STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525552	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheaton Franciscan Hc - Terrace at St Francis	3200 S 20th St Milwaukee, WI 53215

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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 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that 1 of 5 Certified Nursing Assistant (CNA) reviewed received registry verification that the individual has met competency evaluation requirements. CNA-L's Wisconsin Nurse Aide Registry certification expired and CNA-L continued working in the facility. This deficient practice has the ability to affect 41 of 41 residents residing at the facility whom have the potential to and or received cares from CNA-L.Findings include:According to the Wisconsin Nurse's Aide Training and Registry, Nurse Aides must be listed on the Wisconsin Nurse Aide Registry in order to be employed in any federally eligible health care setting in Wisconsin. The registry ensures that that the individual has met competency evaluation requirements to work as a CNA. On [DATE], Surveyor reviewed CNA registry information for 5 randomly CNAs. CNA-L was listed on the registry. Surveyor noted that CNA-L's CNA certification expired on [DATE] and was not renewed. CNA-L had worked in the facility a total of 89 days since the expiration of their CNA certification according to documentation provided by the facility.On [DATE] at 11:25 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding CNA-L's expired CNA certification. NHA-A responded that they were unaware that CNA-L's certification had expired. Surveyor informed NHA-A that per facility documentation, CNA-L has worked a total of 89 days without an active CNA certification. No additional information was provided as to why the facility did not ensure that prior to CNA-L working, the facility ensure that it received registry verification that CNA-L had met competency evaluation requirements.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility did not provide pharmaceutical services that assure proper dispensing of medications, did not ensure drug records are in order, or all controlled drugs are maintained and periodically reconciled.*The facility does not have a process for medications that should be returned to the pharmacy for possible reimbursement or otherwise destroyed; and keeping a log of those medications.*The facility did not ensure that controlled medication logs were accurate and reconciled.This deficient practice has to potential to affect 41 of 41 residents residing at the facility whom have the potential to and or receive pharmaceutical services. Findings:The Facility's policy, titled Discarding and Destroying Medications, dated 01/2024, documents . C. Unless otherwise prohibited under applicable federal or state laws, individual resident medications supplied in sealed unopened containers may be returned to the issuing pharmacy for disposition provided that: 1. No medications covered under the Federal Comprehensive Drug Abuse Prevention and Control Act of 1976 are returned; 2. All such medications are identified as to lot or control number; and 3. The receiving Pharmacist and a Registered Nurse employed by the community sign a separate log that lists the resident's name; the name, strength, prescription number (if applicable) and amount of the medication returned; and the date the medication was returned. F. For unused, non-hazardous controlled substances that are not disposed of by an authorized collector, the EPA recommends destruction and disposal of the substance with other solid waste following the steps below: 1. Take the medication out of the original containers. 2. Mix medication, either liquid or solid with an undesirable substance. Undesirable substance includes sand, coffee grounds, kitty litter, or other absorbent materials. Place the waste mixture in a sealable bag, empty can, or other container to prevent leakage. 3. Dispose with the solid waste (i.e., regular trash) in the presence of two witnesses. 4. Document the disposal on the medication disposition record. 5. Include the signature(s) of at least two witnesses. On 08/19/2025, at 12:00 PM, Surveyor observed the medication room on the second floor. Surveyor noted numerous packages of resident medications in a small bin, filled to the rim on the counter, injectable medication and intravenous medication with resident names, some expired. Surveyor also noted a large garbage size bag, with a zip tie closure, full of medications.On 08/19/2025, at 3:35 PM, Surveyor interviewed DON-B regarding the medication in the medication room. DON-B informed Surveyor that DON-B would look into why there are expired medication sitting in the medication room on the second floor.On 08/19/2025, at 4:12 PM, Surveyor interviewed Pharmacist-H. Pharmacist-H informed Surveyor that Pharmacist-H comes to the facility about once per month and was last at the Facility approximately 1 week ago. Pharmacist-H preforms spot checks of the medication rooms, medication carts, check insulin pens, stock medication and inform the nurse on duty as well as DON-B of any findings. The facility would need to request a nurse if the facility wanted a complete audit of the medication rooms and medication carts. Pharmacist-H indicated that the facility does not return medications to the pharmacy and would need to contact the operations side of pharmacy for those services. Pharmacist-H informed Surveyor that the last spot check report on 08/12/2025 showed expired medications were found and were taken out of circulation.On 08/20/2025, at 8:17 AM, Surveyor observed Narcotic medication count on the third floor with RN-N. Surveyor noted R30's Lorazepam 0.5mg(milligrams) was documented as 22 remaining, but there was only 21 in the medication card. Surveyor noted R30's medication card was not being dispensed in numerical order, and number 9 was circled in pen. RN-N indicated the circled number means missing, that it either fell out into the lock box or something. RN-N indicated RN-N would look into it and inform the nurse manager and get back to Surveyor with additional information.Surveyor noted R27's morphine 20mg/ml (milliliters) is currently documented as 25ml remaining as of 7/31/25. The previous administration was on 7/28/25 with 27.25ml remaining. Surveyor noted R27's order indicates to give 0.5ml by mouth every one hour as needed for pain, which indicates 2.25ml are unaccounted for. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	RN-N informed Surveyor that on 7/31/25 RN-N documented received on the narcotic count log it is documented that RN-N noted 25 ml remaining and informed the nurse manager that the count was inaccurate. Surveyor noted R10's lorazepam 0.5mg had a circle in pen around number 9. RN-N indicated again circled means missing and reported to the unit manager and/or DON for follow up on 5/6/25. Surveyor noted, on 5/6/25 was documented as wasted but then crossed off.Surveyor noted R18's diazepam 2mg had a circle around number 8.On 08/20/2025, at 9:12 AM, Surveyor interviewed DON-B. DON-B informed Surveyor that DON-B started looking at the narcotic medication counts yesterday and noticed R27's morphine looks like it may have spilled, and DON-B may have me sign off on it but would have to check policy regarding spills. DON-B went through all the liquid morphine and began audits since the previous DON had no documentation that audits were done. On 08/20/2025, at 12:51 PM, Surveyor informed the facility of the concerns regarding medication disposal, inaccurate narcotic count logs and expired medications. DON-B informed Surveyor that DON-B went through the Narcotic medications, noted the inconsistencies, did assessments on residents and spoke to the pharmacy consultant. DON-B explained to Surveyor, the morphine counts are always off, per pharmacy- within 5ml, they do not consider the count to be off.Surveyor asked DON-B how the facility is ensuring accurate dispensing and account for liquid narcotic medications. DON-B indicated that they look for repetitive administering of as needed medications given by a nurse that is not given, patterns in how the medication is given, and the pharmacist will have to do a total audit anyway. DON-B informed Surveyor that reeducation and Inservice of staff on notifying DON-B immediately of any discrepancies and ensuring dispensing medication in correct order to avoid further issues. DON-B stated that as of now, the facility does not have a process for returning medications to pharmacy or documenting the destruction of non-narcotic medications. NHA-A and DON-B aware of concerns.On 08/20/2025, at 8:43 AM, RN-N informed Surveyor that the facility utilizes the drug buster in the dirty utility room and medications are never picked up by pharmacy. RN-N indicated that medications come in and the night shift will destroy and stock medications. RN-N was unsure of any form that is used for medication destruction, but 2 nurses are required for controlled medication destruction.On 08/20/2025, at 8:50 AM, Surveyor interviewed UM-O, who indicated that she has only been at the facility for 3 days. UM-O informed Surveyor that the drug buster is used for destruction of all medications. Non-narcotic medications do not need to record destruction but for narcotic medications, there is a page that is filled out by 2 nurses to witness and destroy the medications in the drug buster. UM-O indicated that pharmacy does not come pick up medications and medications should just be destroyed. Surveyor asked UM-O to come into the medication room with Surveyor. Surveyor noted the Facility's stock Insulin, Novolin 70/30, dated 6/27 with instructions to discard 42 days after opening. UM-O indicated the Insulin should not be used and should be discarded.On 08/20/2025, at 11:08 AM, Surveyor asked DON-B to come to the 2nd floor medication room with Surveyor. Surveyor showed DON-B all the medications laying around the medication room, and asked DON-B about the large garbage sized bag of medications, which now had been ripped open. DON-B informed Surveyor that pharmacy delivered medications and night shift will put them in the medication carts for the next day. DON-B was unsure what was going on with the small bin of medications and the expired intravenous medications. DON-B indicated he was still looking into it and will get back to Surveyor.On 08/21/2025, at 6:05 PM, Surveyor emailed NHA-A to ask for any destruction logs the Facility has. NHA-A responded that the Facility utilizes the drug buster to destroy medications, but there is no recording keeping of that.No additional information was provided as to why the facility did not provide pharmaceutical services that assure proper dispensing of medications, did not ensure drug records are in order, or all controlled drugs are maintained and periodically reconciled.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that 4 (R8, R5, R42 and R11) of 6 residents and/or their representative that were reviewed, were provided the risks and benefits for prescribed psychotropic medication. * R8 received an antidepressant and antipsychotic medication with no evidence that the risks and benefits were explained, reviewed or provided. * R5 received an antidepressant medication with no evidence of risks and benefits were explained, reviewed or provided. * R42 received an antidepressant and antipsychotic medication with no evidence of risks and benefits were explained, reviewed or provided. *R11 received an antipsychotic medication with no evidence of risks and benefits were explained, reviewed or provided. The facility's policy and procedure, Psychotropic Medication, dated 6/2025 documents under Section T, Consents for Psychotropic Medications: 1. If a resident is admitted on a psychotropic medication, nursing will obtain appropriate and necessary written consent. 2. A consent will be obtained by nursing prior to a new medication is initiated and each time it is increased. Findings include: 1.) R8 was admitted to the facility on [DATE] with a diagnoses that included vascular dementia, moderate, with psychotic disturbance. R8 has an activated Power Attorney for Health Care since 4/11/2023. R8 Quarterly (Minimum Data Set) MDS assessment completed on 7/18/25 documents the use of antipsychotic and antidepressant medication by R8. R8's Psychiatry Follow-up note dated 2/20/2025 documents that new medications including antipsychotic Abilify 12.5 (milligram) mg daily; antidepressant Zoloft were switched to Lexapro 5 mg daily and Trazadone 50 mg daily. R8 does not have documentation that the consent for risks and benefits of this antidepressant medications and antipsychotic medication were explained, reviewed or provided. R8's Psychiatry Follow-up noted dated 3/20/25 documents an increase to R8's Abilify to 10 mg daily, Trazadone 50 mg daily and Lexapro 20 mg daily. R8 does not have documentation of the consent for risks and benefits of dose changes in the antidepressant and antipsychotic medication were explained, reviewed or provided. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/20/2025, at 1:07 PM, Surveyor interviewed the (Director of Nursing) DON -B and asked who is responsible for obtaining medication consents explaining risks and benefits for psychotropic medications. DON-B informed Surveyor that floor nurses should be responsible for obtaining the consents and the floor nurses are not doing this and plans on following up. No additional information was provided as to risks and benefits for the antidepressant and antipsychotic medications that R8 was prescribed. 2.) R5 was admitted to the facility on [DATE] with diagnoses that included hemiplegia following cerebral infraction, major depressive disorder, dementia with behavioral disturbance. R5's Minimal Data Set (MDS) assessment, dated 3/26/25, documents a Brief Interview for Mental Status (BIMS) of 0, indicating that R1 has severe cognitive impairment. R5's Physician Order, dated 8/14/25, documents: Venlafaxine 37.5 mg tab (sic) by mouth every PM for depression. R5's Care Plan dated 3/21/25, documents: Psychotropic Drug Use, R5 has a potential for drug related complications associated with use of related to antidepressant use. R5 will remain free of drug related cognitive/behavioral impairment, gait disturbance, hypotension or movement disorder. Interventions, observe, document, report to MD (Medical Doctor) prn (as needed) s/sx (signs and symptoms) of drug related complications. Interventions include, Observe for target behaviors/symptoms and document per facility protocol date initiates 3/21/25. Observe for increase in depressive/behavior symptoms and document PRN interventions as appropriate. Date initiated 3/21/25. Surveyor was unable to locate any documentation in R5's medical records that R5 or R5's representative provided consent or were provided with the risks and benefits of the antidepressant medication that R5 was prescribed. On 8/20/25 at 12:27 PM, Nursing Home Administrator (NHA)-A informed Surveyor that there is no signed medication consent by R5 or by R5's representative regarding risks and benefits of Venlafaxine (psychotropic medication for depression). 08/20/2025 1:07 PM Surveyor interviewed Director of Nursing (DON)-B and asked who is responsible for obtaining medication consents explaining risks and benefits for psychotropic medications. DON-B informed Surveyor that the floor nurses should be responsible for this. Surveyor asked if DON-B if this occurring and DON-B stated, if he had to bet, the floor nurses are not having consents signed and plans on following up. Surveyor notified NHA-A and DON-B of concerns regarding that R5 or R5's representative provided consent or were provided with the risks and benefits of the antidepressant medication that R5 was prescribed. NHA-A and DON-B acknowledged the concern. No additional information was provided. 3.) R42 was admitted to the facility 3/14/25 with diagnosis of vascular dementia (decline in mental abilities) and Paranoid Schizophrenia (a persistent brain disorder that can impact one's thoughts, emotions and behaviors. R42 has an activated Power Attorney for Health Care. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R42's admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 3/25/25 documents a Brief Interview for Mental Status (BIMS) score of 4, indicating that R42's cognitive abilities are severely impaired. R42's physician orders documents: Seroquel (an antipsychotic medication) 25 mg twice daily for Paranoid Schizophrenia and Citalopram (an antidepressant medication) 40 mg daily for Depression. Surveyor was unable to locate any documentation of consent for risks and benefits of both R42's antipsychotic or antidepressant medication in R42's electronic health record. On 08/20/2025 at 1:07 PM, Surveyor interviewed Director of Nursing (DON)-B and asked who is responsible for obtaining medication consents explaining risks and benefits for psychotropic medications. The DON-B responded that the floor nurses should be responsible for obtaining the consents and that floor nurses are not currently obtaining the consents. DON-B added that they plan to follow up on these concerns. No additional information was provided by the facility at this time. 4.) R11 was admitted to the facility on [DATE] with diagnoses that include Type II Diabetes, Schizoaffective Disorder, unsteadiness on feet, and Hypertensive Heart Disorder with Heart Failure. R11's Quarterly Minimum Data Set (MDS) assessment dated [DATE], documents that R11 is understood and understands, and R11 has moderately impaired with cognition. R11's physician orders with a black box warning (The most serious warning the Food and Drug Administration can issue for a medication. The warning is to alert the user of the major risks of taking the medication) documented, with a start date of 12/23/2024: Olanzapine 15 Milligrams (MG) by mouth at Hour of Sleep (HS) for Schizophrenia. The last documented date of R11 receiving the above-mentioned medication is on 8/19/2025. R11's Electronic Health Record (EHR) did not include informed consents for this medication, including the explanation of the risks and benefits of the medication, potential side effects or alternative treatments. On 8/19/2025, at 2:02 PM, Surveyor interviewed Nursing Home Administrator NHA-A, regarding the location of the signed consent form for R11's Medication Olanzapine. NHA-A indicated that R11 doesn't currently see a specialist for psychiatric services. NHA-A stated that R11's primary doctor takes care of her schizophrenia diagnosis. On 8/19/2025, at 2:07 PM, Surveyor was informed by NHA-A that informed consent for R11's medication Olanzapine was not able to be located. On 8/20/2025, at 4:33 PM, Surveyor informed NHA-A, of the concern that R11's consent form, explaining the risks and benefits, for Olanzapine was reviewed, explained or provided to R11 or R11's representative. No additional information was provided.

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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 interview and record review the facility did not ensure 5 (R1, R2, R5, R33, and R44) of 5 residents reviewed for hospitalizations received the proper notice of transfer, reason for transfer, location of transfer, appeal rights, and name and address (including mail and email) with the telephone number of the Office of the State Long-Term Care Ombudsman, were notified of the reason for transfer/discharge & bed hold policy in writing to the resident & their representative and the rate to reserve the residents bed, and there was no documentation that the ombudsman was being notified of hospitalizations. *R1 was transferred to the hospital on 3/20/2025, 5/20/2025, and 6/27/2025. A transfer notice and bed hold rate was not provided in writing to R1 and/ or R1's representative. There is not evidence that the ombudsman was notified of R1's hospitalizations. *R2 was transferred to the hospital on 5/12/2025 and 6/2/2025. A transfer notice and bed hold rate was not provided in writing to R2 and/or R2's representative. There is no evidence that the ombudsman was notified of R2's hospitalizations. *R5 was transferred to the hospital on 3/12/2025. A transfer notice and bed hold rate was not provided in writing to R5 and/ or R5's representative. There is no evidence that the ombudsman was notified of R5's hospitalization. *R33 was transferred to the hospital on 3/3/2025 and 5/5/2025. A transfer notice and bed hold rate was not provided in writing to R33 and/ or R33's representative. There is no evidence that the ombudsman was notified of R33's hospitalizations. *R44 was transferred to the hospital on 6/13/2025. A transfer notice and bed hold rate was not provided in writing to R44 and/ or R44's representative. There is no evidence that the ombudsman was notified of R44's hospitalization. Findings include: The facility policy titled Transfer and Discharge Notice last approved 6/2022 documents: Policy Statement- Our community shall provide a resident and/or the resident's representative with a thirty (30) day written notice of an impending transfer or discharge. B. Exceptions to the 30-day requirement apply when the transfer or discharge is effected . in these cases, the notice is provided as soon as practicable and the notice to the ombudsman is sent when practicable: .6. Immediate transfer or discharge is required by the resident's urgent medical needs.C. The community will notify resident and/or resident representative . as soon as practicable . the resident and/or resident representative:1. The reason for the transfer or discharge.2. The effective date of the transfer or discharge.3. The location to which the resident is being transferred or discharged .4. A statement of the resident's rights to appeal the transfer or discharge, including:a. The name, address, email, and telephone number of the entity which receives such requests.b. Information about how to obtain, complete and submit an appeal form.c. How to get assistance in completing the appeal process.5. The community bed hold policy.6. The name, address, e-mail and telephone number of the Office of the State Long-term Care Ombudsman.7. The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disabilities.8. The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with a mental disorder or related disabilities.9. The name, address, email, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices.D, A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman. The facility policy titled Bed-Holds and Returns last approved on 1/2025 documents: Policy Statement: At the time of transfer for hospitalization ., nursing facility must provide to the residents or residents representative written notice which specified the duration for the bed-hold. Policy Interpretation and Implementation: .3. Prior to a transfer, written information will be given to the residents and the resident representatives that explain in detail:a. the duration of the bed-hold.b. The reserve bed payment policy as indicated by the state plan.c. The details of the transfer (per notice of the transfer). 1.) R1 was initially admitted to the facility on [DATE] with a recent readmission to the facility on 7/7/2025 and has diagnoses that include Multiple Sclerosis (disease that affects the central nervous system), quadriplegia (partial/total loss of all four limbs), . and neuromuscular dysfunction of the bladder. R1's quarterly Minimum Data Set (MDS) assessment dated [DATE] documents R1 has a moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 10. Surveyor reviewed R1's medical record and noted R1 was transferred and admitted to the hospital and readmitted to the facility on :- 3/20/2025 – 3/26/2025- 5/20/2025 – 5/25/2025- 6/27/2025 – 7/7/2025 Surveyor reviewed R1's bed hold notices for 3/20/2025, 5/20/2025, and 6/27/2025 and noted that R1's bed hold notifications were not signed or dated by R1's APOA and noted that R1's APOA was made aware via phone call of the bed hold notice on 3/21/2025 (1 day after R1 was admitted to the hospital), 5/21/2025 (1 day after R1 was admitted to the hospital), and 6/30/2025 (3 days after R1 was admitted to the hospital). Surveyor was not able to locate transfer notices in R1's medical records for 3/20/2025, 5/20/2025, or 6/27/2025. On 8/20/25, at 9:01 am, Surveyor interviewed Social Worker (SW)-F, who stated the business office completes the bed hold notice. Surveyor asked who notifies the ombudsman of facility discharges or admission to the hospital. SW-F was not aware who at the facility notifies the ombudsman when a resident transfers to the hospital. On 8/20/25, at 9:03 am, Surveyor interviewed Business Office Manager (BOM)-G, who stated BOM-G is responsible for completing the bed hold notice. BOM-G calls the resident or the resident's representative the day after the resident goes out to the hospital to inform of the bed hold policy. BOM-G stated the private pay rate is verbally provided to the resident or resident representative. Surveyor made BOM-G aware that the pay rate listed on the provided bed hold agreements for R1 documents the pay rate is different from the verbal she provided Surveyor and that the signature on the bed hold agreement document was from an administrator that has not worked at the facility for several years. BOM-G stated that the bed hold notice should have been updated to reflect current information, but since BOM-G does not send it out or give a copy to the resident or representative of a resident, BOM-G has not updated the bed hold agreement. BOM-G stated if a resident has Medicaid insurance, the bed is automatically held for a 15-day period, and BOM-G would only call a resident or resident representative after the 15-day period has passed to confirm if the bed should be held beyond the 15 days. BOM-G stated BOM-G was not responsible for transfer notices and (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	thought the floor nurse may complete those. BOM-G was not aware who at the facility notifies the ombudsman when a resident transfers to the hospital. On 8/20/25, at 10:06 am, Surveyor interviewed Licensed Practical nurse (LPN)-E, who stated the nurse will call the hospital 3 to 4 hours after a resident is sent to the hospital to determine if the resident will get admitted or return to the facility. LPN-E stated a transfer notice or bed hold agreement would only be completed if a resident is being admitted to the hospital. On 8/20/25, at 10:47 am, Surveyor interviewed Registered Nurse unit manager (RNUM)-D who stated the business office usually calls regarding the bed hold policy when a resident is transferred to the hospital. RNUM-D stated the floor nurse on duty should be completing a transfer and discharge notice when a resident goes to the hospital. RNM-D was not sure of this facility's process and was not able to say where a transfer notice or bed hold notice could be located. On 8/20/25, at 10:54 am, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding the bed hold and transfer notice process. NHA-A stated as a resident is leaving, the resident or resident representative should be called regarding the bed hold. NHA-A stated if a resident has Medicaid insurance, the resident's bed would be automatically held, but the family or resident should still be notified. NHA-A was not aware of the process for providing a written transfer notice to a resident. NHA-A stated the social worker would be responsible for notifying the ombudsman monthly of any hospitalizations, but the previous social worker is no longer at the facility. NHA-A was unable to provide any evidence of ombudsman notification of R1's hospitalizations on 3/20/2025, 5/20/2025, and 6/27/2025. On 8/20/25, at 1:25 pm, Surveyor shared concerns with NHA-A and Director of Nursing (DON)-B that a transfer notice or bed hold notice with updated bed hold rate was not provided to R1 or R1's APOA when transferred to the hospital on 3/20/2025, 5/20/2025, and 6/27/2025. Surveyor also shared concern that there was no documentation provided that the ombudsman was notified of R1's hospitalizations on 3/20/2025, 5/20/2025, and 6/27/2025. No additional information was provided. 2.) R2 was admitted to the facility on [DATE], with most recent readmission to facility on 7/3/25, with the following diagnoses: hemiplegia following cerebral infarction (stroke) affecting left nondominant side, diabetes mellitus type 2 with diabetic chronic kidney disease, end stage renal disease (kidney failure), dependence on renal dialysis, and depression. R2's admission Minimal Data Set (MDS) assessment completed by the facility on 7/9/25 documents R2 has a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition, R2 is dependent for activities of daily living and transfers, and R2 receives dialysis services. R2 is their own person. R2 was transferred and admitted to the hospital on [DATE] and 6/2/25, with readmission to the facility 5/27/25 and 7/3/25, respectively. Surveyor reviewed written copy of bed hold agreement for R2 provided by facility dated 5/12/25 and 6/2/25. Surveyor noted the bed hold agreement does not have R2's signature and does not indicate if R2 agreed or disagreed to hold R2's bed. Surveyor was not provided with a transfer notice for R2's hospitalizations on 5/12/25 or 6/2/25, and Surveyor did not locate the transfer notices in R2's electronic health record (EHR). On 8/20/25, at 9:01 am, Surveyor interviewed Social Worker (SW)-F, who stated the business office completes the bed hold notice. SW-F was not aware who at the facility notifies the ombudsman when a resident transfers to the hospital. (continued on next page)

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Wheaton Franciscan Hc - Terrace at St Francis	3200 S 20th St Milwaukee, WI 53215

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/25, at 9:03 am, Surveyor interviewed Business Office Manager (BOM)-G, who stated BOM-G is responsible for completing the bed hold notice. BOM-G stated BOM-G calls the resident or the resident's representative the day after the resident goes out to the hospital to inform of the bed hold policy. BOM-G stated the private pay rate is verbally provided to the resident or resident representative. Surveyor made BOM-G aware that the pay rate listed on the provided bed hold agreements for R2 documents is different than what she informed Surveyor, and BOM-G stated BOM-G will need to update that. BOM-G stated a written copy of the bed hold notice is not provided to the resident or the resident representative. BOM-G stated if a resident has Medicaid insurance, the bed is automatically held for a 15-day period, and BOM-G would only call a resident or resident representative after the 15-day period has passed to confirm if the bed should be held beyond the 15 days. BOM-G stated BOM-G was not responsible for transfer notices and thought the floor nurse may complete those. BOM-G was not aware who at the facility notifies the ombudsman when a resident transfers to the hospital. On 8/20/25, at 10:06 am, Surveyor interviewed Licensed Practical Nurse (LPN)-E, who stated the nurse will call the hospital 3 to 4 hours after a resident is sent to the hospital to determine if the resident will get admitted or return to the facility. LPN-E stated a transfer notice or bed hold agreement would only be completed if a resident is being admitted to the hospital. On 8/20/25, at 10:47 am, Surveyor interviewed Registered Nurse Manager (RNM)-D who stated the business office usually calls regarding the bed hold policy when a resident is transferred to the hospital. RNM-D stated the floor nurse on duty should be completing a transfer and discharge notice when a resident goes to the hospital. RNM-D could not locate any completed transfer notices for R2. On 8/20/25, at 10:54 am, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding the bed hold and transfer notice process. NHA-A stated as a resident is leaving, the resident or resident representative should be called regarding the bed hold. NHA-A stated if a resident has Medicaid insurance, the resident's bed would be automatically held, but the family or resident should still be notified. NHA-A was not aware of the process for providing a written transfer notice to a resident. NHA-A stated the social worker would be responsible for notifying the ombudsman monthly of any hospitalizations, but the previous social worker is no longer at the facility. NHA-A was unable to provide any evidence of ombudsman notification of R2's hospitalizations on 5/12/25 or 6/2/25. On 8/20/25, at 1:25 pm, NHA-A was made aware of the concern that a transfer notice or bed hold notice with updated bed hold rate was not provided to R2 upon leaving the facility 5/12/25 or 6/2/25, and no evidence was provided that the ombudsman was notified of R2's hospitalizations on 5/12/25 or 6/2/25. NHA-A understood the concern. No additional information was provided. 3.) R5 was admitted to the facility on [DATE] and has a diagnoses that include hemiplegia following cerebral infraction, major depressive disorder, dementia with behavioral disturbance. R5's Minimal Data Set (MDS) assessment, dated 3/26/25, documents R1 has a Brief Interview for Mental Status (BIMS) of 0, indicating severe cognitive impairment. R5's Progress Note dated 3/14/25 at 22:33 (10:33 PM), documents in part: Writer observed right leg and notices swelling to from the hip down to the feet on the right side along with a bruise to the back of leg. Writer and DON (Director of Nursing) observed resident and leg.MD made aware.Resident sent to the hospital. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor could not locate a bed-hold and transfer notice in electronic health record (EHR) for R5's hospitalization on 3/14/25 and Surveyor asked Nursing Home Administrator (NHA)-A if there were paper copies of the bed-hold and transfer notice. NHA-A provided Surveyor with a blank copy of R5's bed-hold agreement and form letter to residents regarding bed-hold. The blank copy of R5's bed-hold agreement documented R's name, when R5 was hospitalized and Family Care (payor). There was no documentation of bed hold preference nor signature of resident or resident representative. There was no documentation resident or resident representative received verbal notice. NHA-A did not provide a copy of R5's transfer notice. On 08/20/2025 at12:03 PM, Surveyor asked NHA-A who is responsible to notify the Ombudsman of transfer/discharge notices. NHA-A stated social workers are responsible for this process and each month they should send the residents name, date and reason for transfer/discharge to the Ombudsman. Surveyor asked for last 6 months of documentation and NHA-A stated the social worker is new and cannot locate any evidence of past transfer/discharge notices to Ombudsman. On 08/20/2025 at 1:15 PM, Surveyor notified NHA-A and Director of Nursing (DON)-B of concern regarding incomplete bed hold and no transfer notice for R5. Surveyor notified NHA-A and DON-B of concern regarding no evidence of facility notifying ombudsman of transfer/discharges. NHA-A and DON-B agreed facility the process needs attention. No additional information was provided. 4.) On 8/20/25, the Surveyor reviewed R33's medical record and it indicated R33 was transferred and admitted to the hospital on [DATE] and 5/5/25. R33's medical record did not include documentation that a transfer notice and bed hold information had been given to the resident and/or their representative for the hospitalization. On 8/20/25 at 10:00 AM Nursing Home Administrator (NHA)-A was interviewed and indicated no transfer notice or bed hold information could be found for R33's hospitalizations on 3/3/25 and 5/5/25. NHA-A indicated she could not find any evidence that R33's hospitalizations on 3/3/25 and 5/5/25 were reported to the ombudsman. On 8/20/25 at 1:00 PM, the above findings were shared with NHA-A and Director of Nursing-B. Additional information was requested if available. None was provided as to why a transfer and bed hold notice were not given to R33 and/or their representative for their hospitalizations, and the ombudsman not notified of R33's readmission to the facility on 3/3/25 and 5/5/25. 4.) R44 was admitted to the facility 5/19/25/25 with diagnoses that include stroke, hypertension (high blood pressure) and heart failure. R44's admission Minimal Data Set (MDS) Assessment with an Assessment Reference date (ARD) of 5/23/25 documents R44 is rarely to never understood due to cognitive impairment On 6/13/25, R44 was discharged to the hospital due to a change of condition. Surveyor reviewed R44's electronic health record (EHR). Surveyor could not locate a bed-hold or (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transfer notice for R44's hospitalization on 6/13/25. On 8/19/25 at 3:35 PM at the daily exit meeting, Surveyor asked Nursing Home Administrator (NHA)-A if there were paper copies of the bed-hold and transfer notice that were provided to R44's representative. On 8/20/25 at 8:15 AM, NHA-A provided Surveyor with a blank copy of R44's bed-hold agreement and form letter to residents regarding bed-hold. The blank copy of R's bed-hold agreement documented R44's name and when R44 was hospitalized . There was no signature of resident or resident representative on R44's bed-hold agreement. NHA-A was unable to provide a copy of R44's transfer notice. On 08/20/2025 at12:03 PM, Surveyor asked NHA-A who is responsible to notify the Ombudsman of transfer/discharge notices. NHA-A stated social workers are responsible for this process and each month they should send the residents name, date and reason for transfer/discharge to the Ombudsman. Surveyor requested the last six months of Ombudsman notifications. NHA-A responded that the facility's social worker is new and cannot locate any evidence of past resident transfers or discharges notices to the Ombudsman. On 8/20/2025 at 1:15 PM, Surveyor notified NHA-A and Director of Nursing (DON)-B of concerns regarding R44's incomplete bed- hold and lack of transfer notice for R44. Surveyor notified NHA-A and DON-B of concern regarding lack of evidence of facility notifying Ombudsman of resident transfers/discharges. No additional information was provided by the facility at this time.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not complete neurological (neuro) checks in accordance with policy and procedure for 5 (R27, R5, R42, R8 and R11) of 5 residents reviewed for falls. *R27 had an unwitnessed fall on 08/10/2025, no neurological checks were completed. *R5 had 5 unwitnessed falls, 2 of the falls had incomplete neurological checks and 1 fall had no neuro checks documented. *R42 had had 4 falls, 2 of the falls had incomplete or missing neurological checks. *R8 had 1 unwitnessed fall with incomplete neurological checks. *R11 had 1 unwitnessed fall with no documented neurological checks completed. Findings include: 1.) On 08/18/2025, at 10:08 AM, Surveyor observed R27 with a large bruise to the right side of R27's forehead that extended down under R27's right eye. Surveyor Reviewed R27's Electronic Health Record (EHR) and noted a progress note dated 08/10/2025, indicating R27 had an unwitnessed fall on 08/10/2025 and a neurological assessment was completed. Surveyor requested R27's fall investigation for 08/10/2025 from the Facility. Surveyor reviewed the Facility provided document titled, Root Cause Analysis (RCA) Report for R27's. The RCA report documented R27 had an unwitnessed fall on 08/10/2025 at 5:15 PM, post incident monitoring documents R27 was monitored per post-fall protocol, including neurological checks. Surveyor noted R27's Neurological Checks were not included in the RCA report. Surveyor requested R27's neuro checks from the facility, along with the facility's policy for Neurological checks. On 08/18/2025, at 2:20 PM, Surveyor was informed by Quality Director-C that the Facility does not have an official policy regarding neurological checks. Quality Director-C indicated that if a resident has an unwitnessed fall or has a witnessed fall and hit their head, neurological checks are expected to be completed. On 08/20/2025, at 12:51 PM, Surveyor informed the facility of the concern regarding R27 not having neurological checks completed after an unwitnessed fall on 8/10/25. No additional information was provided, 2.) R5 was admitted to the facility on [DATE] and has a diagnoses that include hemiplegia following cerebral infraction, major depressive disorder, dementia with behavioral disturbance. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's Minimal Data Set (MDS) assessment, dated 3/26/25, documents R1 has a Brief Interview for Mental Status (BIMS) of 0, indicating severe cognitive impairment. Per R5's electronic medical record, R5 had 3 unwitnessed falls where either there was incomplete or no neurological checks completed. R5 had an unwitnessed fall on 5/29/25 with incomplete neurological checks. R5 had an unwitnessed fall on 6/6/25 with incomplete neurological checks. R5 had an unwitnessed fall on 8/725 with no neurological checks. On 08/19/2025 at 9:01 AM, Surveyor interviewed Director of Quality-C regarding neurological checks post a resident fall. Director of Quality-C stated the process of completing neurological checks occurs when there is an unwitnessed fall (UWF) or witnessed fall when a resident hit head. Surveyor asked how often the neurological checks occur and Director of Quality-C stated he/she could not recite off the top of head but would get a neurological form and let Surveyor know. Director of Quality-C returned and reviewed with Surveyor the Neuro Assessment form that documents that neuro checks need to be completed following an unwitnessed fall or a resident hitting their head, every 15 minutes for 1 hour (4 times), every 30 minutes for 1 hour (2 times), every hour for 2 hours (2 times), every 2 hours for 8 hours (4 times), every 4 hours for 12 hours (3 times) and every shift for 48 hours (4 times). Director of Quality-C stated, if neurological checks are not if fall investigation packet, the facility does not have them. On 08/20/2025 at 1:07 PM, Surveyor interviewed Director of Nursing (DON)-B and asked who is responsible for neurological checks following a resident unwitnessed fall and/or hitting head. DON-B stated, the floor nurses are responsible for this. Surveyor notified NHA-A and DON-B of concerns regarding incomplete or no evidence of R5's neurological checks following unwitnessed falls on 5/29/25, 6/6/25 and 8/7/25. No additional documentation was provided. 3.) R42 was admitted to the facility 3/14/25 with diagnoses of Vascular Dementia (a decline in mental abilities) and Paranoid Schizophrenia (a persistent brain disorder that can impact one's thoughts, emotions and behaviors. R42's admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 3/25/25 documents a Brief Interview for Mental Status (BIMS) score of 4, indicating that R42's cognitive abilities are severely impaired. R42 was assessed by the facility to be at risk for falls. Surveyor reviewed R42's Electronic Health Record (EHR). Surveyor noted that R42 sustained a total of three unwitnessed falls on 6/2/25, 7/17/25 and 8/5/25. Surveyor reviewed the facility's fall investigations including root cause analysis and staff statements for R42's unwitnessed falls on 6/2/25, 7/17/25 and 8/5/25. Surveyor noted Neurological Checks were completed for R42's unwitnessed falls that occurred on 6 /2/25 and 8/5/25. Surveyor reviewed a sample of a facility document titled Neuro Assessment flow sheet. Surveyor notes that the flow sheet instructs staff to document Neurological Check Assessments at the following intervals: Every 15 min (minutes) x 4 (Every 15 minutes for 1 hour), Every 30 min x 2 (1 hour), Every 1 hour x 2 (2 hours), Every 2 Hrs (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Hours) x 4 (8 hours), Every 4 Hrs x 3 (12 hours), Every shift x 4 (48 hours). Surveyor noted the neurological checks for R42's unwitnessed fall was missing documented entries on 7/20/25 for the following time slots: 0300 and 0700. On 08/18/2025, at 2:20 PM, Surveyor interviewed Quality Director-C. Surveyor was informed by Quality Director-C that the facility does not have an official policy regarding neurological checks. Quality Director-C indicated that if a resident has an unwitnessed fall or has a witnessed fall and hit their head, neurological checks should be expected to be completed in their entirety. On 08/20/2025, at 12:55 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B and informed of them of the above concerns regarding missing neurological check entries related to R42's 7/17/25 unwitnessed fall. No additional information was provided by the facility. 4.) R8 was admitted to the facility on [DATE] with diagnoses of Vascular Dementia (a decline in mental abilities), Anemia (a lack of oxygen rich red blood cells in one's body which may result in tiredness or weakness) and Depression. R8's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 4/19/25 documents a Brief Interview for Mental Status (BIMS) score of 9, indicating that R8's cognitive abilities are moderately impaired. R8 was assessed by the facility to be at risk for falls. Surveyor reviewed R42's Electronic Health Record (EHR). Surveyor noted that R8 sustained an unwitnessed fall on 8/3/25 in their room. Surveyor reviewed the facility's fall investigation including root cause analysis and staff statements for R8's unwitnessed fall on 8/3/25. Surveyor noted neurological checks were not completed for R8's unwitnessed falls that occurring on 8/3/25. Surveyor reviewed a sample of a facility document titled Neuro Assessment flow sheet. Surveyor notes that the flow sheet instructs staff to document Neurological Check Assessments at the following intervals: Every 15 min (minutes) x 4 (Every 15 minutes for 1 hour), Every 30 min x 2 (1 hour), Every 1 hour x 2 (2 hours), Every 2 Hrs (Hours) x 4 (8 hours), Every 4 Hrs x 3 (12 hours), Every shift x 4 (48 hours). Surveyor could not identify a completed Neuro Assessment flow sheet for R8's unwitnessed fall from 8/3/25. On 08/18/2025 at 2:20 PM, Surveyor interviewed Quality Director-C. Surveyor was informed by Quality Director-C that the facility does not have an official policy regarding neurological checks. Quality Director-C indicated that if a resident has an unwitnessed fall or has a witnessed fall and hit their head, neurological checks should be expected to be completed in their entirety. On 08/20/2025, at 12:55PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B and shared concerns related to R8 not having any documented neurological checks completed after R8's unwitnessed fall on 8/3/25. No additional information was provided. 5.) R11 was admitted to the facility on [DATE] with pertinent diagnoses that include Type II Diabetes, Schizoaffective Disorder, unsteadiness on feet and Hypertensive Heart Disorder with Heart Failure. R11's Quarterly Minimum Data Set (MDS) assessment, dated 3/28/2025 indicates that R11 is understood and understands, and that R11 has moderately impaired cognition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed R11's Fall Scene Investigation Form (RCA) dated 6/3/2025, which documented a fall that was not witnessed. The RCA packet contained statements from staff that documented that R11 was found in the bathroom, on the floor, and that R11 stated R11 rolled from her bed to the bathroom. Surveyor did not locate neurological checks within the RCA packet. Surveyor reviewed R11's Electronic Health Record (EHR) and could not locate any neurological checks for the fall on 6/3/2025. On 8/19/2025, at 8:59 AM, Surveyor interviewed Director of Quality (DOQ) -C, who indicated that if the neurological checks were not in the fall packet, then the neurological checks were not completed. DOQ-C stated that the neurological checks should be done for 3 days that it is hard for nurses to get these done because it is for 3 days. DOQ-C stated that if there is an unwitnessed fall or a fall with a head injury that neurological checks should be initiated. On 8/20/2025, at 4:33 PM, Surveyor informed NHA-A, of a concern that the fall investigation from 6/3/2025 had missing neurological checks. Surveyor also informed NHA-A, that surveyor interviewed DOQ-C, who indicated that if the neurological checks were not in the RCA fall packet, then they weren't completed. No additional information was provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not timely act upon recommendations based on a pharmacist medication regimen review report for 4 (R6, R5, R8 and R42) of 5 residents reviewed for unnecessary medications. Findings include: The facilities policy titled Pharmacy Services-Role of the Consultant Pharmacist dated 2/25 was reviewed and documented: The Director of Nurses (DON), or designee will ensure the recommendations are followed through on a timely basis, which does not exceed 30 days. Irregularities will be addressed as soon as possible, but not to exceed 24 hours. The attending physician will document in the resident's medical record that the irregularity was received and what action was taken to accommodate it. 1) R6 was admitted to the facility on [DATE] with diagnosis that included Depression and Schizophrenia. R6's Pharmacist's Medication Regimen Recommendations (MRR) documented: * 3/19/25: R6 is currently receiving clozapine, for which the following lab oratory monitoring is recommended: Complete Blood Count (CNC) with Absolute Neutrophil Count (ANC) during the first 6 months of clozapine treatment. If ANC remains above 1,500 monitoring may be downgraded to biweekly the next 6 months. If ANC remains, then monitoring may be downgraded to monthly and should continue indefinitely. Additionally, the following is recommended. Complete Metabolic Panel (CMP) and Thyroid Stimulating Hormone (TSH) at least annually. Blood pressure, pulse and weight checks regularly. Neurological function testing as warranted. The recommendation is not signed by R6's Physician. * 4/16/25, 5/14/25, 6/18/25 and 7/16/25 have the exact same recommendations. 4/16/25, 5/14/25, 6/18/25 were not signed by R6's physician and the 7/16/25 MRR was signed by R6's physician on 7/29/25. On 8/20/25, R6's physician orders were reviewed and indicated R26 had been receiving clozapine (an antipsychotic) since admission to now. The orders for the recommended labs from the MRR were not put into R6's orders until 7/29/25. On 8/20/25 at 10:20 AM, Director of Nursing(DON)-B was interviewed and indicated that R6's MRR's were not addressed until 7/29/25 and when the physician put the orders in. Labs for R6 had been completed sporadically until then but not always weekly as ordered. Vitals and Weights were checked regularly. On 8/20/25 at 1:00 PM, the above findings were shared with Nursing Home Administrator-A and DON-B. Additional information was requested if available. None was provided as to why R6's MRR's were not followed up on for 3/19/25, 4/16/25, 5/14/25, and 6/18/25. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) R5 was admitted to the facility on [DATE] and has diagnoses that include hemiplegia following cerebral infraction, major depressive disorder and dementia with behavioral disturbance. R5's Minimal Data Set (MDS) assessment, dated 3/26/25, documents R1 has a Brief Interview for Mental Status (BIMS) of 0, indicating severe cognitive impairment. R5's physician orders to treat dementia and depression include: Donepezil tab 10 mg (milligrams) - 1 tb (tablet) by mouth every PM for dementia ordered 3/22/25 and Venlafaxine 37.5 mg tab by mouth every PM for depression ordered 8/14/25 Surveyor reviewed R5's Medication Regime Review (MRR) completed by a pharmacist for April, May, June, and August of 2025. Surveyor was unable to locate any documentation that an MMR was completed for July 2025 for R5. The MMR recommendation forms for April, May, June, and August of 2025, documented the recommendations from pharmacy. These MMR recommendation forms did not have the facility physician signature, date of signature or response whether or not the physician agrees, disagrees or other. Surveyor reviewed R5' electronic health record (EHR) and could not locate any documentation that showed R5's MRR recommendations were followed. On 4/17/25, R5's MMR recommendation was a [NAME] discontinuation of divalproex. At this time, divalproex was not discontinued and there is no contraindication from the physician explaining why the physician did not order a trial discontinuation. On 5/15/25, R5's MRR recommendation was changing venlafaxine to immediate Release 37.5 BID if crushing is required. At this time, there was no change and there is no contraindication from the physician explaining why the physician did not make the change. The second MRR recommendation was to discontinue bisacodyl, consider vit (vitamin) c and vit B1 supplement remains necessary. The physician discontinued the bisacodyl, vitamin c and vitamin B1, but this was not documented on R5's MRR form. On 6/19/25, R5's MRR recommendation was changing venlafaxine to immediate Release 37.5 BID if crushing is required. At this time, there was no change and there is no contraindication from the physician explaining why the physician did not make the change. The second MRR recommendation was to discontinue divalproex order per psych recommendation. Divalproex sprinkle cap 125 mg by mouth every day for mood behavior was discontinued on 6/20/25, but not documented on R5's MRR form. On 8/20/25 at 12:16 PM, NHA-A informed Surveyor that NHA-A cannot locate a completed MRR for R5 for July 2025. On 8/11/25 recommended MRR recommendation was trial reduction of venlafaxine ER to 37.5 QAM.(once every morning). At this time, there was no change and there is no contraindication from the physician explaining why R5's physician did not make the change. 08/20/2025 10:46 AM Director of Nursing (DON)-B stated there is an issue with locating the signed MRR's, as medical records had some staffing changes. DON-B stated the MRR recommendations are (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	being followed but stated if the physician disagrees with MRR recommendations, there is no documentation to be found. On 08/20/2025 at 1:07 PM, Surveyor interviewed DON-B and asked who is responsible for the pharmacy reviews being completed. DON-B stated that DON-B was responsible. DON-B stated, the process is DON-B received the MRR recommendations from the pharmacy and and divides up the recommendations for each physician, the physician signs and dates, and documents whether or not physician agrees or disagrees. the facility inputs orders as indicated. Medical records scans copies but there is an issue with scanning and consistency with staff. Now there is a consistent staff member and she is playing catch up. DON-B stated, the signed MRR's might be located in the future once medical records staff catches up. DON-B stated, in the future DON-B will house all the signed MRR recommendations in a binder so this issue of not being able to locate does not occur again. No additional information was provided. 3.) R8 was admitted to the facility on [DATE] with diagnoses that include vascular dementia, moderate, with psychotic disturbance. R8 Quarterly (Minimum Data Set) MDS assessment completed 7/18/25 documents that R8 uses antipsychotic and antidepressant medication. R8 had a (Medication Record Review) MRR conducted on 2/12/2025 by the facility's contracted pharmacy. The report recommends tapering the Lexapro dose or switch to a different antidepressant. R8 is currently on Lexapro 30 mg daily. This report does not have documentation of being reviewed by R8 physician to agree with the recommendations or disagree. R8 had a MRR conducted on 3/20/2025 by the facility's contracted pharmacy. The report recommends initiating Zyprexa 25mg at bedtime for delusional disorder and taper Lexapro to Vibryd, R8 is currently on Lexapro 20 mg daily. This report does not have documentation of being reviewed by R8 physician to agree with the recommendations or disagree. R8 had a MRR conducted on 4/17/2025 by the facility's contracted pharmacy. The report recommends initiating Zyprexa 25mg at bedtime for delusional disorder and taper Lexapro to Vibryd, R8 is currently on Lexapro 20 mg daily. This report does not have documentation of being reviewed by R8 physician to agree with the recommendations or disagree. R8 had a MRR conducted on 5/15/2025 by the facility's contracted pharmacy. The report recommends initiating Zyprexa 25mg at bedtime for delusional disorder and taper Lexapro to Vibryd, R8 is currently on Lexapro 20 mg daily. This report does not have documentation of being reviewed by R8 physician to agree with the recommendations or disagree. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8 had a MRR conducted on 8/11/2025 by the facility's contracted pharmacy. The report recommends conducting an (Abnormal Involuntary Movement Scale) AIMS/ (Dyskinesia Identification System Condensed User Scale) DISCUS semiannually and 4 weeks after dose changes. R8 is currently on an antipsychotic medication which requires monitoring. This report does not have documentation of being reviewed by R8 physician to agree with the recommendations or disagree. On 8/20/2025, at 10:38 AM, Surveyor interviewed the (Director of Nursing) DON -B and (Nursing Home Administrator) NHA -A regarding the MMR reports. Both stated that they were not able to locate the physician signed reports for R8's pharmacy recommendations. DON-B stated when we get the reports we will fax them to the physician. The physician will fax them back to me then the Nurse Managers will input the orders. DON-B stated that R8 has psychiatry consults monthly that review their psychotropic medications and adjust the dosing. No additional information was provided as to why the facility did not act timely upon recommendations based on R8's pharmacist medication regimen review reports. 4.) R42 was admitted to the facility 3/14/25 with diagnosis of vascular dementia (decline in mental abilities) and Paranoid Schizophrenia (a persistent brain disorder that can impact one's thoughts, emotions and behaviors. R42's admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 3/25/25 documents a Brief Interview for Mental Status (BIMS) score of 4, indicating that R42's cognitive abilities are severely impaired. Surveyor reviewed R42's Electronic Health Record (EHR) including physician orders. Surveyor noted R42 receives Seroquel (an antipsychotic medication) 25 mg twice daily for Paranoid Schizophrenia and Citalopram (an antidepressant medication) 40 mg daily for Depression. R42 had a Monthly Medication Record Reviews (MRR) conducted on 3/19/25 and 5/14/25 by the facility's contracted pharmacy. MRR dated 3/19/25 recommends reducing the dosage of R48's Citalopram from 40 mg daily to 20 mg daily. MRR dated 5/14/25 recommends reducing the dosage of R48's Citalopram from 40 mg daily to 20 mg daily. All the MMR reports do not have documentation of being reviewed by R42's physician to agree with the recommendations or disagree regarding R48's Citalopram dosing. Surveyor can not identify any Monthly MRRs recommended for R42 since 5/14/25. On 8/20/2025 at 10:38 AM, Surveyors interviewed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A regarding the Monthly MMR reports. They were not able to locate the physician signed reports for R42's pharmacy recommendations on 3/19/25 or 5/14/25. The DON-B stated when we get the reports we will fax them to the physician. The physician will fax them back to me then the Nurse Managers will input the orders .Sometimes the reports do not always come back . Surveyor shared concerns related to R42's physician not addressing the Pharmacy's recommendation to reduce R42's Citalopram medication and the facility's inability to supply Surveyor documentation that R42's Monthly MRRs were conducted for June 2025 and July 2025. The facility did not provide any additional information.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility did not ensure resident's right to personal privacy and confidentiality of his or her personal and medical records for 1(R9) of 41 residents reviewed.*On 08/19/2025, at 7:23 AM, R9's personally identifiable information (PII) or Personal Health Information (PHI) was observed to be thrown into the regular garbage during medication pass.Findings:The Facility's policy, titled Health Insurance Portability and Accountability Act (HIPPA) Privacy Program last revised 06/01/2023, documents in part, . [Name] Health Alliance is committed to protecting the privacy rights of our patients and residents (individuals). In compliance with Health Insurance Portability and Accountability Act of 1996 (HIPPA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and applicable federal and state laws and regulations (together, HIPPA Rules), this [Name] Procedure (Procedure) sets forth the HIPPA Privacy Program policies, procedures, and standards (the Program) for [Name], and describes how [Name] implements, enforces, updates, and documents its compliance with the HIPPA Rules. This [Name] Procedure and supporting standards replaces and supersedes all HIPPA privacy policies within [Name]. 2. Enforcement: a. The Privacy Officer has general responsibility for implementation of the HIPPA Privacy Program. d. Workforce Member Responsibilities i. Accounting for Disclosures of PHI ii. De-Identification of PHI and Limited Data Sets iii. Privacy Training iv. Privacy Investigations and Breach Notification v. Mitigation of HIPPA Related Incidents vi. Sanctions for HIPPA- Privacy Violations vii. Safeguarding PHI . On 08/19/2025, at 7:23 AM, Surveyor observed Licensed Practical Nurse (LPN)-E prepare R9's medications. Surveyor noted the facility utilizes prepackaged medications that contains R9's personally identifiable information, as well as the name of the medication R9 receives, listed on the packaging. Surveyor observed LPN-E discard R9's package into the garbage located on the medication cart. Surveyor noted LPN-E did not attempt to protect R9's PII before discarding in the garbage. Surveyor asked LPN-E if discarding the medication packages, with resident PII, into the regular garbage was standard procedure. LPN-E indicated yes, LPN-E will typically throw the medication packages with resident PII into the medication cart garbage, but that there is also a shredder in the nurses' station, but that would require holding on to all the garbage till the end of med pass.On 08/19/2025, at 3:35 PM, Surveyor interviewed and informed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A regarding disposal of R9's PII and PHI. DON-B indicated that PII and PHI should be disposed of in the shredder or the resident's name and PII should be marked off with black marker so the PII cannot be read.On 08/20/2025, at 12:51 PM, Surveyor informed NHA-A and DON-B of the concerns regarding R9's PII and PHI was thrown into the regular garbage. NHA-A indicated that education regarding proper disposal of PII and PHI would be conducted.No additional information was provided.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that an alleged violation involving misappropriation was thoroughly investigated for 1 of 1 Facility Reported Incidents reviewed.*The facility could not provide documentation that weekly audits of narcotic medication counts were preformed, following a narcotic discrepancy identified on [DATE].Findings:Surveyor reviewed the Facility Reported Incident (FRI) submitted to the State Agency on [DATE] regarding a discrepancy in the appearance of R27's liquid Morphine (a controlled, narcotic medication), indicating the Morphine was lighter in color instead of the usual dark blue hue.The facility indicated the police were notified, the medication was removed from the medication cart, pain assessments were completed for residents, residents were interviewed as well as staff, weekly audits during medication counts for the next six weeks and medication audit found medication were properly stored.On [DATE], Surveyor requested the full investigation for the FRI from the Facility. The Facility provided Surveyor with the Facility's investigation.Surveyor reviewed the Facility provided document titled INVESTIGATION SUMMARY and noted the following documented, Conclusion: Based on the findings of this investigation, there is no substantiated evidence of misuse of the resident's medication. It is plausible that the change in color was due to extended circulation of the bottle and having low volume, especially considering it is PRN medication that is not administered frequently and filled [DATE] and a discard date of [DATE]. We will continue to work with the Milwaukee Police Department to find out if there were any changes in concentration. To enhance monitoring and ensure the integrity of all liquid medications, the facility will implement a weekly audit, overseen by DON or a designee, during medication counts for the next six weeks. This audit will include documentation of the color and consistency of all liquid solution medications. It is also important to note that all medications, including liquid solutions, were found to be properly stored, not expired and no residents were reported to have been adversely affected. On [DATE], at 12:40 PM, Surveyor requested the audits conducted by the Facility. NHA-A indicated she would look for the audits.On [DATE], at 2:07 PM, Surveyor was informed by Nursing Home Administrator (NHA)-A that NHA-A had to reach out to the previous Director of Nursing (DON) and indicated DON-B is working on obtaining the audits. On [DATE], at 11:41 AM, Surveyor spoke with Pharmacist Consultant-H via phone. Pharmacist Consultant-H indicated that generally, liquid morphine has a blue tint, but over time the color is expected to fade, especially if the product has been open for an extended amount of time and not used.On [DATE], at 3:13 PM, NHA-A informed Surveyor that the narcotic medication audits could not be located.On [DATE], at 3:25 PM, Surveyor informed the NHA-A and DON-B of the concern that the narcotic audits were not located and available for review to determine if a thorough investigation into potential misappropriation of resident's medication was completed. No additional information was provided that an alleged violation involving misappropriation was thoroughly investigated.

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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 ensure for 2 (R11, R6) of 2 residents reviewed for PASARR (Preadmission Screening and Resident Review) screenings had a PASARR level two screening completed after triggering for it on the level one PASARR. *R11 had a completed level 1 PASARR, which indicated a level 2 was needed and the facility did not ensure a level 2 PASARR was completed within the required time frame after the 30-day extension was exceeded. *R6 had a completed level 1 PASARR, which indicated a level 2 was needed and the facility did not ensure a level 2 PASARR was completed after the 30-day extension was exceeded. Findings include: The facility policy and procedure titled PASARR (Pre admission Screening & Resident Review) dated 4/2025 documents: Policy Statement. The purpose of this policy is to outline the screening of residents with a history of serious mental illness in developmental disability. Procedure A. Complete level I screen of the PASARR on new admissions. 3. Those residents who is attending physician has certified, before admission to the community that the individual is likely to require less than 30 days of nursing facility services, do not require a PASARR to be completed. 1.) R11 was admitted to the facility on [DATE] and has diagnosis of schizophrenia. R11's PASARR level one screening dated 12/23/2024 documents: Does the person have a major mental disorder? YES. Has this person received psychotropic medications to treat symptoms or behaviors of a major mental disorder? Yes. Surveyor noted, the box checked Yes for both questions. Surveyor noted in Section titled: screening result which documents, Resident is suspected of having a serious mental illness. Provider response: AGREE Surveyor noted that based on R11's level 1 PASARR screen completed on 12/23/2024, a level 2 PASARR screening for R11 was triggered and should be completed after 1/23/25. On 8/19/2025, Surveyor requested the Level 2 PASARR from Nursing Home Administrator (NHA)-A as Surveyor was unable to locate it in R11's Electronic Health Record (EHR). Surveyor was provided a PASRR level 2 PASARR screening that was not submitted until 4/25/2025. On 8/20/2025, at 10:36 AM, Surveyor interviewed Social Worker (SW)-F who stated SW-F does not have access to forward health portal to do the PASARR. SW-F stated the PASARR must be done by the due date if residents are here over 30 days. SW-F stated they are working on the process for the level 2 PASARR system. On 8/20/2025, at 4:33 PM, Surveyor informed NHA-A, of the concern that R11's PASARR level 2 was not completed in a timely manner after the 30-day extension after the completion of R11's PASARR level 1 screen. No additional information was provided. 2.) R6 was admitted to the facility on [DATE] with diagnoses that includes Schizophrenia (a chronic (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mental disorder that affects how a person thinks, feels, and behaves). On 08/20/2025, at 9:44 AM, Surveyor reviewed the facility provided document, titled readmission SCREEN AND RESIDENT REVIEW (PASARR) LEVEL 1 SCREEN SUMMARY, which documents R6 has a major mental disorder, received psychotropic medication(s) to treat symptoms or behaviors of a major mental disorder and that the screening result indicates R6 is suspected of having a serious mental illness, triggering a PASARR level 2 screen. However the PASARR level 1 screen documents a Hospital Discharge exemption-30 day maximum to completing the PASARR level 2 screen. Surveyor noted that R6 resided in the facility past the 30-day exemption, indicating R6 would require a level 2 screen to be completed. Surveyor requested the level 2 PASARR from the Facility. On 08/20/2025, at 10:39 AM, Surveyor spoke with Interim Social Worker-I. Social Worker-I informed Surveyor that she started at the facility on 08/07/2025 and does not have access to forward health portal to do the PASARR screenings yet. Social Worker-I indicated that admission staff complete the level 1 PASARR of residents and attaches the screen to an email that is sent out for new admits. Social Worker- I stated that admission staff would also complete a level 2 PASARR screen since they have access to the portal. Social Worker-I indicated that R6 should have a PASARR level 2 completed but has not had one completed yet. Social Worker-I informed Surveyor that the facility is working on the process of completing level two PASARR screens. On 08/20/2025, at 10:42 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. NHA-A indicated that the level 1 PASARR is completed upon admission by admissions staff and/or the Social Worker. NHA-A indicated that ideally the Social Worker would be completing the level 2 PASARR screens. Surveyor informed NHA-A of the concern R6 did not have a level 2 PASARR completed. NHA-A indicated Interim Social worker-I is working on getting access to the portal to be able to complete the PASARR screens. No additional information was provided.

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F 0686 Level of Harm - Minimal harm or potential for 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 1 (R8) of 2 residents reviewed whom is at risk for the development of pressure injuries received the necessary care and services for prevention and healing of pressure injuries/wounds.*R8 was at risk for developing pressure injuries. Surveyor had multiple observations R8 without pressure relieving interventions in place on 8/18/25 and 8/19/25.Findings include:R8 was admitted to the facility on [DATE] with diagnoses of Vascular Dementia (a decline in mental abilities), Anemia (a lack of oxygen rich red blood cells in one's body which may result in tiredness or weakness) and Depression. R8's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 4/19/25 documents a Brief Interview for Mental Status (BIMS) score of 9, indicating that R8's is moderately cognitively impaired. The MDS documents that R8 requires extensive to total assist with Activities of Daily Living (ADLs) including transfers, toileting, dressing and bed mobility.R8's Quarterly MDS dated [DATE] documents that R8 was assessed by the facility to be at risk for the development of pressure injuries. R8's physician's order dated 10/18/24 documents: Pressure relieving devices to R8's bilateral heels when in bed. R8's comprehensive pressure injury care plan with an initiation date of 10/18/24 documents: R8 will maintain skin integrity without new skin related injuries over the next review period. Interventions were documented as: .Observe skin for redness and breakdown during routine care.Assist R8 to reposition frequently when in bed.On 8/18/2025 at 9:30 AM, Surveyor observed R8 in bed lying on their back. Surveyor observed R8's heels directly on mattress On 8/18/2025 at 11:30 AM, Surveyor observed R8 in bed lying on their back. Surveyor observed R8's heels directly on mattress and not offloaded to prevent the development of pressure injuries. On 8/18/2025 at 1:50 PM, Surveyor observed R8 in bed lying on their back. Surveyor observed R8's heels directly on mattress and not offloaded to prevent the development of pressure injuries. On 8/18/2025 at 3:35 PM, Surveyor observed R8 in bed lying on their back. Surveyor observed R8's heels directly on mattress and not offloaded to prevent the development of pressure injuries. On 8/19/2025 at 9:50 AM, Surveyor observed R8 in bed lying on their back. Surveyor observed R8's heels directly on mattress and not offloaded to prevent the development of pressure injuries. On 8/19/2025 at 10:00 AM, Surveyor conducted interview with Certified Nursing Assistant (CNA)-P. Surveyor asked CNA-P if they could accompany Surveyor to R8's room. CNA-P walked with Surveyor to R8's room. Surveyor asked CNA-P what interventions should R8 have in place due to their risk for pressure injuries. CNA-P responded that they weren't aware of any special devices to use for R8, like pillows or heel boots. Surveyor asked CNA-P to show Surveyor R8's heels. Surveyor observed R8's heels with intact skin at this time. On 08/20/2025, at 12:55PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. Surveyor shared concern that R8 has a physician's order for bilateral heel boots to be worn in bed and that R8 was observed by Surveyor in bed without bilateral heel boots on 8/18/25 & 8/19/25.No additional information was provided as to why the facility did not ensure that R8 received the necessary care and services for prevention and healing of pressure injuries/wounds.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure 3 (R8, R19 & R27) of 4 residents reviewed were free from accidents and hazards as possible. *R8 was observed without fall interventions in place in accordance with their comprehensive care plan on on 8/18/25 & 8/19/25. *R19 sustained an unwitnessed skin tear to their elbow. The facility did not investigate the root cause of R19's unwitnessed skin tear or implement new interventions to prevent further accidents. *R27 sustained a fall. The facility did not implement comprehensive care plan interventions, including therapy services, to prevent future falls and accidents. Findings Include: 1.) R8 was admitted to the facility on [DATE] with diagnoses of Vascular Dementia (a decline in mental abilities), Anemia (a lack of oxygen rich red blood cells in one’s body which may result in tiredness or weakness) and Depression. R8’s Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 4/19/25 notes R8with a Brief Interview for Mental Status (BIMS) score of 9, indicating that R8’s cognitive abilities are moderately impaired. R8 was assessed by the facility to be at risk for falls. R8 requires extensive to total assist with Activities of Daily Living (ADLs) including transfers, toileting, dressing and bed mobility. Surveyor reviewed R8’s Electronic Health Record (EHR). Surveyor noted that R8 sustained an unwitnessed fall on 8/3/25 in their room. Surveyor reviewed the facility’s fall investigation including root cause analysis and staff statements for R8’s unwitnessed fall on 8/3/25. Surveyor noted the following documentation for R8’s 8/3/25 fall root cause analysis: “…Recommendations/Corrective actions: 1.) Maintain bed in the lowest position at all times, 2.) Fall mat already on the floor bedside…” Surveyor reviewed R8’s fall care plan with an initiation date of 10/18/24. R8’s fall care plan documents the following: “…R8 has potential for falls related to Psychotropic Medications, Delusional Disorder, PVD (Peripheral Vascular Disease, the lack of proper blood flow to one’s extremities), CAD (Coronary Artery Disease, a condition that causes arteries to one’s heart to become narrowed or blocked), Hx (History) of CVA (Cerebral Vascular Accident, also known commonly as “stroke” BLE (Bilateral Lower Extremity) Weakness, Cognitive Impairment, Anxiety, Depression, HTN (Hypertension, also known commonly as High Blood Pressure).” R8’s fall care plan interventions are documented as follows: “….10/18/24: Fall Mat beside the bed…8/4/25: Make sure R8 is positioned in the center of bed.” Surveyor does not note the recommended fall intervention to maintain bed in lowest position at all times to be added to R8’s fall care plan on 8/4/25. On 8/18/2025 at 9:30 AM, Surveyor observed R8 in bed lying on their back. Surveyor observed R8’s bed to not be in the lowest possible position. Surveyor did not observe a fall mat at R8’s bedside. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheaton Franciscan Hc - Terrace at St Francis	3200 S 20th St Milwaukee, WI 53215

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/18/2025 at 11:30 AM, Surveyor observed R8 in bed lying on their back. Surveyor observed R8’s bed to not be in the lowest possible position. Surveyor did not observe a fall mat at R8’s bedside. On 8/18/2025 at 1:50 PM, Surveyor observed R8 in bed lying on their back. Surveyor observed R8’s bed to not be in the lowest possible position. Surveyor did not observe a fall mat at R8’s bedside. On 8/18/2025 at 3:35 PM, Surveyor observed R8 in bed lying on their back. Surveyor observed R8’s bed to not be in the lowest possible position. Surveyor did not observe a fall mat at R8’s bedside. On 8/19/2025 at 9:50 AM, Surveyor observed R8 in bed lying on their back. Surveyor observed R8’s bed to not be in the lowest possible position. On 8/19/2025 at 10:00 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-P. Surveyor asked CNA-P if they could accompany Surveyor to R8’s room. CNA-P walked with Surveyor to R8’s room. Surveyor asked CNA-P if R8’s bed was in the lowest possible position. CNA-P confirmed that R8’s bed was not in the lowest possible position and adjusted R8’s bed to the lowest position with the bed’s remote control. Surveyor asked CNA-P what fall interventions should R8 have in place due to their risk for falls. CNA-P responded that they knew that R8 should have a fall mat next to their bed but were not sure if anything else would be used. On 08/20/2025, at 12:55PM, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the above concerns related to multiple observations of the absence of R8’s fall mat at bedside on 8/18/2025 and multiple observations on 8/18/25 and 8/19/25 of R8’s bed not being maintained in the lowest possible position per R8's fall interventions. No additional information was provided by the facility at this time. 2.) R19 was admitted on [DATE] with a diagnosis of chronic atrial fibrillation (irregular heart rate) requiring blood thinning medication. The blood thinning medication helps in preventing blood clots and increases your risk of bleeding/bruising. R19's progress notes documentation the following: On 2/12/25 R19 sustained a skin tear during round while the (Certified Nursing Assistant) CNA was providing cares. The CNA stated they grabbed the arm with a bruise on it and that’s how the skin tear occurred. The skin tear is on the right forearm measuring 6 (centimeter) cm by 5.5 cm. On 4/13/25, R19 sustained a skin tear to the right elbow. This occurred when R19 was being repositioned in bed. The skin tear measures 3 cm by 2.5 cm. On 5/15/25, R19 sustained an abrasion that was scabbed over was discover on the right great toe. The area measure 1 cm by 1 cm. On 5/26/25, during a bath there was additional bruising to R19's right hand. R19 reports they bruise easily, and it occurred with a Hoyer transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor was unable to locate any documentation of an investigation into causative factors, and preventative interventions, into the above skin events. On 8/19/202, at 8:57 AM, Surveyor interviewed (Registered Nurse Manager) RNM-D. RNM-D stated R19 does not wear any Tubi grips, and their skin is kept moisturized with lotion. R19 does not get out of bed much and that RNM-D is not involved with R8's plan of care. On 8/19/2025, at 12:03 PM, Surveyor interviewed the (Director of Nurses) DON-B, (Nursing Home Administrator) NHA-A and (Director of Quality) DOQ-C. The DON-B and NHA-A have not been in the facility roles very long. The DOQ-C stated they do discuss skin concerns in the morning meetings. There was not documentation provided into the causative factors for R8 skin events, possible accidents or falls that may have caused R19's skin injuries and no documentation that the facility put in place any preventative measures to prevent further injuries to R8 as a result of accidents and hazards. No additional information was provided. 3.) R27 was admitted to the facility on [DATE], with diagnoses which include Dementia (the loss of cognitive function, including memory, thinking, and reasoning, that interferes with daily life), weakness and repeated falls. R27’s Annual Minimum Data Set (MDS), dated [DATE], documents R27 has severely impaired cognitive skills, does not exhibit any behaviors, has no limitation in upper or lower extremities, requires substantial/maximal assistance with toileting, substantial/maximal assistance with sitting to standing, has occasion urinary and bowel incontinence, has a prognosis resulting in a life expectancy of less than 6 months, no falls since admission and falls are addressed in care plan. On 08/18/2025, at 10:08 AM, Surveyor observed R27 with a large bruise to the right side of R27’s forehead that extended down under R27’s right eye. Surveyor Reviewed R27’s Electronic Health Record (EHR) and noted a progress note dated 08/10/2025 indicating R27 had an unwitnessed fall on 08/10/2025. Surveyor requested R27’s fall investigations for the last 3 months from the Facility. Surveyor reviewed the Facility provided document titled, “Root Cause Analysis (RCA) Report” for R7’s fall on 7/13/2025. Surveyor noted that under the recommendations and preventive measures section it documents: proactive toileting, to reinforce care plan intervention to offer toileting when signs of agitation are present- especially during evening hours. Surveyor reviewed the Facility provided document titled, “Root Cause Analysis (RCA) Report” for R7’s fall on 8/10/2025. Surveyor noted the following documented for corrective actions and preventive strategies “1. Toileting schedule adjustment: Toileting upon rising, before meals, after meals. and before bedtime whenever seeming anxious . 3. Therapy Evaluation: Initiate physical and occupational therapy assessments to evaluate transfer safety, balance and strength.” Surveyor noted the same intervention from R27’s fall on 7/13/2025 was implemented as a new intervention for R27’s fall on 8/10/2025. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R27’s care plan in the Facility’s Electronic Health Record and noted the last revision to R27’s “potential for falls” care plan was on 07/15/2025 and documents “Toileting upon rising, before meals, after meals and before bed time, whenever seeming anxious.” Surveyor requested R27’s Care Plan from the Facility. Surveyor reviewed the Facility provided document titled “Care Plan” for R27. Surveyor noted no dates of revisions or dates of implementation are identified on the Facility provided document. On 08/19/2025, at 11:33 AM, Surveyor interviewed Physical Therapy Assistant-M. Physical Therapy Assistant-M indicated that R27 is on hospice and therapy does not generally work with hospice patients but are able to evaluate Hospice patients with Hospice approval. Physical Therapy Assistant-M informed Surveyor that R27 was last seen by Speech Therapy in July 2025 but has not had an order to be seen by Physical or Occupational therapy since R27’s fall. On 08/20/2025, at 10:51 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B regarding R27’s fall on 8/10/2025. Surveyor inquired on what interventions were implemented into the care plan and if R27 had received therapy evaluation, per the RCA report. NHA-A and DON-B indicated R27 should have been evaluated for therapy per the RCA report but would have to get back to Surveyor with more information. On 08/20/2025, at 12:51 PM, Surveyor informed the facility of the above concerns. The facility did not comment on the concern or provide further information. No additional information was provided.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure consistent communication for 1 (R2) of 1 resident who receives dialysis services.R2's dialysis communication tools were missing for 5 days of 14 days reviewed.Findings include:The facility's Dialysis policy with origination date 12/2017 and last approved date 01/2025 documents: Policy Statement: It is the policy of this community to provide coordination of care with the resident's dialysis provider. Policy Interpretation and Implementation:-Residents needing dialysis services will be admitted with the co-ordination of their dialysis provider off site with a predetermined schedule-Communities are to review contracts to assure resident's needs are met while residing at the facility -The community will co-ordinate care with the dialysis provider in developing an appropriate plan of care to include, but not limited to:a. Specific days of the week resident will attend dialysis .f. Dialysis center's expectation of care to be completed by SNF (skilled nursing facility) (if any) such as; -checking thrills/bruit of grafts and fistulas, documented on TAR (treatment administration record) .-no B/P (blood pressure) or lab draws obtained from arm with dialysis site .-monitor for sign and symptoms of infection including, not limited to, fever; redness, tenderness, bleeding at fistula site .a. A communication tool is utilized to receive a report on the resident to the community after each dialysis session. A verbal report is accepted, and the licensed nurse will document this in the resident's medical record. The facility's Long Term Care Facility Outpatient Dialysis Services Care Coordination Agreement contract with effective date 12/31/2024, documents: B. Obligations of Operator's Long Term Care FacilityInformation sharing: for the purposes of care coordination, in advance of each Resident's dialysis treatment, Long Term Care Facility shall furnish all information and documentation necessary for Dialysis Facility to provide safe and appropriate care, including any and all information reasonably requested by Dialysis Facility R2 was readmitted to the facility on [DATE] with diagnoses that included hemiplegia following cerebral infarction (stroke) affecting left nondominant side, diabetes mellitus type 2 with diabetic chronic kidney disease, end stage renal disease (kidney failure), dependence on renal dialysis, and depression.R2's admission Minimal Data Set (MDS) assessment completed by the facility on 7/9/25 documents a Brief Interview for Mental Status (BIMS) score of 15, indicating that R2 has intact cognition. The MDS documents that R2 is dependent for activities of daily living and transfers and that R2 receives dialysis services. R2's physician order dated 7/20/25 documents: [Dialysis Name] MWF (Monday, Wednesday, Friday) at 1430 (2:30 pm), obtain weight and vitals prior to ambulance pick up.R2's physician order dated 7/10/25 documents: Dialysis observation (pre and post dialysis) twice daily).R2's care plan for the category Renal documents: . DIALYSIS: [R2] receives hemodialysis and has potential for complications and has the following interventions: Dialysis days on MWF ; Vital signs per order; Observe for weight gain or loss, or edema. Inform physician of concerns; Observe dialysis port/site per order for bleeding and report concerns to MD.Surveyor reviewed R2's dialysis communication tools provided by facility for the following dates: 7/18/25, 7/21/25, 7/23/25, 7/25/25, 7/28/25, 7/30/25, 8/6/25, 8/15/25, 8/18/25.Surveyor noted that no dialysis communication tools were provided for the following dates when R2 was scheduled to receive dialysis: 8/1/25, 8/4/25, 8/9/25, 8/11/25, or 8/13/25. Surveyor reviewed R2's nursing progress notes in the electronic health record (EHR) and could not locate any documentation indicating R2 received dialysis treatment or that a licensed nurse received a verbal report from the dialysis center on the dates with missing dialysis communication tools.Surveyor reviewed R2's attachments link in R2's EHR and did not locate any additional dialysis communication tools for the above missing dates.On 8/19/25, at 8:10 am, Surveyor interviewed R2 who confirmed R2 went to dialysis the day prior (8/18). R2 stated R2 brings a folder to and from dialysis and then gives it back to the nurse on duty upon returning to the facility.On 8/19/25, at 9:34 am, Surveyor interviewed Licensed Practical Nurse (LPN)-E who stated a dialysis folder is provided to a resident receiving dialysis to bring back (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and forth to the facility that includes a face sheet, current physician orders, current medications, and a dialysis communication form. LPN-E was unsure where the completed dialysis communication forms go once R2 returns from dialysis, as R2 returns from dialysis on a different shift.On 8/19/25, at 11:06 am, Surveyor interviewed Registered Nurse (RN) Manager-D who stated the dialysis communication forms get completed and returned to the nurse on duty when a resident arrives back to the facility after dialysis. RN Manager-D informed Surveyor that the forms are then given to medical records.On 8/19/25, at 12:13 pm, Surveyor interviewed Health Information Management Assistant (HIMA)-I, who stated HIMA-I scans in the dialysis communication forms into a resident's EHR after HIMA-I obtains the forms. HIMA-I confirmed all available dialysis communication tools have been scanned into R2's EHR, and no other dialysis communication tools have been provided to HIMA-I.On 8/19/25, at 3:54 pm, Surveyor interviewed Nurse Supervisor-J who stated that when a resident returns from dialysis, vital signs and dialysis access site are checked by the nurse, and the dialysis communication tool is filled out, then put into the designated mailbox on the unit.On 8/20/25, at 8:26 am, Surveyor notified Nursing Home Administrator (NHA)-A of the concern that dialysis communication tools were missing for R2 on 8/1/25, 8/4/25, 8/9/25, 8/11/25, and 8/13/25.On 8/20/25, at 1:25 pm, NHA-A confirmed no additional documentation was able to be located for the missing dates and understood the concern that these dialysis communication tools were not available.No additional information was provided.

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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. Based on observation, interview, and record review, the facility did not ensure the medication rate was not 5 percent or greater. This deficient practice was observed in 2 (R32 and R9) of 6 residents receiving medications. The facility medication error rate was 18.52 percent.*R32 was given 15 milliliters (ml) of liquid Potassium Chloride, but is only ordered to receive 3.75ml. R32 received medication through an enteral feeding tube. The Enteral Tube was not flushed prior to administering the medications and was not flushed after administering the medications, until approximately 1 hour later.*R9 was administered Insulin that was past the discard by date.Findings include:The Facility policy titled, Administering Medications dated 12/2024 documents: .C. Medications shall be administered in accordance with the orders and within the allowable time frame per best practice/regulatory guidelines. H. The expiration/beyond use date on the medication label is to be checked prior to administering. The Facility policy titled, Medication Administration vis Enteral Tube dated 12/2024 documents: . K. Procedure: . 9. Flush enteral tube with at least 15ml of water prior to administering medications unless otherwise ordered by prescriber . 13. Flush the tube with a final flush of at least 15 ml of water to ensure drug delivery and clear tube.On 08/19/2025, at 7:23 AM, Surveyor observed Licensed Practical Nurse (LPN)-E prepare R9's medications. Surveyor noted that R9's Insulin, Humalog (Lispro) did not have an open date on the vial but noted a discard by date of 07/15/2025 on the packaging. LPN-E administered 6 units of R9's insulin despite being passed the discard date.On 08/19/2025, at 7:48 AM, Surveyor observed Licensed Practical Nurse (LPN)-E prepare R32's medications. The medications that were observed to be prepared were: -Linzess 72 micrograms (mcg)-Acetaminophen 325 milligrams (mg) x2-Drizalina 60mg-Florastor 250mgLPN-E was observed pouring a Potassium Chloride Solution 40 meq/15ml into a separate medication cup. Surveyor noted LPN-E measured out 15ml into the medication cup. LPN-E then mixed all the medications together and added water. Surveyor noted R32 had a tube feeding running through R32's enteral tube. LPN-E stopped R3's feeding and disconnected the feeding. LPN-E then used a 60ml syringe to administer the medications through R32's enteral tube. Surveyor noted LPN-E did not flush R32's enteral tube prior to the administration of R32's medications. Surveyor asked if R32 receives a flush after the administration of medications through R32's enteral tube. LPN-E informed Surveyor that R32 receives preprogramed flushes every 4 hours while receiving tube feedings and is not due for a manual flush until 9:00 AM.Surveyor observed LPN-E come back to R32's room at 9:01 AM and administered a manual water flush through R32's enteral tube.On 08/19/2025, at 10:02 AM, Surveyor interviewed Director of Nursing (DON)-B. DON-B indicated that enteral tubes are to be flushed before and after administration of medications and that all insulins should have a open date on the vial and should be discarded by the date listed on the packaging or 28 days after the open date, which ever comes first.Surveyor reviewed R32's and R9's Physician orders. Surveyor noted R32's order for liquid Potassium Chloride is to give 3.75ml.On 08/19/2025, at 1:09 PM, Surveyor interviewed LPN-E regarding the amount of Potassium Chloride administered to R32. LPN-E indicated that R32 should have received 3.75ml per the order but was given 15ml. LPN-E then began the Facility's protocol for medication errors.On 08/19/2025, at 1:20 PM, DON-B was made aware of the medication error and assisted LPN-E with completing the facility's medication error protocol.On 08/19/2025, at 3:35 PM, Surveyor informed the facility of the medication errors observed.On 08/20/2025, at 12:51 PM, Surveyor informed Nursing Home Administrator-A and DON-B that Surveyor completed the Medication Administration observations and informed them of the concerns. No additional information was provided.

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F 0725 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record review, the facility did not ensure that a licensed nurse was designated to serve as a charge nurse on each tour of duty.Surveyor reviewed last 30 days of facility nursing schedules and nurse staff postings. Surveyor noted that the facility did not designate a charge nurse for each tour of duty on each daily nursing schedule.This deficient practice has the potential to affect a pattern of all 41 residents residing in the facility.Findings include:On 8/18/2025, Surveyor reviewed the last 30 days of facility nursing schedules and nurse staff postings from 7/18/2025 to 8/18/2025. Surveyor noted that the facility did not designate a charge nurse for each daily nursing schedule for any of the schedules reviewed from 7/18/2025 to 8/18/2025.On 8/19/2025 at 10:11 AM, Surveyor interviewed Scheduler-K. Surveyor asked Scheduler-K if they were aware that there was not a charge nurse designated on the facility's nursing schedules from 7/18/2025 to 8/18/2025. Scheduler-K told Surveyor that they were unaware that it was a requirement to designate a charge nurse on schedules for each tour of duty.On 8/19/2025 at 11:25AM, Surveyor conducted interview with Nursing Home Administrator (NHA)-A. Surveyor shared concern related to facility's schedules not designating a charge nurse for each tour of duty from 7/18/2025 to 8/18/2025.No additional information was provided as to why the facility did not designate a charge nurse for each tour of duty from 7/18/25 to 8/18/25.