

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Brookside Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3506 Washington Rd Kenosha, WI 53144	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to reduce the transmission of disease and infection for 6 (R26, R96, R133, R67, R55, and R106) of 28 residents reviewed for Infection control practices. *Staff did not implement Enhanced Barrier Precautions (EPB) for R26, R96, and R133 despite each meeting the criteria to require such precautions. *R67 was observed during wound care to the sacrum to have stool present at the rectum and was not provided with incontinence care prior to completing the treatment creating an unsanitary environment.*Staff were observed to handle R55, and R106's medications with bare hands. Findings include: The facility's policy titled, Enhanced Barrier Precautions with a last review date of 1/26/2026 indicates when a resident is admitted or found to be infected or colonized with a Novel or targeted Multidrug Resistant Organism (MDRO), indwelling devices, chronic wound (wound that is non healing greater than 12 weeks, etc. will have an isolation kit with gowns, gloves, alcohol sanitizer will be placed on resident's door with signage that says Enhanced Barrier Precautions, which clearly indicated high contact resident care activities (dressing, transferring, providing hygiene, changing briefs, toileting, etc. 1) R26 was admitted to the facility on [DATE], with diagnoses including urinary retention. R26's admission Minimum Data Set (MDS), dated [DATE], indicates they have an indwelling urinary catheter. On 06/15/26, at 9:23 AM, Surveyor observed no PPE (Personal Protective Equipment) available in or outside of R26's room. On 06/15/26, at 9:53 AM, Surveyor observed Certified Nursing Assistant (CNA)-X and CNA-Y transfer R26 from the bed to the wheelchair. Surveyor noted, neither CNA had gowns on, and began assisting R26 with clothing adjustments, sitting up at the edge of the bed and transferring, using a mechanical lift. 2) R96 was admitted to the facility on [DATE] with diagnoses including urethral stricture, overactive bladder, and crossing vessel and stricture of ureter. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R96's Significant Change Minimum Data Set (MDS), dated [DATE] indicates they have an indwelling urinary catheter. On 06/15/26, at 11:09 AM, Surveyor observed no PPE available in or outside of R26's room. On 06/15/26, at 11:13 AM, Surveyor observed CNA-Z in R96's room with no PPE. R96 was sitting in their wheelchair and CNA-Z sat on R96's bed, facing R96 and began assisting R96 with putting on stockings and shoes. On 06/17/26, at 9:44 AM, Surveyor interviewed Infection Preventionist (IP)-C regarding EBP. IP-C indicated EBP are required for anyone with any tube feedings, midline, drains, foley, suprapubic or chronic wounds. IP-C informed surveyor that anyone with an indwelling urinary catheter should be on EBP and is unsure why they were not. IP-C expects staff to wear EBP PPE when performing direct care and transfers. 3) R133 was admitted to the facility on [DATE]. On 5/27/26, R133 developed moisture associated skin damage that evolved on 6/1/2026 into a pressure injury. On 6/16/26 at 9:01 AM, Surveyor accompanied Registered Nurse (RN)-M and Nurse Practitioner (NP)-N to do R133's treatment to the coccyx pressure injury. Surveyor noted R133 did not have a sign posted on the door for Enhanced Barrier Precautions (EBP) or gowns and gloves available outside of the room. RN-M and NP-N proceeded into R133's room and completed the wound treatment without wearing gowns. Surveyor asked RN-M and NP-N why R133 did not have EBP with the presence of a pressure injury. NP-N stated they were wondering the same thing. RN-M stated R133's wound was new and would find out and clarify about the need for EBP. On 6/16/26 at 12:46 PM, RN-M provided Surveyor with a policy and procedure documenting EBP are not implemented for a wound that is non healing greater than 12 weeks. RN-M stated R133 has only had the wound since May 2026, so it is not at the 12 week time frame. On 6/16/2026 at 3:00 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Assistant DON (ADON)-K the concern R133 was not in EBP with a pressure injury. Surveyor shared the concern the policy and procedure provided was not the standard of practice for EBP; the wound should be protected from potential multidrug resistant organisms with the use of gown and gloves, and a pressure injury is considered a chronic wound unlike a skin tear or abrasion. On 6/17/2026 at 7:51 AM, NHA-A stated the nursing administrative staff looked at what Surveyor had presented the day before regarding EBP and they are currently revising their policy and procedure. NHA-A agreed with what was said about pressure injuries being chronic wounds and any resident with a chronic wound should be in EBP. 4) R67 was admitted to the facility on [DATE]. R67 was admitted with pressure injuries to the buttocks as well as moisture associated skin damage with open areas. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	feel bad for doing that and they have been off for an extended period and trying to get their groove back. On 06/16/26, at 12:51 PM, Surveyor interviewed IP-C regarding expectation for medication administration. Surveyor shared the observations of LPN-E. IP-C agreed this was not a good infection prevention method.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provide a notice of discharge to the Office of the State Long-Term Care Ombudsman for 2 of 4 residents (R1 and R67) reviewed for discharge from the facility. R1 was transferred to the hospital 6 times between 2/7/26 and 5/17/26. No notice was provided to the Ombudsman. R67 was transferred to the hospital 2 times between 3/31/26 and 4/20/26. No notice was provided to the Ombudsman. Findings include: 1) R1 was admitted to the facility on [DATE]. R1 was transferred to the hospital on 2/7/26, 2/11/26, 3/20/26, 4/2/26, 4/23/26, and 5/17/26. On 6/16/26 at 3:00 PM, Surveyor asked Nursing Home Administrator (NHA)-A who sends notification to the Ombudsman of resident transfers. NHA-A stated Social Worker (SW)-V sends a monthly email to the Ombudsman with all the names of the residents that were discharged for that month. Surveyor requested to see the list of names SW-V had sent to the Ombudsman for the last six months. On 6/17/26, NHA-A provided the monthly list of residents that were discharged and sent to the Ombudsman. R1 was not included on the list of residents. On 6/17/26 at 9:39 AM, Surveyor asked SW-V how the discharged resident list was determined. SW-V stated they pull a report from the electronic charting system, and it comes up with a list of residents that were discharged to home. SW-V stated they did not know the Ombudsman list needed to include any resident that sent to the hospital. 2) R67 was admitted to the facility on [DATE]. R67 was transferred to the hospital on 3/31/26 and 4/20/26. On 6/17/26, NHA-A provided the monthly list of residents that were discharged and sent to the Ombudsman. R67 was not included on the list of residents. In an interview on 6/17/2026 at 9:39 AM, Surveyor asked SW-V how the discharged resident list was determined. SW-V stated they pull a report from the electronic charting system, and it comes up with a list of residents that were discharged to home. SW-V stated they did not know the Ombudsman list needed to include any resident that discharged to the hospital. NHA-A provided a document to Surveyor on 6/17/26 from the Long Term Care Community Coalition that documents: As of November 2016, federal regulations have required that nursing homes provide a notice of discharge to the state LTC Ombudsman Program (LTCOP) when a resident is discharged or transferred from a facility. NHA-A stated the same document had been provided to SW-V.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R14) of 3 residents received treatment and care in accordance with professional standards of practice. R14 returned to the facility on 4/9/26. There is no evidence a skin assessment, including R14's vascular wounds, was completed. Findings Include: The Facility policy titled, Skin care management, initiated 12/21/26 documented: policy: each resident will have a skin assessment and treatment plan for the maintenance of skin integrity and wound management if required. R14's significant change minimum data set (MDS) completed on 4/22/26 documented R14 has 3 venous and arterial ulcers present at the time of the MDS assessment. On 4/3/26, R14 was sent to the hospital and returned on 4/9/26. R14's electronic medical record (EMR) did not include a skin assessment when R14 readmitted to the facility on [DATE]. R14 has a physician order dated 4/9/26 to apply betadine to R14's left lateral foot, left great toe tip, and left 2nd toe daily. May cover for protection. The treatment end date was 6/10/26. On 6/18/26, at 11:31 AM, Surveyor interviewed Wound Care Nurse (WCN)-M regarding the procedure of when wounds are assessed. WCN-M stated the body assessments are completed on admission or readmission to the facility. The nurse completing the admission is responsible for documenting the assessment of any wounds or skin concerns found at the time of admission. The nurse then emails the wound team so the wound team can assess and treat the wound. The nurse can either get an order to treat the skin concern from the physician or the wound team. On 6/18/26, at 12:42 PM, Surveyor interviewed Director of Nursing (DON)-B regarding expectations for skin assessments. DON-B stated nurses are expected to complete skin assessments on admission and when skin issues are found when skin checks are completed. Skin checks are completed weekly on resident bath days. Surveyor asked DON-B if a skin assessment for R14 was completed when they readmitted to the facility on [DATE]. DON-B said they were not sure if one was completed and that they would look into it. On 6/18/26, at 1:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding R14's missing admission skin assessment from 4/9/26. NHA-A stated that it is expected a skin assessment is completed on admission. The admission skin assessment includes all skin alterations present at that time. NHA-A stated they would investigate the matter.		

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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 residents received care consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 (R67 and R133) of 4 residents reviewed for pressure injuries.*R67's pressure injuries were not assess upon admission or upon 2 subsequent readmissions. In addition, multiple open areas were measured as one wound with no characteristics documented of what the wound looked like. *R133 had moisture associated skin damage to the coccyx that developed into an Unstageable pressure injury. The wound was documented as scattered full-thickness wounds with no documentation of how many wounds or how big the wounds were. Findings include: The facility policy and procedure titled Wound/Pressure Ulcer Documentation dated 12/14/22, and reviewed 3/17/25, includes, .Each wound/PU/PI will be identified by a number and location. Ex. Area 1 Left heel; Area 2 Left lateral malleolus, etc .Each wound/decubitus will be measured in cm using disposable measuring tools found in each cart or med room. The length, width and depth should always be documented. Input these measurements into (the charting system) to obtain the PUSH score. Document any undermining/tunneling/sinus tracts .Describe any exudate - type, amount, or odor .Describe the wound bed (various types of tissue in the wound) .Amount - Describe in percent (Example: 50% wound bed covered with soft yellow slough, 50% beefy red granulation tissue) .When a new wound, including wounds on admission, is identified the following needs to take place: 1. Assessment of wound with measurement 2. Any appropriate interventions put into place, such [sic] air mattress, heel lift 3. Call to MD to request a treatment and (facility) wound care team to eval and treat 4. Notify Dietician for nutritional intervention 5. Care plan updated 6. Notification to POA, if there is one 7. All the above documented in (the charting system) 8. Set up weekly assessment 9. Email wound care team 10. Always date and initial dressings PLEASE OBTAIN A TREATMENT RIGHT AWAY, THE WOUND CARE TEAM WILL ASSESS AS SOON AS POSSIBLE .A note regarding wound/pressure injury status must also be made at the time of summary charting or Medicare charting. Information regarding the presence of a wound/pressure injury must be transferred to the care plan by the nurse first identifying the wound. This must be done as soon as it is identified. 1) R67 was admitted to the facility on [DATE]. R67's Significant Change Minimum Data Set (MDS) assessment dated [DATE] documents R67 is cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and was dependent for toileting, bed mobility, and transfers. R67 had an indwelling urinary catheter. R67 had an activated Power of Attorney (POA). The hospital Inpatient Wound Consult dated 1/26/26 documented R67 had a pressure injury of deep tissue of the right buttock which was nonblanchable, deep purple discoloration with scattered open areas, some covered with slough, and a pressure injury of deep tissue of the left buttock which was nonblanchable, deep purple discoloration with scattered open areas, some covered with slough. Treatments were ordered for the left and right buttock pressure injuries on the discharge summary. In addition to the left and right buttock pressure injuries, the active problem list included a Stage 2 decubitus ulcer of the sacral region. On 1/29/26, R67 had a treatment order for the right buttock: cleanse with Vashe, then Aquacel AG, cover with sacral Mepilex every other day or as needed if soiled. Surveyor noted this was the order from the hospital discharge summary. No order was entered for the left buttock wound. On 1/29/26, the admission Observation form documented R67 had an open area to the coccyx, an open area to the right buttock, and excoriation to bilateral buttocks. There was no comprehensive assessment that would include measurements, wound descriptors, or type of wounds were documented. No treatment was obtained (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the open area to the coccyx. On 2/4/26 on the Wound Documentation form, Wound Registered Nurse (WRN)-W documented R67 had moisture associated skin damage (MASD) to bilateral buttocks and coccyx measuring 8 cm x 12 cm with granulation tissue. WRN-W documented the wound was to the entire buttocks area and the treatment in place was calcium alginate. Surveyor noted the treatment to R67's right buttock was not calcium alginate, and the documentation did not give a percentage of granulation tissue in the wound bed or depth measurement of the wound. On 2/9/2026 on the Wound Documentation form, WRN-W documented R67 had MASD to bilateral buttocks measuring 7 cm x 10 cm with granulation tissue. Surveyor noted WRN-W did not document the percentage of granulation tissue or depth of the wound. On 2/10/26, Wound Nurse Practitioner (WNP)-N made an initial assessment of R67's skin. WNP-N documented R67's MASD of the gluteal cleft had scattered full-thickness wounds that measured 5 cm x 5 cm x 0.1 cm with about 20% granulation tissue and 80% moisture damaged epithelial tissue. Surveyor noted WNP-N did not document the number or size of the open areas within the wound to get a full picture of how the wound presented. On 2/17/26, WNP-N documented R67's MASD to the gluteal cleft healed. On 3/25/26 on the Bath Day Skin/Feet Assessment form, nursing documented a R67 had excoriation to the buttocks and an order for barrier cream with zinc was obtained. No measurements of the wound were documented. On 3/31/26, R67 was transferred to the hospital for complaints of difficulty breathing and chest pain. R67 was admitted to the hospital for sepsis. On 4/9/26, R67 was readmitted to the facility. On 4/9/26 on the admission Observation form, nursing documented, R67's left inner thigh had an open blister, the right heel had unblanchable redness measuring 2.2 cm x 3.6 cm, the sacrum/coccyx and buttocks had multiple small open areas, and the right buttock had two open areas that measured 1.5 cm x 2 cm and 1 cm x 1 cm. There was no comprehensive assessment that would include the type of wounds present, no depths were measured, and no description was documented of the wound beds. On 4/14/26 on the Wound Documentation form, WRN-M documented R67 had a Stage 2 pressure injury to the right buttock that was present on readmission measuring 1 cm x 1 cm with granulation tissue being treated with Medihoney, a Stage 2 pressure injury to the inner right buttock that was present on readmission measuring 0.5 cm x 0.5 cm with granulation tissue being treated with zinc barrier cream, and a Stage 2 pressure injury to the left buttock measuring 3.2 cm x 0.5 cm with epithelial tissue being treated with zinc barrier cream. No depths were documented. No documentation was found of the left inner thigh blister or the right heel unblanchable area. On 4/20/26, R67 was transferred to the hospital and admitted with pneumonia. On 4/27/26, R67 was readmitted to the facility. On 4/27/26 on the admission Observation form, nursing documented in the skin section of the form, R67's right heel has a dark area, and the bottom area is red with multiple open areas: left buttock wound measuring 0.5 cm x 0.6 cm, inner left buttock wound measuring 1.9 cm x 0.7 cm, right buttock wound measuring 1 cm x 1 cm, and right buttock wound measuring 0.6 cm x 0.6 cm. On 4/27/26, R67 was assessed by WNP-N (Wound Nurse Practitioner). WNP-N documented R67 returned from a brief hospitalization with a pressure injury to the sacrum. The sacrum Stage 3 pressure injury had scattered full-thickness wounds measuring approximately 7 cm x 7 cm x 0.1 cm with 40% granulation tissue and 60% hyperpigmented blanchable epithelial tissue. WNP-N did not describe or measure the individual full-thickness wounds within the area or how many open areas there were to give a complete picture of how the wound presented. On 4/28/26 on the Wound Documentation form, WRN-M documented R67's sacrum Stage 3 pressure injury measured 7 cm x 7 cm with 40% granulation and 60% epithelialization and the right heel deep tissue injury measured 1.6 cm x 1.6 cm that was nonblanchable with epithelial tissue to an open area measuring 0.6 cm x 0.6 cm. Surveyor noted a deep tissue injury does not have the characteristics of an open area and would be classified as a (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staged pressure injury. On 5/5/26 on the Wound Documentation form, WRN-M documented the right heel deep tissue injury healed. On 5/5/26, WNP-N documented R67's sacrum Stage 3 pressure injury had scattered full-thickness wounds measuring approximately 5 cm x 4 cm x 0.1 cm with 20% granulation and 80% hyperpigmented blanchable epithelial tissue. WNP-N did not describe or measure the individual full-thickness wounds within the area or how many open areas there were to give a complete picture of how the wound presented. On 5/12/26, WNP-N documented R67's sacrococcygeal Stage 3 pressure injury full-thickness wound measured approximately 1.6 cm x 0.4 cm x 0.1 cm with 100%. Surveyor noted WNP-N did not document what type of tissue was in the wound bed. WNP-N documented R67 had MASD with scattered full thickness open areas to the bilateral gluteal cleft measuring 6 cm x 6 cm x 0.1 cm with 60% epithelial tissue and 40% granular tissue. WNP-N did not describe or measure the individual full-thickness wounds within the area or how many open areas there were to give a complete picture of how the wound presented. On 5/18/26 on the Wound Documentation form, WRN-W documented R67's sacrum Stage 3 pressure injury measured 1.5 cm x 0.7 cm with 100% granulation. No depth was documented. On 5/25/26 on the Wound Documentation form, an RN documented R67 had two open areas and excoriation to the buttocks measuring 6.27 cm x 7.02 cm with granulation tissue. The two open areas were not measured, no depth was documented, and the percentage of granulation tissue was not documented. On 5/27/26 on the Wound Documentation form, WRN-W documented R67's healing Stage 3 pressure injury measured 6 cm x 3 cm with non-granular tissue with two small open areas measuring 0.3 cm x 2 cm to the right inner gluteal cleft and 0.2 cm x 0.2 cm to the coccyx with smooth pink non granular tissue to both areas. No depth was documented. On 6/1/26 on the Wound Documentation form, WRN-W documented R67's buttocks Stage 3 pressure injury measured 1.5 cm x 0.6 cm with epithelial tissue and a thin scab to the right buttock and was almost healed. Surveyor noted the location of the pressure injury changed and the location of the open areas could not be determined from previous assessments. On 6/8/26 on the Wound Documentation form, an RN documented R67's coccyx had an open area that measured 12 cm x 4 cm with epithelial tissue. No staging, depth, or percentage of tissue type was documented. On 6/11/26 on the Wound Documentation form, WRN-W documented R67's right buttock/coccyx Stage 3 pressure injury had scabbed over and healed. WRN-W documented R67 had MASD to bilateral buttocks measuring 9 cm x 9 cm with non-granulation tissue. On 6/15/26 on the Wound Documentation form, WRN-W documented the coccyx MASD measured 5 cm x 2.5 cm with epithelial tissue. On 6/16/2026, WNP-N documented R67's sacrococcygeal Stage 3 pressure injury with scattered full-thickness wounds measured approximately 4.3 cm x 2 cm x 0.1 cm with 80% blanchable epithelial and 20% granular tissue and bilateral gluteal cleft MASD had healed. Surveyor noted WRN-W had resolved the pressure injury and continued the MASD while WNP-N resolved the MASD and continued the Stage 3 pressure injury. Surveyor noted confusion between the facility and WNP-N with labeling of areas and descriptions of the wounds. On 6/16/26 at 8:37 AM, Surveyor observed WNP-N and WRN-M complete wound care with R67. R67 had an air mattress in place and heel boots on. WRN-M assisted R67 to roll onto the left side and held R67 in place while WNP-N measured and treated the wounds. WNP-N stated the MASD had healed and the Stage 3 pressure injury to the coccyx measured approximately 4.3 cm x 2 cm. Surveyor observed a small open area on the inner right buttock and the coccyx that were actively bleeding after WNP-N removed the zinc barrier cream from the area. Surveyor asked WNP-N how many open areas were present. WNP-N stated there were three wounds. WNP-N showed Surveyor the additional wound to the inner left buttock. Surveyor asked WNP-N why the individual open areas were not measured. WNP-N stated R67 was admitted with one wound that had healed in the middle making it now three smaller wounds and did not want to document that R67 now had three (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brookside Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3506 Washington Rd Kenosha, WI 53144	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wounds. On 6/17/26 at 1:42 PM, Surveyor spoke with DON-B. DON-B stated they were aware WNP-N measures the whole area for MASD. Surveyor shared with DON-B that WNP-N does the same for pressure injuries and does not describe what the entire area looks like. DON-B stated each wound should be measured separately. 2) R133 was admitted to the facility on [DATE]. R133's Significant Change MDS assessment dated [DATE] documented R133 did not have any pressure injuries at the time of the assessment and had elected hospice services. R133 had an activated Power of Attorney (POA). On 5/13/226 at 2:01 PM in the progress notes, nursing documented R133 had a blanchable redness to the coccyx. Hospice was notified and an order for Calmoseptine twice daily was obtained. On 5/27/26 at 12:18 AM in the progress notes, a Licensed Practical Nurse (LPN) documented R133 had two open areas; the coccyx wound measured 1.5 cm x 1 cm and the right buttocks wound measured 1 cm x 0.5 cm. The hospice agency was notified and ordered to continue with the scheduled Calmoseptine cream and apply a protective dressing. The hospice nurse would follow up in the morning. On 5/27/2026 on the Wound Documentation form, Wound Registered Nurse (WRN)-W documented R133 had moisture associated skin damage (MASD) to the coccyx measuring 5 cm x 1 cm with non-granulation tissue. No depth was documented and did not indicate there were any open areas as noted in the progress note on 5/27/2026 at 12:18 AM. On 6/1/26 on the Wound Documentation form, WRN-W documented the wound to the coccyx started as MASD and was now an Unstageable pressure injury measuring 6 cm x 1.5 cm with necrotic tissue. No depth or percentage of necrotic tissue was documented. The original note documented 2 separate open areas, however, this note only documents 1. On 6/2/26, R133 was initially assessed by WNP-N. WNP-N documented R33's coccyx unstageable pressure injury had scattered full-thickness wounds measuring approximately 4 cm x 5 cm x unable to determine with 5% smooth pink tissue, 10% slough, 5% non-blanching erythema, and 80% blanchable epithelial tissue. No description of the scattered full thickness wounds was documented, including number, appearance, and locations. Surveyor noted that 10% slough would not cover the entire wound bed and therefore the wound should be staged according to the characteristics of the wound. On 6/9/26, WNP-N documented R133's coccyx unstageable scattered full-thickness pressure injury measured approximately 3 cm x 3.5 cm x unable to be determined with 20% slough and 80% epithelial tissue. No description of the scattered full thickness wounds was documented, including number, appearance, and locations. On 6/15/26 on the Wound Documentation form, WRN-W documented R133's coccyx unstageable pressure injury measured 1.1 cm x 1.5 cm with slough. No depth or percentage of slough was documented. On 6/16/26 at 9:01 AM, Surveyor observed WNP-N and WRN-M complete wound care with R133. WP-N measured and treated the wound. The wound had defined edges measuring approximately 1.5 cm x 1.5 cm x 0.2 cm with 100% slough. The surrounding skin did not look macerated or broken down. On 6/16/26, WNP-N documented R133's coccyx unstageable full-thickness pressure injury measured 1.3 cm x 1.3 cm x unable to determine with 100% thin layer of slough. On 6/18/26 at 9:28 AM, Surveyor shared with DON-B the concerns with documentation of R133's wounds by not being comprehensive and measuring large areas with multiple scattered open areas and no description or measurements of those areas. DON-B stated they were aware WNP-N measures the whole area for MASD. DON-B stated each wound should be measured separately. On 6/18/26 at 11:30 AM, Surveyor spoke with WRN-M and asked what the facility's process was for newly admitted residents with an open area. WRN-M stated the nurse on the floor will do the body check and the wound observation. WRN-M stated the wound care team comes in to assess wounds; on Monday and Wednesday WRN-W assesses wounds and on Tuesday and Thursday WRN-M assesses wounds. They do not have any wound rounds on Friday, Saturday, or Sunday, but WRN-M and WRN-W work alternate weekends so staff will find them, and they will look at wounds (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	even though that is not what they are at work to do. Surveyor asked WRN-M how quickly the wound team will come to assess a resident with a wound. WRN-M stated they will come and look at it right away, but WNP-N comes in only on Tuesdays. Surveyor asked WRN-M if open areas are measured as one area or individual wounds. WRN-M stated they know WNP-N will measure the area as one wound if open areas are close together and the tissue in between is not good. Surveyor shared with WRN-M the concern R67's admission assessment on 1/29/26 had wounds present and they were not comprehensively assessed until 2/4/26. WRN-M stated they should have been assessed right away.		

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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 adequate supervision and safety to prevent accidents from occurring for 1 of 6 residents (R90) reviewed for falls. R90 was care planned to have a floor mat alongside the bed. Observations were made of R90 lying in bed without the floor mat in place. Findings include: 2) R90 was admitted to the facility on [DATE] with diagnoses including Dementia, orthostatic hypotension, hemiplegia, and hemiparesis affecting right dominate side. R90's Comprehensive MDS, dated [DATE], indicates severe cognitive impairment, no impairment in upper or lower extremities and dependent for transfers from bed to chair. R90's Care Plan indicates R90 is at risk for falls with the following interventions:-Assessment and treatment for postural/orthostatic hypotension.-Call light within reach at all times.-Floor mat next to bed while in bed.-Exercise program that targets strength, gait and balance.-Increased staff supervision with tensity based on need.-Comprehensive medication review by pharmacist.-Provide individual toileting interventions on needs/pattern. On 06/16/26, at 7:03 AM, Surveyor observed R90 in their bed with both legs hanging off the side of the bed. Surveyor observed R90 attempting to get out of bed and appeared to be close to sliding out of bed. Surveyor noted there was no fall mat on the floor next to R90's bed and there were no staff readily available. Surveyor intervened by going to get a staff member. Certified Nursing Assistant (CNA)-O was found and assisted R90 get situated back in bed. On 06/17/2026, at 7:29 AM, Surveyor observed R90 in bed with no fall mat on the floor next to R90's bed. At 7:34 AM, Surveyor asked Licensed Practical Nurse (LPN)-P to come to R90's room with Surveyor. Surveyor asked LPN-P what fall interventions R90 should have in place. After LPN-P reviewed R90's care plan, Surveyor asked LPN-P if R90 has a fall mat in place. LPN indicated no and looked around R90's room for a fall mat but could not locate one. LPN-P informed Surveyor that she is unsure why a fall mat is not in place but is should be due to R90 being at an increased risk for falls and would get a fall mat for R90. On 06/17/2026, at 11:12 AM, Surveyor informed Registered Nurse (RN) Supervisor-Q, RN Educator-R and Director of Nursing (DON)-B of Surveyors observations of R90. RN Supervisor-Q informed Surveyor that R90 should have a fall mat in place. RN Supervisor-Q indicated she was informed this morning about R90 not having a fall mat in and a fall mat has now been provided to R90.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility did not ensure the attending physician addressed the identified irregularity noted by the pharmacist for 1 (R5) of 5 residents reviewed for unnecessary medications.*R5 had an order for olanzapine, an antipsychotic medication, that was ordered for skin picking disorder/excoriation. The pharmacist documented that was not an approved diagnosis for the use of the medication. The physician did not address the diagnosis for use. Findings include: R5 was admitted to the facility on [DATE]. R5's Significant Change Minimum Data Set (MDS) assessment dated 5/19/26 documents R5 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 10. R5 was seen on 12/16/25 by a psychiatric Nurse Practitioner (NP) who documented R5 had previously been diagnosed with major depressive disorder, generalized anxiety disorder, insomnia, and was diagnosed on that visit with excoriation (skin-picking) disorder. The excoriation disorder was based on repetitive skin picking observed at the nose and arms, as reported by R5, R5's spouse, and facility staff. A new medication of olanzapine 2.5 mg daily was ordered to treat the disorder. On 2/6/26, the pharmacist identified and documented an irregularity during R5's medication review. The Note to Attending Physician/Prescriber completed by the pharmacist documented R5 was receiving the antipsychotic agent Zyprexa (olanzapine) but lacks an allowable diagnosis to support its use. The pharmacist provided a list of appropriate diagnoses for the physician. The document had a hand-written note by Director of Nursing (DON)-B stating as of 12/16/25, olanzapine was started for skin picking (excoriation) disorder with a diagnostic code of F42.4 as diagnosed by the psych NP. The physician initialed the document, but no changes were made to R5's diagnosis connected to the olanzapine. On 5/11/26, the pharmacist again identified and documented the same irregularity during R5's medication review. The Note to Attending Physician/Prescriber was the same information as given to the facility on 2/6/26. No changes were made to the diagnosis for the use of olanzapine. On 6/18/26 at 10:06 AM, Surveyor spoke with Assistant Director of Nursing (ADON)-K about R5's pharmacy review and that the irregularities were not addressed. ADON-K indicated they were not aware of the recommendation and would get more information. On 6/18/26 at 10:13 AM, Surveyor spoke with the Medical Director (MD)-U and DON-B about the diagnosis for R5's use of olanzapine. MD-U stated the diagnosis should be dementia with behaviors and has to be treated pharmacologically because the skin is a big area and R5 picks the face and arms until they bleed. Surveyor shared with Director of Nursing (DON)-B the list provided by the pharmacist for appropriate diagnosis for the use of olanzapine.		