The Certified Nursing Assistant (CNA) Care Card for Unit: [Name} under section room/shower for R1 documents [Room #] Tues/Sat (Tuesday/Saturday) AM (morning) shift. Surveyor reviewed under the task tab of R1's electronic medical record, showers/bathing/personal care for the past 30 days. Surveyor noted there is only documentation of no data found. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/10/25, at 11:43 a.m., Surveyor asked Certified Nursing Assistant (CNA)-H if R1 receives showers. CNA-H informed Surveyor R1 is very nervous, anxious and makes the caregivers nervous. On 11/10/25, at 1:07 p.m., Surveyor asked CNA-G if R1 takes showers. CNA-G replied yes if PT (physical therapy) can get him up otherwise bed baths. On 11/10/25, at 1:24 p.m., Surveyor asked Director of Nursing (DON)-B where Surveyor would be able to locate when a resident received a shower. DON-B informed Surveyor it's under the task section. On 11/11/25, at 7:46 a.m., Surveyor asked DON-B how often Residents receive a shower. DON-B informed Surveyor residents are offered two times a week. Surveyor informed DON-B Surveyor does not have evidence R1 was provided with showers two times a week. DON-B replied let me see what I can pull. On 11/11/25, at 8:47 a.m., Surveyor observed R1 in bed on his back with the head of the bed up high and R1's breakfast tray on the overbed table in front of R1. Surveyor asked R1 permission to observe morning cares today. R1 informed Surveyor today is his shower day, and they said they were going to give him a shower this morning after breakfast. Surveyor asked permission to observe which resident gave. On 11/11/25, at 9:27 a.m., CNA-F informed Surveyor CNA-G is with another resident but she's going to get started. CNA-F placed gown & gloves on and entered R1's room. CNA-F informed R1 she was going to change him, and CNA-G is going to meet them. CNA-F filled a washbasin and placed the washbasin & towels on the overbed table and a clear garbage bag on the floor. R1 washed his own face, CNA-F placed Dove body soap on a washcloth and R1 washed under his neck and under his underarms. CNA-F rewashed under R1's neck & underarms and then handed R1 deodorant. CNA-F lowered the head of the bed, removed bedding and washed R1's inner thighs. At 9:41 a.m. CNA-G entered R1's room with the appropriate PPE (personal protective equipment) and CNA-F cleaned the tubing of the catheter and R1's frontal perineal area. CNA-G positioned R1 on the side, CNA-F wiped R1's rectal area with the incontinence product, folded the draw blanket under R1 and washed R1's rectal area & buttock, and applied remedy cream on R1's buttocks. A draw blanket and incontinence product were placed under R1 and R1 was positioned onto his back. R1's urinary collection bag was attached to the right side of the bed frame and R1 was positioned on the right side to remove the soiled product & draw sheet and straightened out the draw blanket & incontinence product. CNA-F sprayed cologne on R1 per his request, R1 was covered with bedding, and the bed was lowered. Surveyor noted R1 received a bed bath and did not receive a shower during this observation. On 11/11/25 at 9:56 a.m., Surveyor asked CNA-F how she knows which residents are to receive a shower. CNA-F explained she looks at the assignment sheet as they are listed for AM (morning) and PM (evening) or the care plan will let them know. Surveyor asked CNA-F if there is any paper, they are required to fill out. CNA-F informed Surveyor there are shower sheet, she fills out her part, hands it to the nurse and the nurse signs them. Surveyor asked CNA-F why she didn't give R1 a shower. CNA-F replied there is still time for him to get a shower, probably will be a bed bath because it's too much strain on my body and name of R1. Surveyor asked what the difference will be from what Surveyor observed this morning. CNA-F explained his arms, legs, all of that. Surveyor asked CNA-F when she will do this. CNA-F replied probably before I get him dressed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/11/25, at 10:58 a.m., Surveyor asked R1 what time he was getting up. R1 informed Surveyor he doesn't know, and they said they were going to get me in the shower. R1 stated I don't know they say one thing. They said they were waiting for therapy. Surveyor asked R1 if he ever refuses showers. R1 replied no, suppose to be two times a week, therapy not here on Saturday. Surveyor asked R1 if he receives his showers on Tuesday. R1 replied yes. Surveyor asked about Saturday showers. R1 replied that's the one they are scared to give me, they say they don't want to do it. Surveyor asked R1 so Tuesday is not a problem, but Saturday is because they are scared to do it. R1 replied yes. On 11/11/25, at 11:08 a.m. Surveyor reviewed R1's Saturday shower sheets from July 22, 2025 to November 2025 and noted the following: Week of 7/20 to 7/26/25 Surveyor was not provided with a shower sheet for 7/26/25 (Saturday) R1 received a bed bath on 7/24/25. Week of 7/27 to 8/2/25 Surveyor was not provided with a shower sheet for 8/2/25 (Saturday) R1 received a shower on 7/31/25. Week of 8/3 to 8/9/25 Surveyor was not provided with a shower sheet for 8/9/25 (Saturday). Week of 8/10 to 8/16/25 Surveyor was not provided with a shower sheet for 8/16/26 (Saturday) R1 received a shower on 8/14/25. Week of 8/17 to 8/23/25 R1 received a bed bath on 8/23/25 (Saturday). Week of 8/24 to 8/30/25 Surveyor was not provided with a shower sheet for 8/30/25 (Saturday). Week of 8/31 to 9/6/25 R1 received a bed bath on 9/6/25 (Saturday). Week of 9/7 to 9/13/25 R1 received a bed bath on 9/13/25 (Saturday). Week of 9/14 to 9/20/25 R1 received a shower on 9/20/25 (Saturday). Week of 9/21 to 9/27/25 Surveyor was not provided a shower sheet for Saturday 9/27/25. R1 received a bed bath on 9/26/25. Week of 9/28 to 10/4/25 Surveyor was not provided with a shower sheet for Saturday 10/4/25. Week of 10/5 to 10/11/25 R1 received a bed bath on 10/11/25 (Saturday). Week of 10/12 to 10/18/25 R1 received a bed bath on 10/18/25 (Saturday). Week of 10/19 to 10/25/25 R1 received a bed bath on 10/25/25 (Saturday). Week of 10/26 to 11/1/25 R1 received a shower on 11/1/25 (Saturday). Week of 11/2 to 11/8/25 R1 received a bed bath on 11/8/25 (Saturday). (continued on next page)

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	525547	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Glendale West	6263 N Green Bay Ave Glendale, WI 53209

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/11/25, at 12:56 p.m., Surveyor asked Physical Therapy Assistant (PTA)-J if he assists staff with R1's showers. PTA-J informed Surveyor he is not involved with R1's showers but he assists with getting him in the shower chair and back. Surveyor asked PTA-J if he's not here to help what do staff do. PTA-J informed Surveyor they use a Hoyer lift or sit to stand. Surveyor asked PTA-J if he works on Saturday. PTA-J informed Surveyor he is usually not here on Saturday unless he missed a day during the week and then may work Saturday. Surveyor asked PTA-J if he's not here on Saturday what does R1 receive. PTA-J informed Surveyor he's guessing a bed bath. On 11/11/25, at 3:05 p.m., during the end of the day meeting Nursing Home Administrator (NHA)-A, DON-B, and Regional RN-M were informed of the above. No additional information was provided to Surveyor as to why R1 was not provided showers on Saturdays. 3.) R2 was admitted to the facility on [DATE] with diagnoses of Chronic Kidney Disease (progressive damage and loss of function in the kidneys), Chronic Obstructive Pulmonary Disease (lung disease that block airflow and make it difficult to breathe), Type 2 Diabetes Mellitus (adult onset of trouble controlling blood sugar), Anemia (lack of blood), Peripheral Vascular Disease (circulatory condition in which narrowed blood vessels reduce blood flow to limbs), Metabolic Encephalopathy (brain dysfunction resulting from underlying condition that disrupts the metabolic processes), Rheumatoid Arthritis (autoimmune disease that causes chronic inflammation in the joints and can affect other parts of the body), Obesity, Lupus Anticoagulant Syndrome (autoimmune disorder where body produces antibodies that mistakenly attack phospholipids, and Osteomyelitis (bone infection that can be caused by bacteria, fungi, or other germs spreading through the bloodstream or from nearby tissues). R2 is currently her own person. R2's Quarterly Minimum Data Set (MDS) completed 9/24/25 documents R2's Brief Interview for Mental Status (BIMS) score to be 12, indicating R2 demonstrates moderately impaired skills for daily decision making. R2's MDS documents R2 has range of motion (ROM) impairment on both sides of both upper and lower extremities. R2 requires set-up for eating. R2 requires partial/moderate assistance for showers, upper dressing, mobility, and transfers. R2 requires substantial/maximum assistance for lower dressing. R2 has an indwelling catheter due to neurogenic bladder and is frequently incontinent of bowel. R2 has no mood or behavior symptoms. R2's admission MDS completed 2/2/25 documents it is somewhat important for R2 to choose between tub bath, shower, bed bath, or sponge bath. R2's current weight documented on 11/6/25 is 216.5. R2's current physician orders document R2's shower days are on Wednesday and Saturday. R2's Activities of Daily Living (ADL) self-care performance deficit due to disease process, wounds to feet, impaired mobility initiated 1/29/25 and revised on 6/20/25. Showering: R2 is able to assist with upper body task, shower 2x weekly Initiated 1/30/25 Revised 6/20/25 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Certified Nursing Assistant (CNA) Care Card instructs R2 is to receive a shower on Wednesday and Saturday AM and to use a shower chair. Surveyor reviewed R2's electronic medical record (EMR) for documentation R2 has been receiving showers on Wednesday and Saturday. On 11/10/25, at 11:17 AM, Surveyor interviewed R2 in regard to receiving showers. R2 stated R2 was informed by the facility at admission that R2 could not receive showers because of R2's feet. R2 stated that R2 has never received a shower since admission and has only received bed baths. R2 stated that no one from the facility has washed R2's hair. R2 explained that R2 has paid someone to wash R2's hair. R2 informed Surveyor that R2 would love a shower. On 11/11/25, at 7:47 AM, Director of Nursing (DON)-B informed Surveyor that residents are offered a shower two times a week and the expectation is that skin checks should be done on shower days and documented On 11/11/25, at 8:11 AM, Director of Nursing (DON)-B informed Surveyor that showers should be documented in the residents' EMR. The CNAs chart the showers, and a skin check form should be completed. The CNA should get the nurse to verify the skin issues and then both the CNA and the nurse sign off. DON-B stated the facility has boxes of completed shower sheets and will need to look for R2's completed shower sheets. On 11/11/25, at 8:40 AM, Certified Nursing Assistant (CNA)-R informed Surveyor that the nurse gets the shower sheets ready for the day for the residents that are scheduled to get a shower that day. CNA-R stated that the shower given to each resident should be documented in the residents' EMR. CNA-R stated the expectation is to complete the shower sheets with every shower, and then the nurse signs off on the residents' shower sheet. On 11/11/25, at 9:07 AM, Surveyor reviewed the provided shower documentation(Body Audit Form) by the facility of R2's showers from May-November. Based on the calendar the following shower days are not documented as being completed: May 5/10/25, 5/13/25, 5/24/25, 5/31/25-no shower documented as being provided 5/21/25-R2's Body Audit Form does not document if R2 has had a tub bath or shower 5/28/25-R2's Body Audit Form does not document if R2 has had a tub bath or shower June 6/7/25, 6/21/25-no shower documented as being provided 6/4/25-Body Audit Form is not signed by the nurse as having completed the skin check 6/11/25- Body Audit Form does not document if R2 has had a tub bath or shower (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/14/25- Body Audit Form does not document if R2 has had a tub bath or shower July 7/2/25-Body Audit Form is not signed by the CNA who provided the shower 7/5/25- Body Audit Form does not document if R2 has had a tub bath or shower 7/16/25-R2 received a bed bath 7/19/25- Body Audit Form is not signed by the nurse as having completed the skin check August 8/20/25-no shower documented as being provided 8/9/25-Body Audit Form is not signed by the CNA providing the shower and the nurse as having completed the skin check 8/23/25-Body Audit Form is not signed by the CNA who provided the shower 8/27/25-R2 provided a bed bath and is not signed by the CNA and nurse 8/30/25- Body Audit Form does not document if R2 has had a tub bath or shower September 9/3/25- Body Audit Form does not document if R2 has had a tub bath or shower October 10/8/25, 10/18/25, 10/29/25, 10/31/25- no shower documented as being provided November 11/1/25- Body Audit Form is not signed by the CNA who provided the shower On 11/11/25, at 10:46 AM, Surveyor interviewed Unit Manager (UM)-N explained that if a resident refuses showers, the nurse should be informed and it should be documented in the resident's EMR. UM-N does not recall if R2's feet was a barrier to receiving showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/11/25, at 12:13 PM, Surveyor interviewed CNA-Q. Surveyor had noted that CNA-Q had signed a majority of R2's Body Audit Forms. CNA-Q states that CNA-Q has never given R2 a shower, only a bed bath. CNA-Q stated R2's hair is not washed with the bed bath. CNA-Q states that the facility does not have a shower chair that fits R2 due to R2's weight. CNA-Q specifically stated that R2's hips are too big for the shower chair. CNA-Q states that none of the staff give R2 a shower because everyone is afraid R2 will slide off the small shower chair and get injured. CNA-Q states its too unsafe to use the current available chair for R2. CNA-Q repeated that R2 will slide out or fall off. Surveyor asked CNA-Q why CNA-Q signed the Body Audit Forms documenting R2 has received showers. CNA-Q explained that CNA-Q has never given R2 a shower, just documented on paper as a shower. CNA-Q stated CNA-Q does not know of anyone who gives R2 a shower. On 11/11/25, at 12:34 PM, Social Worker (SW)-S informed Surveyor that SW-S is not aware of R2 refusing showers. On 11/11/25, at 3:04 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, DON-B and Regional Registered Nurse (RN)-M of R2 not receiving scheduled showers on Wednesday and Saturday on a consistent basis. Surveyor shared staff have never given R2 a shower because the shower chair does not fit R2 and it would not be safe to provide a shower to R2. Surveyor was informed by staff that the facility does not have appropriate equipment to give residents showers including appropriate sized shower chairs and shower cots. No further information has been provided by the facility at this time as to why R2 did not receive scheduled showers on a consistent basis.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure residents received assessment, treatment and care in accordance with professional standards of practice for 1 (R1) of 2 residents reviewed for a change in condition.*On 8/26/25 R1 received Oxycodone 5 mg during the night shift & rated his pain level at 8. This was the first time R1 received Oxycodone during the night shift & at this pain level. There was no assessment of what was causing R1's pain and other vitals. R1's physician ordered vital signs taken every day due to hypertension. The last vital sign documented in August is on 8/13/25. Interviews with CNA's revealed on 8/25/25 & 8/26/26 R1 was not feeling good, didn't look good and on the morning of 8/26/25 interviews revealed there was no urine in R1's urinary collection bag. R1 informed Surveyor he told the nurse his urine was loud and was informed this was due to his medication and he was going out for an appointment with the doctor. R1 was transferred from the doctor's office to the emergency room and admitted to the ICU (intensive care unit). R1's admitting diagnoses included Sepsis with acute renal failure and septic shock due to unspecified organism, unspecified acute renal failure.Findings include:According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process:(a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis.(b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis.(c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants.(d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis.According to N6.04(1), In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a provider .(b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient .(e) Perform the following other acts when applicable:1. Assist with the collection of data.2. Assist with the development and revision of a nursing care plan.3. Reinforce the teaching provided by an R.N. provider and provide basic health care instruction.4. Participate with other health team members in meeting basic patient needs.The facility's policy titled, Acute Condition Changes - Clinical Protocol Med Pass Inc. (Revised March 2018) Updated 10/2019 under Assessment and Recognition documents 2. In addition, the nurse shall assess and document/report the following baseline information: a. vital signs; b. Neurological status; c. Current level of pain, and any recent changes in pain level; d. Level of consciousness; e. Cognitive and emotional status; f. Resident's age and sex; g. Onset, duration, severity; h. Recent labs; i. History of psychiatric disturbances, mental illness, depression etc.; j. All active diagnoses; and k. All current medications.3. Direct care staff, including nursing assistants will be trained in recognizing subtle, but significant changes in the resident (for example, a decreased in food intake, increased agitation, changes in skin color or condition) and how to communicate these changes to the Nurse.*R1 was admitted to the facility on [DATE] with diagnoses which includes hypertension, radiculopathy (1 or more nerve roots in spinal column become compressed or irritated) lumbar region, lumbago with sciatica (lower back pain & pain that travels down the leg along the path of the sciatic nerve), benign prostatic hyperplasia (enlarged prostate, obstructive & reflux uropathy (urine flows backward from bladder into ureters), neuromuscular dysfunction of bladder, and anxiety disorder (group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life). R1's admission MDS (minimum data set) with an assessment reference date of 7/2/25 has a BIMS (brief interview mental status) score of 15 which indicates R1 is cognitively intact. R1 is assessed as not having any behavior. R1 is assessed as requiring set up for eating, supervision/touching assistance for roll left and right, substantial/maximal assistance for chair/bed to chair transfer and toilet transfer. R1 is assessed as having an indwelling urinary catheter and is frequently incontinent of bowel.R1's urinary CAA (care area assessment) dated 7/8/25 under analysis of findings for nature of the problem condition documents Resident is noted with an indwelling foley - admit with. Under care plan considerations for describe impact of this problem/need on the resident and your

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility did not maintain an infection prevention and control program designed to reduce the transmission of disease and infection for 1 (R1) of 1 Residents.* Appropriate hand hygiene was not observed during incontinence cares for R1, R1's urinary collection bag was observed on the floor and Licensed Practical Nurse (LPN)-I was not wearing a gown while removing the urinary collection bag off the floor and removing R1's pants who is on EBP (enhanced barrier precautions). Findings include:The facility's policy titled, Hand Hygiene and dated 6/25 under Policy documents All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Under Policy Explanation and Compliance Guidelines documents 1. Staff will perform hand hygiene when indicated, using proper technique consistent with acceptable standards of practice.The facility's policy titled, Enhanced Barrier Precautions and dated 9/25 under Policy documents It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Under Policy Explanation and Compliance Guidelines documents 2. Initiated of Enhanced Barrier Precautions documents b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC (peripherally inserted central catheter) lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO (multi drug resistant organism). (Peripheral IV's (intravenous), continuous glucose monitors, insulin pumps, or ostomies without an associated indwelling medical device are not an indication for EBP). 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i. e., wound irrigation, tracheostomy care). b. PPE (personal protective equipment) for enhanced barrier precaution is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. 4. High-contact resident care activities include: a. Dressing. b. Bathing. c. Transferring. d. Providing hygiene. e. Changing linens. f. Changing briefs or assisting with toileting. g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters. h. Wound care: any skin opening requiring a dressing. CDC (Centers for Disease Control and Prevention) Summary of Recommendations, Guideline for Prevention of Catheter-Associated Urinary Tract Infections (2009) under section III. Proper Techniques for Urinary Catheter Maintenance includes documentation of Keep the collection bag below the level of the bladder at all times. Do not rest the bag on the floor.R1's diagnoses includes hypertension, radiculopathy (1 or more nerve roots in spinal column become compressed or irritated) lumbar region, bilateral primary osteoarthritis of knee benign prostatic hyperplasia (enlarged prostate, obstructive & reflux uropathy (urine flows backward from bladder into ureters) and anxiety disorder (group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life). R1's quarterly MDS (minimum data set) with an assessment reference date of 9/8/25 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R1 is assessed as requiring substantial/maximal assistance for toileting hygiene and partial/moderate assistance for roll left and right. R1 is assessed as having an indwelling urinary catheter and is always incontinent of bowel.R1's physician orders include an order dated 10/9/25 which documents Isolation: Enhanced Barrier Precautions; Resident is currently on Enhanced Barrier Precautions, follow isolation guidelines.R1's requires enhanced barrier precautions care plan initiated 10/9/25 includes an intervention of Gown and gloves to be worn by staff during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Includes: dressing, bathing/showering, transferring, provide hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. Initiated 10/9/25.On 11/10/25, at 8:49 a.m., Surveyor observed a plaque/sign on R1's door indicating enhanced barrier precautions.On 11/10/25, at 1:52 p.m., Surveyor observed Licensed Practical Nurse (LPN)-I in R1's room. Surveyor observed LPN-I did not have the appropriate PPE (personal protective equipment) on for R1 who is on enhanced barrier precautions. LPN-I was only wearing gloves and did not have a gown on. LPN-I informed Surveyor R1 likes to be nude and stated urinary bag is under, showing Surveyor R1's collection bag is under the portion of R1's bed frame which stabilizes the bed. Surveyor