STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525548	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peabody Manor	2600 S Heritage Woods Dr Appleton, WI 54915

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure the Office of the State Long-Term Care Ombudsman was updated regarding hospital transfers and/or discharges for 4 residents (R) (R6, R43, R55, and R62) of 4 sampled residents.R6 was transferred to hospital on 1/7/26. Long-Term Care Ombudsman (LTCO)-C was not updated regarding R6's hospital transfer. R43 was trasferred to the hospital on [DATE] and 11/9/25. LTCO-C was not updated regarding R43's hospital transfers.R55 was transferred to the hospital on 9/28/25. LTCO-C was not updated regarding R55's hospital transfer.R62 discharged from the facility on 1/31/26. LTCO-C was not updated regarding R62's discharge.Findings include: The facility's Long Term Care (LTC) Discharge and Transfer Policy, revised 4/24/25, indicates: .7. The facility will forward a copy of all discharge/transfer notices to the Office of the State LTC Ombudsman. 1. Between 3/17/26 and 3/19/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including multiple sclerosis, diabetes, and left below-the-knee amputation (BKA). R6's Minimum Data Set (MDS) assessment, dated 1/13/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R6 had intact cognition. R6 made R6's own healthcare decisions. An emergency room (ER) admission note, dated 1/7/26, indicated R6 was sent to the ER for possible infection of the left BKA stump and to rule out possible sepsis. The facility did not provide documentation when asked to indicate LTCO-C was notified of R6's hospital transfer. (See interview under example 4.) 2. Between 3/17/26 and 3/19/26, Surveyor reviewed R43's medical record. R43 had a cardiac pacemaker and was admitted to the facility on [DATE]. R43 had diagnoses including asthma and paroxysmal atrial fibrillation (an irregular heartbeat). R43's MDS assessment, dated 10/29/25, contained a BIMS score of 11 out of 15 which indicated R43 had moderate cognitive impairment. R43 had an activated Power of Attorney for Healthcare (POAHC) to assist with healthcare decisions. A Nurse Practitioner note, dated 11/7/25 at 6:44 AM, indicated R43 had left-sided chest pain at a level 9 out of 10, a rapid and irregular heart rate, and shortness of breath. R43 was sent to ER for evaluation. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility did not provide documentation when asked to indicate LTCO-C was notified of R43's hospital transfer. A provider note, dated 11/9/25 at 5:45 PM, indicated R43 complained of chest pain at a level 8 out of 10. R43 was shaky, hypertensive, and had an oxygen saturation of 85% on room air. R43 was sent to the ER for evaluation. The facility did not provide documentation when asked to indicate LTCO-C was notified of R43's hospital transfer. (See interview under example 4.) 3. On 3/18/26, Surveyor reviewed R55's medical record. R55 was admitted to the facility on [DATE] and had diagnoses including cancer, indwelling catheter, and history of urinary tract infection. R55's MDS assessment, dated 2/11/26, had a BIMS score of 13 out of 15 which indicated R55 had intact cognition. R55's medical record indicated R55 was transferred to the hospital on 9/28/25 due to sepsis. On 3/18/26 at 2:29 PM, Surveyor requested Ombudsman notification for R55's hospital transfer. The informatin was not provided. (See interview under example 4.) 4. Between 3/17/26 and 3/19/26, Surveyor reviewed R62's medical record. R62 was admitted to the facility on [DATE] and had diagnoses including coronary artery disease, heart failure, and diabetes. R62's MDS assessment, dated 1/7/26, had a BIMS score of 13 out of 15 which indicated R62 had intact cognition. R62's medical record indicated R62 was discharged from the facility on 1/31/26. On 3/19/26 at 9:45 AM, Surveyor interviewed Social Worker (SW)-D who verified SW-D did not send transfer/discharge notices to LTCO-C. SW-D stated SW-D was told by a previous Social Worker that LTCO-C had asked the facility not to send transfer/discharge notices because the facility had too many residents. On 3/19/26 at 10:51 AM, Regional Field Operations Supervisor (RFOS)-M contacted LTCO-C via email to verify if LTCO-C asked the facility not to send transfer/discharges notices. On 3/19/26 at 1:11 PM, LTCO-C indicated via email it is a facility requirement to notify LTCO-C of transfers and discharges and LTCO-C would not advise a facility not to do so.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interview, and record review, the facility did not ensure menus met the nutritional needs of residents in accordance with established national guidelines. This practice had the potential to affect more than 4 of the 58 residents residing in the facility.The facility did not implement a menu that delineated portion sizes for residents.Findings include:The facility's Long Term Care (LTC) Dining Services Policy, dated 8/12/25, indicates: The Dietary Coordinator will observe meal preparation and services to assess ordered diet, portion sizes, temperature, flavor, variety, and tray passing for accuracy, and will report any concerns to the Administrator, Director of Nursing (DON), Dietitian, or other necessary leader as needed.On 3/18/26 at 12:10 PM, Surveyor observed Dietary Aid (DA)-E prepare scoops/ladles for plating food. The meal consisted of a baked potato, broccoli and cheese served on top of the baked potato, minestrone soup with noodles, and peaches served on top of cottage cheese. Surveyor interviewed DA-E who stated there is no specific scoop or ladle size used for the food served and DA-E uses scoops and ladles that seem best suited for the food, including a larger ladle which works best for soup. DA-E wasn't sure how many ounces of protein or other food items should be on each resident's plate. DA-E stated some residents eat less and DA-E uses half of the scooped/ladeled amount. DA-E stated DA-E knows which residents eat small or large portions. DA-E verified meal tickets do not always indicate if a resident wants small or large portions.On 3/18/26 at 12:22 PM, Surveyor observed DA-I use a purple scoop to put 2 scoops of cottage cheese and 1-2 slotted spoonfuls of peaches in bowls for residents. Surveyor noted it was a different portion than DA-E had put in bowls earlier. DA-E used a large spoon for the cottage cheese and a large ladle for the peaches.On 3/18/26 at 1:05 PM, Surveyor interviewed Dietary Supervisor (DS)-F who was aware portion sizes were not consistent and staff were not educated to use specific portions for each type of food, including protein. DS-F indicated there was a plan to institute a new food program with consistent recipes and portion sizes. DS-F stated staff would be educated on using measured scoops/spoodles to ensure residents receivenconsistent portions to support a nutritious diet.On 3/18/26 at 3:35 PM, Surveyor interviewed Registered Dietician (RD)-G who indicated scoop and portion sizes are not on residents' meal tickets; however, residents' preferences for smaller or larger portions are on the meal tickets. RD-G indicated staff need additional education to correctly portion food onto plates. RD-G stated RD-G was working with DS-F to implement a new food program with consistent recipes and portion sizes.On 3/19/26 at 4:15 PM, Surveyor reviewed residents' meal tickets for the evening meal which contained residents' diets, allergies, food textures, and food requests. The meal tickets did not contain portion sizes with the exception of 1 meal ticket that had small portions manually written on the pre-printed ticket.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, the facility did not ensure food was stored, prepared, or served under sanitary conditions. This practice had the potential to affect more than 4 of the 58 residents residing in the facility.Multiple food items were undated, expired, and/or not sealed properly.Findings include:The facility's Food Procurement, Storage, Preparation, and Service Policy, revised 2/8/26, indicates: Date marking of food prepared and packaged in a food processing plant and served in a food establishment: These foods must be clearly marked with the date the original container is opened; and they must be consumed or discarded within seven days including the day the container is opened. Must be maintained at 41 degrees or less for the duration of the seven days .At no time will the food be sold or served beyond the expiration date placed on the original container by the food manufacturer.On 3/17/26 at 9:02 AM, Surveyor began an initial tour of the kitchen with Head [NAME] (HC)-H and observed the following: ~ Thawed bread and buns in the kitchen prep area without a pull-date~ An undated open bag of ziti pasta~ An undated open bag of egg noodles ~ A bowl of green grapes with a discard date of 3/11/26~ An open and undated plastic bin of powdered sugar that contained a measuring cup~ An open and undated plastic bin of all-purpose flour not in the original packaging~ An open and undated plastic bin of granulated sugar ~ An open and undated plastic bin that contained a bag of long grain white rice.On 3/17/26 at 9:02 AM, Surveyor interviewed HC-H who indicated the bread and buns should have been dated when they were removed from the freezer. HC-H indicated both bags of pasta should have open dates and the green grapes should have been discarded. HC-H removed the measuring cup from the bin of powdered sugar and verified the measuring cup should not have been in the bin. HC-H indicated the powdered sugar, all-purpose flour, granulated sugar, and long grain white rice should have been dated when opened. On 3/17/26 at approximately 9:30 AM, Surveyor interviewed Dietary Supervisor (DS)-F who joined the kitchen tour. DS-F agreed the bread and buns should have been dated when pulled from the freezer, the grapes should have been discarded, and the measuring cup should not have been in the bin of powdered sugar. DS-F also verified the powdered sugar, granulated sugar, all-purpose flour, and long grain white rice should have been dated when opened.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure monitoring for adverse consequences of psychotropic medication was provided for 1 resident (R) (R7) of 5 sampled residents. R7 had orders for buspirone (an antipsychotic medication) and olanzapine (an antipsychotic medication). The facility did not complete quarterly Abnormal Involuntary Movement Scale (AIMS) assessments (used to monitor patients on long-term antipsychotic medications for involuntary muscle movements associated with tardive dyskinesia) for R7.Findings include:The facility's Psychotropic Monitoring policy, revised 8/12/25, indicates: .Long Term Care (LTC) will monitor residents who are receiving antipsychotic drug therapy for significant adverse effects of such therapy .will monitor residents on antipsychotic drug therapy through use of the Abnormal Involuntary Movement Scale (AIMS). 2. Team members will complete the AIMS for residents on antipsychotic drug therapy: a. Upon admission; b. At the start of a new antipsychotic medication; c. Upon each Quarterly MDS assessment .On 3/18/26, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, depression, and anxiety. R7's Minimum Data Set (MDS) assessment, dated 12/31/25, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R7 had severely impaired cognition. R7 had an activated Power of Attorney for Healthcare (POAHC).R7's medical record contained the following orders: ~ Buspirone 5 milligrams (mg) and buspirone 10 mg at bedtime~ Olanzapine 2.5 mg at bedtimeR7's medical record indicated R7's most recent AIMS assessment was completed on 7/12/25.On 3/19/26 at 10:53 AM, Surveyor interviewed Director of Nursing (DON)-B who verified R7's last AIMS assessment was completed on 7/12/25. DON-B indicated AIMS assessments should be completed quarterly per the facility's policy.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, staff interview, and record review, the facility did not ensure 1 resident (R) (R63) of 2 sampled residents received care and treatment to prevent accidents. R63 was observed smoking outside the facility. R63's medical record did not contain a smoking assessment to ensure R63 was safe to smoke independently and/or without supervision. Findings include: The facility's Smoking Policy, dated 1/31/24, indicates: Team members will enforce a non-smoking campus by designating safe smoking areas, providing resident education, and completing resident assessments for smoking to ensure precautions are taken for the individual safety as well as the safety of others in the facility .a. Any resident choosing to smoke will be assessed by a licensed nurse utilizing the Smoking Evaluation Risk Flowsheet. This assessment will be completed prior to the resident smoking and will be repeated as needed and with a change of condition. Between 3/17/26 and 3/19/26, Surveyor reviewed R63's medical record. R63 was admitted to facility on 2/28/26 and had a diagnosis of necrotizing fasciitis. R63's Minimum Date Set (MDS) assessment, dated 3/2/26, indicated R63 was independent with hygiene, toileting, transfers, and dressing. R63 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R63 had intact cognition. A care plan, dated 3/1/26, indicated R63 should follow the smoking policy for safety considerations and was safe to smoke. R63's medical record did not contain a smoking assessment. Surveyor requested R63's smoking assessment from Nursing Home Administrator (NHA)-A. On 3/18/26 at 9:24 AM, Surveyor observed R63 smoking outside the facility with another resident. On 3/18/26 at 10:36 AM, Surveyor interviewed NHA-A who indicated the facility did not have a smoking assessment for R63. NHA-A verified a smoking assessment should have been completed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 1 resident (R) (R52) of 1 sampled resident received the necessary care and services to prevent or monitor weight loss.R52 had significant weight loss. R52's weight was not monitored as ordered. In addition, appropriate follow-up was not completed, including timely notification of the physician.Findings include:On 3/17/26, Surveyor reviewed R52's medical record. R52 was admitted to the facility on [DATE] and had a diagnosis of high blood pressure. R52's Minimum Data Set (MDS) assessment, dated 10/22/25, had a Brief Interview for Mental Status (BIMS) score of 3 out 15 which indicated R52 had severe cognitive impairment. R52 had an activated Power of Attorney for Healthcare (POAHC).R52's care plan indicated R52 should be weighed weekly (with a start date of 11/3/25).Surveyor reviewed R52's weights and noted the following:~ On 1/8/26, R52 weighed 198.2 pounds (lbs).~ On 2/19/26, R52 weighed 183.1 lbs (which was a significant weight loss of 7.62%).R52's medical record did not contain a re-weight or indicate the physician was notified of the weight loss.On 3/18/26 at 2:47 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed the physician was not notified regarding R52's weight loss of more than 5% in one month. DON-B verified the physician should have been notified and staff should have attempted to re-weigh R52.On 3/18/26 at 3:40 PM, Surveyor interviewed Registered Dietitian (RD)-G who was aware of R52's weight loss. RD-G confirmed staff should have re-weighed R52 and notified the physician if R52 had a weight loss of more than 5% in one month.On 3/19/26 at 8:15 AM, Surveyor requested R52's order for weight monitoring.On 3/19/26 at 8:29 AM, Surveyor interviewed Registered Nurse (RN)-J who reviewed R52's medical record and indicated the start date for weekly weights was 1/9/25. RN-J indicated R52 is weighed weekly with showers. RN-J stated if R52 has significant weight loss or gain, RN-J updates the physician and RD-G.On 3/19/26 at 9:24 AM and 9:34 AM, Surveyor interviewed DON-B who indicated R52 refused to re-weighed. DON-B verified the refusal was not documented in R52's medical record. DON-B indicated R52 did not have a physician order for weights and the facility would do a minimum of monthly weights.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure it was free of a medication error rate of 5% or greater. During observations of medication administration, 2 errors occurred during 30 opportunities which resulted in a 6.67% medication error rate that affected 1 resident (R) (R32) of 4 residents observed during medication administration.R32 had an order for pantoprazole (used to treat acid reflux). The order stated to give the medication on an empty stomach. On 3/18/26, staff administered pantoprazole to R32 after R32 started eating breakfast. In addition, R32 had an order for isosorbide (used to prevent/treat chest pain). The order indicated not to crush the medication. Staff crushed the medication prior to administration.Findings include:The facility's Oral Medications That Should Not Be Crushed or Altered form, updated 3/9/26, indicates: The following table contains drugs .that have characteristics that may make it inappropriate to crush or alter the dosage form to help facilitate drug delivery .Medications which should not crushed fall into one of the following categories: extended release products .pantoprazole tablet is slow release .On 3/18/26, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] and had diagnoses including acid reflux, congestive heart failure, and coronary artery disorder. R32's Minimum Data Set (MDS) assessment, dated 2/25/26, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R32 had intact cognition.On 3/18/26 at 8:24 AM, Surveyor observed Registered Nurse (RN)-K prepare and administer R32's AM medication. R32 was eating breakfast in the dining room. Surveyor observed RN-K crush isosorbide with other medications, except pantoprazole. RN-K administered the crushed medications in applesauce.Surveyor reviewed R32's Medication Administration Record (MAR) which contained the following physician orders:~ Pantoprazole 20 milligram (mg) tablet, give daily before morning meal. Administration instructions: Take on an empty stomach. Do not crush or chew.~ Isosorbide dinitrate 10 mg tablet, give 2 times daily. Administration instructions: Do not crush. On 3/18/26 at 12:32 PM, Surveyor interviewed RN-K and Director of Nursing (DON)-B. RN-K confirmed RN-K crushed R32's isosorbide and administered R32's pantoprazole during breakfast. DON-B indicated RN-K had just started working at the facility and was not familiar with R32. DON-B confirmed RN-K should have followed the administration instructions for both medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 2 residents (R) (R2 and R6) of 2 sampled residents.During wound care for R2, Registered Nurse (RN)-J did not appropriately change gloves and cleanse hands. In addition, RN-J applied Medi-honey to R2's wound bed with a soiled glove.Staff did not comply with enhanced barrier precautions (EBP) during wound care for R6.Findings include: The Wisconsin Department of Health Services webpage titled Healthcare-Associated Infections, last updated on 2/24/26 indicates: Hand hygiene refers to cleaning your hands, either by washing with soap and water, or using alcohol-based hand rub (ABHR). Hand hygiene should be performed before and after contact with a patient or resident, immediately after touching blood, body fluids, non-intact skin, mucous membranes, or contaminated items (even when gloves are worn during contact), immediately after removing gloves, when moving from contaminated body sites to clean body sites while providing care, and after touching objects and medical equipment in the immediate patient-care vicinity. The Centers for Disease Control and Prevention (CDC) (6/28/24) states enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBP involves gown and glove use during high-contact resident care activities for residents known to be colonized or infected with an MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). 1. Between 3/17/26 and 3/19/26, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including diabetes, and anxiety. R2's Minimum Data Set (MDS) assessment, dated 2/11/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R2 had intact cognition. On 3/19/26 at 9:15 AM, Surveyor observed RN-J remove R2's left foot dressing. RN-J then removed gloves, completed hand hygiene, and donned clean gloves. RN-J put wound cleanser on a 4 x 4 gauze pad and cleansed R2's open wound. RN-J then opened an island dressing, put Medi-honey on the tip of RN-J's soiled glove, and put the Medi-honey on the wound bed. RN-J removed gloves, dated the dressing, and completed hand hygiene. RN-J donned clean gloves and put the dressing on R2's left foot wound. On 3/19/26 at approximately 9:30 AM, Surveyor interviewed RN-J who verified RN-J should have removed gloves and completed hand hygiene after cleansing the wound and before putting Medi-honey on the wound bed. On 3/19/26 at 10:20 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated RN-J should have completed hand hygiene and donned clean gloves between dirty and clean aspect of wound care. DON-B indicated staff should use a Q-tip or applicator to apply Medi-honey. 2. Between 3/17/26 and 3/19/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including multiple sclerosis, diabetes, suprapubic catheter for neurogenic bladder, and pressure injuries to the right heel, right buttock, and perineum, right mid-foot diabetic ulcer, and left below-the-knee amputation (BKA). R6's MDS assessment, dated 1/13/26, had (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a BIMS score of 15 out of 15 which indicated R6 had intact cognition. R6 made own R6's own healthcare decisions. On 3/18/26 at 9:46 AM, Surveyor observed an EBP sign and a personal protective equipment (PPE) cart outside R6's room. The sign indicated staff must wear a gown and gloves during high-contact resident care such as wound care. Surveyor observed Licensed Practical Nurse (LPN)-L and RN-K complete hand hygiene and don gloves. LPN-L and RN-K did not don gowns prior to entering R6's room. RN-K touched R6 and R6's Prevalon heel boot (used to offload heels). When Surveyor asked if LPN-L and RN-K should wear gowns during wound care for a resident on EBP, RN-K stated yes.