STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525567	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Lights Hcc	706 Bratley Dr Washburn, WI 54891

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility did not ensure the safety of food handling in accordance with professional standards for food service safety. The facility practices had the potential to affect 42 out of 43 residents that eat orally at the facility. A fan in the clean dish washing station, which had notable dust and debris, was blowing on a rack of clean dishes. The cook did not allow the thermometer probe to air dry after cleaning with isopropyl alcohol prior to inserting into foods items intended to be served to residents for lunch. A dietary aide was observed not properly wearing a beard restraint. This is evidenced by: Example 1 The facility policy titled, “Food Safety- Director of Food and Nutrition Services’ Responsibilities” dated 2021, states in part, “5. Employees will follow proper cleaning and sanitizing instructions for all kitchen equipment… 8. Dishwashing guidelines and techniques will be understood by staff and carried out in compliance with state and local health codes.” On 7/28/25 at 9:47 AM, during initial tour of kitchen, Surveyor noted in the clean dish washing area a rack of dishes drying with an industrial-type fan blowing on the clean dishes. Surveyor noted fan had dust-like substance covering the back of the fan. Fan was loud and appeared to be on high. Surveyor interviewed [NAME] P about the fan blowing on the clean dishes on the drying rack. [NAME] P reported there are not usually clean dishes in front of the fan, and he turned the fan off. Example 2 The Food and Drug Administration (FDA) Food Code states in part, “4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food. On 7/29/25 at 11:27 PM, Surveyor observed [NAME] Q take the internal temperatures of the foods going from the oven into the warming table for resident’s lunch. Surveyor noted [NAME] Q would wipe probe with probe wipe and immediately put probe into the next food which was regular (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	pork, ground pork, and pureed pork. Surveyor interviewed [NAME] Q, who stated she was not aware she was supposed to wait to allow for chemical to dry after wiping probe and before sticking it into the resident’s food. On 07/29/25 at approximately 12:00 PM, Surveyor interviewed Culinary Director R, who reported understanding the importance of waiting for the chemical to dry after wiping the food probe before immediately putting wiped probe into resident's food. Culinary Director R also reported the fan is not supposed to have been in the dishwashing area. Surveyor noted the fan in the dishwashing area had been removed. Example 3 Facility policy titled, “Employee Sanitary Practices” dated 2021, reads in part: “All employees will…. wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food.” On 07/28/25 at 12:02 PM, Surveyor observed Dietary Aide (DA) I with beard net around neck and not covering beard when entering kitchen. When DA I exited the kitchen a couple minutes later, he had the beard net on the lower part of his chin only. DA I delivered a tray and returned to the kitchen. DA I exited the kitchen the third time with beard net over entire lower face including mouth/mustache.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not maintain an infection prevention program designed to provide a safe and sanitary environment to prevent the transmission of communicable disease and infection for all 43 residents. Findings include: Example 1 The facility policy titled, “Enhanced Barrier Precautions” (EBP) with revised date of April 1, 2024, states, in part: “…Use of Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP will be applied, when Contact Precautions do not otherwise apply, to residents with any of the following: Wounds or indwelling medical devices, regardless of Multidrug-resistant organism (MDRO) colonization status… …precautions, including use of gown and gloves, will be used during any high contact resident care activities to include … device care (… urinary catheter…) R5 was admitted on [DATE] with diagnoses that includes obstructive and reflux uropathy and history of urinary tract infection. R5’s orders include Foley catheter care every shift. On 07/30/2025 at 10:05 AM, Survey observed Certified Nursing Assistant (CNA) N emptying R5’s catheter. CNA N had on gloves but did not have on a gown. Surveyor interviewed CNA N about EBP with R5’s indwelling catheter care. CNA N stated he is aware he should be wearing a gown with R5’s catheter care but he doesn’t always do so. On 07/29/25 at 10:49 AM, Surveyor interviewed Director of Nursing (DON) B, who stated her expectation is that a gown and gloves should be worn with cares of residents with an indwelling device such as a catheter. DON B reported the staff recently had a training on infection control and the use of proper protective equipment (PPE). Example 2 The facility policy titled, “Handwashing” revised April 2025, states, in part, “…Alcohol based hand sanitizer should be used: …Before moving from work on a soiled body site to a clean body site on the same patient…” R40 was admitted to the facility on [DATE] with diagnosis that includes Alzheimer’s disease, heart disease with heart failure, hypotension, weakness, history of falls, and candidiasis of the skin and nails. R40’s most recent Minimum Data Set (MDS), dated [DATE], indicated R40 had a Brief Interview for Mental Status (BIMs) of 6/15, indicating severe cognition impairment. R40’s MDS also indicated R40 “is incontinent of bowel and bladder, no open skin areas, and is dependent (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with all cares and repositioning.” On 07/29/25 at 8:44 AM, Surveyor observed CNA K and H provide incontinence care and repositioned R40. Surveyor observed CNA K perform peri care and wiped stool from R40's buttocks with a premoistened cloth. CNA K did not change gloves after contact with stool and continued to wipe R40's open skin area on upper buttocks with another wipe, and with same gloves, applied barrier cream to R40’s open wounds. CNA K continued to dress R40 with same gloves before removing them. On 07/29/25 at 8:54 AM, Surveyor interviewed CNA K, who reported she did not remove gloves or use hand hygiene after contact with soiled area and before cleaning and applying barrier cream to R40’s open skin areas, and she realized she should have. On 07/29/25 at 10:49 AM, Surveyor interviewed DON B, who stated her expectation is that proper hand hygiene and use of PPE be performed with cares of all residents. DON B reported the staff recently had a training on infection control and the use of proper protective equipment. Example 3 On 07/28/2025 at 12:13 PM, Surveyor observed CNA H assisting multiple residents (R29, R16, R9, and R26) with no hand hygiene in between. On 07/28/2025 at 12:16 PM, Surveyor observed CNA K bring R13 to the dining room table for breakfast and did not offer hand hygiene to R13. CNA K also set up R13’s breakfast touching plate, utensils, and drinks without prior hand hygiene after pushing R13’s wheelchair. Example 4 Facility policy titled, “Linen Handling,” with a revised date of 11/2022, states: “Policy: When handling, storing, processing, and transporting linens, facility personnel use procedures designed to prevent the spread of infection. Procedure: 4. Take soiled linen container/bag to the laundry room when full. 5. Dirty laundry should not be held close to a person’s body.” On 07/29/25 at 8:36 AM, Surveyor observed CNA E exit a resident’s room with dirty clothes and linens in gloved hand. Soiled linens were observed carried in CNA E’s gloved hand; no bag to contain items. CNA E carried items to end of resident hallway and disposed of in soiled linen closet. On 07/29/25 at 10:08 AM, Surveyor observed CNA E exit R28’s room, after providing cares, carrying dirty linens in gloved hand down resident hallway to soiled linen room. The dirty linens were not contained in a bag. On 07/29/25 at 11:13 AM, Surveyor interviewed CNA E regarding observation. Surveyor asked CNA E how staff are trained to transport dirty linens. CNA E stated staff are supposed to use gloves. On 07/30/25 at 7:02 AM, Surveyor interviewed Director of Nursing (DON) B regarding transporting dirty linens. DON B stated that staff are expected to transport dirty linens in a closed bag, away from the body.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility did not ensure 8 of 9 residents (R30, R29, R13, R18, R9, R16, R26 and R14) were treated with respect and dignity.Facility staff stood over R9, R16, R18, and R29 while assisting them to eat.Facility did not ensure residents (R30, R26, R13, R14) received meal within a similar time frame as others at the same table.Facility set up R13's meal uncovered at dining room table and R13 was not present.Findings include:Facility policy titled, Dining and Food Service, last revised on 02/15/24, reads in part: The community will enhance the resident's dining experience to promote their quality of life.On 07/28/25 at 12:05 PM, Surveyor observed R30 with no food in front of him at a table with 3 other residents eating (R9, R26, and R2). Surveyor observed R26 put utensil down and stated, Did you order? when speaking to R30. R30 responded with, I think so. R30 received meal at 12:14 PM.On 07/28/25 at 12:12 PM, Surveyor observed Certified Nursing Assistant (CNA) H standing next to R29, providing a bite of food and then moved on to assist another resident. On 07/28/25 at 12:16 PM, Surveyor observed CNA K set up R13's meal on the dining room table uncovered with R13 not present. R13 was brought to the table at 12:19 PM. On 07/28/25 at 12:21 PM, Surveyor observed CNA H standing next to R18 placing food on fork and providing R18 a bite of food.On 07/28/25 at 12:24 PM, Surveyor observed CNA H standing next to R9, cutting up food, and providing R9 with a bite.On 07/28/25 at 12:25 PM, Surveyor observed CNA H walk over to R16. R16 was back away from the table. CNA H assisted R16 closer to the table and assisted R16 with a bite of food and offered a drink while standing next to R16.On 07/29/25 at 7:41 AM, Surveyor observed 5 residents at a shared table (R26, R13, R2, R35, and R14) awaiting breakfast.On 07/29/25 at 7:43 AM, R35 received meal.On 07/29/25 at 7:48 AM, R2 received meal.Survey observed 2 wing carts of food leave the kitchen for delivery to resident rooms. The first cart left the kitchen at 7:49 AM, the second at 7:59 AM. R26, R13, and R14 still had no meal. Surveyor observed Nursing Home Administrator (NHA) A and CNA J sitting in the dining room. Surveyor had to exit the dining observation at this time.On 07/29/25 at 1:27 PM, Surveyor interviewed R21. R21 stated residents do not get their meals at the same time when sharing a table. R21 stated when the meals are delivered depends on when and how many staff are in the dining room for the meal. R21 stated sometimes trays get sent to rooms on the carts and residents must wait for staff to bring them back to the dining room before they can eat.On 07/29/25 at 2:55 PM, Surveyor interviewed NHA A and Director of Nursing (DON) B. Surveyor discussed observations of staff assisting with eating while standing.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not implement policies and procedures for ensuring the reporting of physical abuse in accordance with section 1150B of the Act when an allegation of physical abuse was not reported immediately, but no later than 2 hours to the administrator and local law enforcement in accordance with state law through established procedures for 1 of 1 resident (R) reviewed (R28).This is evidenced by:Facility policy titled, Abuse, Neglect, and Exploitation, Suspected Crimes, with a reviewed date of 11/2024, states: Procedure: 3. Prevention: a. Staff, families, and residents are encouraged to report incidents of suspected abuse, neglect.5. Investigation: a. Any person who knows or has reasonable cause to suspect that a resident has been or is being abused, neglected, or exploited shall immediately report such knowledge or suspicion to the administrator. b. The administrator, director of nursing, or designee will notify the appropriate regulatory, investigative, or law enforcement agencies immediately, in accordance with state regulations.R28 was admitted to the facility on [DATE], with pertinent diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.R28's most recent quarterly Minimum Data Set (MDS) assessment, dated 07/17/25, noted a Brief Interview for Mental Status (BIMS) score of 00, indicating severely impaired cognition. R28 had impaired range of motion (ROM) on both sides in upper and lower extremities.Surveyor reviewed R28's electronic medical record (EMR) and noted the following incident:On 07/04/25 at 12:30 PM, a Certified Nursing Assistant (CNA) reported to the Licensed Practical Nurse (LPN) that while providing cares to R28 in bed, a cut on R28's left eye lid measuring 2 cm was discovered. The cut was cleaned and gauze applied. R28's activated power of attorney (POA), charge nurse, and provider were notified.On 07/08/25, provider responded to monitor for change in vision and infection.-Of note: no additional documentation of incident was noted.On 07/29/25 at 3:14 PM, Surveyor interviewed Director of Nursing (DON) B regarding incident. DON B stated she was on vacation during this time and was unaware of the incident. DON B stated that staff did not follow procedure of notifying the administrator or other leadership to follow-up and investigate. DON B stated that this incident, if brought to her attention, would have been investigated and reported. DON B stated education would be completed with staff.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure care plans were revised to reflect residents' current needs and to provide the needed direction to staff in providing necessary care and services for 1 of 13 residents (R)(R28) reviewed.R28's care plan interventions to offload heels while in bed was not updated when changed from using heel pads to wedge. This is evidenced by:Facility policy titled, Person-centered Plan of Care - Comprehensive, with a revision date of 01/2023, states: Person-centered Care: Integrated health care services delivered in a setting and manner that is responsive to the individual and their goals, values and preferences, in a system that empowers patients and providers to make effective care plans together. The care plan describes.services that are furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Procedure: 3. Write interventions in terms of staff behavior, e.g., what the staff will do to accomplish an objective.R28 was admitted to the facility on [DATE], with pertinent diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.R28's most recent quarterly Minimum Data Set (MDS) assessment, dated 07/17/25, noted a Brief Interview for Mental Status (BIMS) score of 00, indicating severely impaired cognition. R28 had impaired range of motion (ROM) on both sides in upper and lower extremities. R28 required substantial/maximum assist with upper body dressing and rolling left to right. R28 required dependent assist with personal hygiene, sit to lying, lying to sitting, and chair/bed transfers. R28 was noted to be at-risk for pressure injuries with no current skin conditions noted.R28's CNA task list, dated 07/16/24, states: Ensure heel pads are on while in bed every shift. This task was documented as completed every shift.-Of note: R28 was observed in bed with a foam wedge in place to elevate heels off bed. No heel pads were observed on R28 at any time during survey.On 07/29/25 at 5:44 PM, Surveyor interviewed Certified Nursing Assistant (CNA) F regarding R28's heel pads. Surveyor asked CNA F if heel pads were used for R28. CNA F stated yes. Surveyor asked CNA F to show the heel pads. CNA F looked in room and couldn't find them. CNA F stated staff heel pads were used previously, but now a wedge is used because R28 kept pushing the heel pads off. Surveyor asked CNA F when this change occurred. CNA F stated months ago but couldn't recall exactly. Surveyor asked CNA F who is responsible for updating the changes in the CNA care tasks. CNA F stated the nurse.On 07/30/25 at 9:29 AM, Surveyor interviewed CNA D regarding heel pads. CNA D stated R28 used to use heel pads but was transitioned to the wedge a while ago. CNA D could not remember when the transition occurred, but it was some time ago. Surveyor asked why the CNA task documentation shows heel pads were applied every shift. CNA D stated this is marked complete because the wedge is put into place. On 07/30/25 at 10:12 AM, Surveyor interviewed Director of Nursing (DON) B regarding R28's care plan revisions. DON B stated the nurse should have updated R28's care plan when this was changed.

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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 promote the prevention of or implement interventions to prevent pressure injuries for 2 out of 4 residents (R) reviewed for pressure injuries, (R5, R40) resulting in stage II pressure injuries (PI).Findings include: R40 and R5 had open skin areas that were not reported to nursing when observed and documented by Certified Nursing Assistant (CNA) per facility policy and current standards of practice.R40 and R5, who are at risk for developing PI, did not have thorough and adequate skin integrity assessments performed by nursing staff on a weekly basis per facility policy.R40 and R5 did not have a wound care treatment plan consistent with profession standards of practice.R40 and R5 were not repositioned every 2 hours as indicate in their care plans.R40's care plan was not updated promptly to address interventions for a stage II PI.R5's care plan was not updated to address pressure relieving interventions with current use of recliner instead of previously used Broda chair.The facility policy, titled Pressure Injury/Skin Integrity, reviewed November 2024, states in part: Based on the comprehensive assessment of a resident, (the facility) will ensure: A resident receives care, consistent with the professional standards of practice. To prevent pressure injuries and does not develop pressure injuries unless the individuals clinical condition demonstrates that they were unavoidable: and . Routine ongoing documentation should be conducted related to the resident's skin condition and the resident's response to the care and treatment of the skin.The frequency of documentation shall be determined based on the resident's individual needs in accordance with accepted standards of practice, at least weekly.1) All residents admitted to the facility will receive undergo an initial skin assessment within 4 hours of admission and on a weekly basis per bathing schedule.all incontinent residents receive peri-care with application of barrier ointment/cream with each incontinent episode.2) Wound rounds will be completed weekly by a licensed nurse. 3) Weekly documentation of wounds is completed by a licensed nurse.Interventions will be implemented to mitigate the risk for potential skin breakdown, based on individual risk factors, and may include but are not limited to:a. The use of pressure redistribution devices. b. Interventions should be documented in the residents' medical record, including the resident-centered plan of care.Routine ongoing documentation should be conducted relating to the resident's skin condition and the resident's response to care and treatment of the skin. The frequency of documentation shall be determined based on the resident's individual needs in accordance with acceptable standards of practice, at least weekly.All Clinical Staff will have education provided during their orientation process as well as on a minimum of an annual basis related to, but not limited to wound care techniques, pressure injury prevention, and appropriate wound care/monitoring documentation.Example 1R40 was admitted to the facility on [DATE] with diagnosis that includes Alzheimer's disease, heart disease with heart failure, hypotension, weakness, history of falls, and candidiasis of the skin and nails.R40's most recent Minimum Data Set (MDS) dated [DATE] indicated R40 had a Brief Interview for Mental Status (BIMs) of 6/15, indicating severe cognition impairment. R40's MDS also indicated R40 is at risk for developing PIs, is incontinent of bowel and bladder, had no open skin areas, and is dependent with all cares and repositioning.R40's care plan, date initiated 03/27/24, states, in part:.At risk for skin breakdown r/t reduced mobility and need for assistance with repositioning. Also, at risk due to bowel and bladder incontinence. Currently right buttock excoriation being treated. Healed as of 11/22/2024 and revision of care plan on 01/02/25.interventions include, in part: Will have clean, dry, intact skin through next review date, barrier cream on with each incontinence change, Follow community skin protocol. Staff will keep skin as clean and dry as possible and minimize exposure to moisture. Will also keep linens clean and dry, Incontinence care with incontinent brief changes, observe skin with AM/PM cares and with toileting for redness, rashes, open areas, pain, swelling and report them to team leader. Weekly skin check. Lotion to dry skin. Review skin concerns with MD. Report any new or abnormal skin concerns such as (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bruises, open areas, reddened areas, tender areas, cuts or abrasions.Pressure reduction cushion in wheelchair (initiated on 3/27/24).Pressure reduction mattress on bed (initiated 3/27/24).Reposition on all rounds in bed and chair & PRN. Use lift sheet when assisting with bed mobility to avoid shearing skin during repositioning (initiated on 3/27/24) .Encourage physical activity, mobility, and ROM to maximal potential to help reduce breakdown.Provide nutritional supplements as recommended to help maintain good skin condition. Offer and encourage fluids during and between meals to help maintain good hydration. Reposition Resident on all rounds and as needed. Requires documentation. Skin Observation.Record review indicated R40's skin assessments/weekly skin checks performed by nursing staff, on 07/06/25 and 07/13/25 are documented No Skin Issues Noted. On 07/19/25 and 07/27/25 is documented redness to groin and buttock.On 07/30/25, Surveyor reviewed Certified Nursing Assistant (CNA) tasks charting which indicated R40 had skin tear on 07/01/25, 07/02/25, 07/11/25, 07/14/25, 07/15/25, 07/16/25, 07/18/25, 07/21/25, 07/23/25, 07/25/25, 07/27/29, and 07/29/25. CNA tasks charting indicates R40 had open skin area on 07/2/25, 07/03/25, 07/04/25, 07/06/25, 07/09/25, 07/10/25, 07/13/25, 07/15/25, 07/16/25, 07/17/25, 07/18/25, 07/24/25, 07/28/25, and 07/29/25.On 07/28/25 at 10:55 AM, Surveyor observed CNAs don gowns and gloves prior to entering R40's room to provide care. Surveyor did not note any signage on R40's door nor did matrix indicate why a gown would be required for cares. Surveyor was unable to observe or interview at that time as to why CNAs donned gowns.On 07/28/2025 at 11:13 AM, Surveyor interviewed CNA K who reported they donned gowns to provide incontinence cares to R40 because R40 has an open skin area on right buttock.On 07/29/25 at 8:44 AM, Surveyor observed CNAs K and H provide incontinence care and reposition R40. Survey observed CNAs provide incontinence cares for R40. R40 had an open skin area with pink, moist tissue noted on right buttock. Per Surveyor's observation, this wound met the National Pressure Injury Advisory Panel of a stage II PI. The size appeared to be approximately 1cm in diameter, no rolled edges noted. R5 denied pain to wound area. CNA K wiped open skin area with a premoistened cleansing cloth, applied A & D to open wound, and applied baby powder to inside of R40's adult brief. CNA K reported the wound nurse was aware of R40's open skin area and told the CNAs to continue applying barrier cream to buttocks. On 07/29/25 at 8:54 AM, Surveyor interviewed CNA K, who reported open sore on R40's buttocks had been reported to RN G and the wound nurse about a week ago. CNA K reported RN G told her because R40's open skin area gets worse then gets better again, they do not need to do dressing on R40's open skin areas, and the CNAs were told to continue to apply barrier cream to open area. CNA H was present during interview and confirmed these statements.Applying barrier cream and baby powder, and leaving PI open to air, is not considered acceptable treatment in the current standards of practice for a stage II PI.On 07/29/25 at 10:40 AM, Surveyor interviewed Licensed Practical Nurse (LPN) L, who reported recently taking over for RN G. LPN L stated in report from RN G, LPN L was told R40 has a wound on right buttock, and it was taken care of. When Surveyor asked what that meant, LPN L stated it meant the wound nurse was notified.On 07/29/25 at 10:49 AM, Surveyor interviewed Director of Nursing (DON) B, who reported she was made aware of R40's wound yesterday and there is a call to the provider and wound care nurse. DON B reported her expectation for a resident with a PI is that there would be wound care orders. Surveyor stated there are no orders or nursing documentation of R40's PI. DON B reported her expectation would be for a CNA that found any open skin area is that it would be reported to the nurse in charge, assessed immediately, staged by the wound care nurse, and treatment orders be put into place. Surveyor asked DON B if she thought applying A&D ointment to open skin and leaving uncovered is an acceptable treatment for R40's open skin area. DON B reported she doesn't know without having seen it.On 07/29/25 at 10:32 PM, Surveyor observed R40 in bed asleep in a semi-Fowlers position with neck pillow behind his head. Surveyor interviewed CNA M, who reported R40 was last repositioned by the PM shift staff around 9 PM, but it is not documented exactly when. CNA M reported he will do checking for incontinence changes and repositioning at midnight.On 07/30/25 at 12:14 AM, Surveyor interviewed CNA M, who reported R40 was repositioned at 11:30 pm (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and R40 is repositioned about every 2 hours. This would have been 2 and a half hours since R40 was repositioned. CNA charting indicated repositioning is done every 2 hours per CNA's initials. CNAs do not document a specific time done.On 07/30/25, Surveyor reviewed documentation from RN G from 07/29/25, Resident has open area to right inner buttocks and excoriation to left buttocks. Area cleansed and barrier cream applied per order. SBAR written for (provider) to review. Wound nurse notified. Voice message left for Power of Attorney (POA) to call back for update. Surveyor did not find an updated order for wound treatment in R40's medical record.On 07/30/2025 at 10:28 AM, Surveyor interviewed RN G regarding R40's open skin area. RN G reported she was unaware of R40's PI until on 07/28/25 and she didn't get a chance to document until 07/29/25. RN G reported her expectations are that CNAs report any skin changes immediately and they should be providing incontinence cares and reposition R40 every 2 hours.On 07/30/25 at 11:50 AM, Surveyor interviewed DON B, who reported R40 does have a PI, she was told it was looked at by wound care nurse, that it is a stage II, and facility is working on getting orders for treating it. DON B reported the expectation is that all residents who require assistance with repositioning get repositioned at least every 2 hours (current standards of practice for a resident with a PI would be to reposition every hour) incontinence cares are performed every 2 hours and as needed and that any open skin areas or changes in skin observed by a CNA are to be reported to nursing staff immediately. DON B reported the CNA tasks charting is not reviewed by nursing staff. DON B stated the process for all residents would be that CNAs report any skin changes to the nursing staff. The expectation is that nursing staff would follow up immediately with any reported changes in resident's skin condition and that the nurse be assessing skin areas thoroughly every week, documenting, and reporting any open skin area immediately to the provider to obtain an order for wound care treatment on that day, or if at night, immediately the next day, to notify the Power of Attorney, the Registered Dietician, and the Wound Care Nurse for wound care assessment to be added to the weekly schedule. DON B verbalized this does not seem to have happened with R40's PI and DON B plans to follow up with wound care nurse. DON B does believe the wound care nurse did look at R40's PI and is not sure why there is not documentation of this yet in R40's medical record. Example 2 R5 was admitted to the facility on [DATE] with diagnosis that includes history of transient ischemic attack and cerebral infarction, hemiplegia and hemiparesis affecting left side, weakness, spinal stenosis.R5's most recent Minimum Data Set (MDS) dated [DATE] indicates R5 had a BIMS of 7/15 indicating severe cognition impairment, was at risk for developing PIs, and that R5 is dependent with all cares and repositioning.R5's care plan, dated 5/26/25, states, in part: At Risk for impaired skin integrity including skin tears, bruising AND/OR pressure R/T non-ambulatory interventions include, in part:.Will have clean, dry, intact skin through next review date. Assist / Encourage Pressure Relief as needed / accepted.Follow community skin protocol, Incontinence care with incontinent brief changes. Observe skin with AM/PM cares and with toileting for redness, rashes, open areas, pain, swelling and report them to team leader. pay close attention to. where there may be added pressure. Weekly skin check. Lotion to dry skin. Review skin concerns with MD. Pressure reduction cushion in Broda chair (initiated on 3/22/24, revised on 5/21/25) Pressure reduction mattress on bed (initiated on 1/21/25) , Reposition Q 2 hours in bed and chair & as needed (PRN) (initiated 3/22/24) .Turn & Reposition Resident on routine rounds and as needed.Record review indicated R5's skin assessments/weekly skin checks performed on 07/01/25, 07/08/25, 07/15/25, and 07/22/25 documented No Skin Issues Noted and signed by RN G and on 07/29/25 also is documented No Skin Issue Noted and signed by LPN L.On 07/30/25, Surveyor reviewed CNA tasks charting in which indicated R5 had open skin area on 07/15/25, 07/23/25, 07/24/25, 07/25/25, and 07/29/25.On 07/29/25 at 10:32 PM, Surveyor observed R5 in bed asleep in a semi-Fowlers position. Surveyor interviewed CNA M, who reported R5 was last repositioned by PM shift around 9 PM but it is not documented exactly when. CNA M reported he will do checking for incontinence changes and repositioning at midnight.On 07/30/25 at 12:14 AM, Surveyor interviewed CNA M, who reported R5 was repositioned at 11:30 pm and R5 is repositioned about every 2 hours. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This would have been 2 and a half hours since R5 was repositioned. CNA charting indicated repositioning is done every 2 hours per CNA's initials. CNAs do not document a specific time done. On 07/30/25 at 10:07 AM, Surveyor observed R5's personal cares and noted R5 had an open skin area with pink, moist tissue on his right upper buttock. Per Surveyor's observation, this wound meets the National Pressure Injury Advisory Panel of a stage II PI. Area was approximately 1.5cm x 1cm in size. R5 had barrier cream with powder caked on it around edges. R5 denied pain to wound area. R5 has a pressure reduction air mattress on his bed. R5 does not have any cushion in his recliner. Surveyor had a prior observation of R5 in recliner a large portion of the day. There was no Broda chair as indicated in R5's care plan, in R5's room.On 07/30/25 at 10:15 AM, Surveyor interviewed CNA N who reported R5 has had the skin tear for about a week. Surveyor asked which nurse CNA N reported it to; CNA N stated he works various shifts and has reported it to various nurses. CNA N stated 3-4 different nurses have looked at it. CNAs were instructed to put barrier cream on R5 buttocks/ perineal area. CNA N reported R5 is supposed to be checked for incontinence and repositioned every 2 hours. CNA N stated they try to check and reposition R5 every 2 hours but sometimes they get busy with other residents. On 07/30/2025 at 10:18 AM, Surveyor observed RN G don gloves and gown. RN G looked at wound and reported it is an open skin area. RN G attempted to scrape dried on paste of powder and barrier cream from around wound edges. Immediately after, Surveyor interviewed RN G, who reported she was not made aware of open skin area on R5 and R5's wound was not found on nurse's weekly skin check performed on 7/29/25 by RN G. RN G reported CNAs are supposed to reposition R5 every 2 hours and notify RN with any skin changes.On 07/30/25 at 11:50 AM, Surveyor interviewed DON B and asked DON B what the expectations are for repositioning residents who are at risk for skin breakdown. DON B reported the expectation is that all residents requiring assistance with repositioning are repositioned every 2 hours, incontinence cares are performed every 2 hours and as needed and that any open skin areas or changes in skin observed by a CNA it is to be reported to nursing staff immediately. DON B reported the CNA tasks charting is not reviewed by nursing staff. The expectation is that staff would follow up with any reported changes in skin condition and be assessing skin areas thoroughly weekly, documenting, and reporting any open skin area immediately to the provider in order to obtain an order for wound care treatment on that day, or if at night, immediately the next day, to notify the Power of Attorney, the Registered Dietician, and the Wound Care Nurse for wound care assessment to be added to the weekly schedule.DON B reported the care plan for R5 had not been updated to have a pressure relieving device in R5's recliner chair instead of Broda chair, as R5 no longer requires a Broda chair, and the PI was not reported or identified until today.DON B reported R40 should have had wound care orders immediately after open skin had been noted. DON B is unsure why the CNA documentation is marked as open skin areas, but this is not noted in RN charting or reviewed by the RNs for both R40 and R5. DON B stated the process would be that CNAs report any skin changes to the nursing staff. The expectation is that nursing staff would follow up immediately with any reported changes in resident's skin condition and that the nurse be assessing skin areas thoroughly every week, documenting, and reporting any open skin area immediately to the provider to obtain an order for wound care treatment on that day, or if at night, immediately the next day, to notify the Power of Attorney, the Registered Dietician, and the Wound Care Nurse for wound care assessment to be added to the weekly schedule.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure a resident with limited mobility receives appropriate restorative services, and assistance to maintain or improve mobility with the maximum practicable independence for 1 out of 5 residents (R)(R28).R28's passive range of motion (PROM) exercises and application of palm guard was not completed as ordered. This is evidenced by:R28 was admitted to the facility on [DATE], with pertinent diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.R28's most recent quarterly Minimum Data Set (MDS) assessment, dated 07/17/25, noted a Brief Interview for Mental Status (BIMS) score of 00, indicating severely impaired cognition. R28 had impaired range of motion (ROM) on both sides in upper and lower extremities.R28's care plan, dated 06/27/25, with a target date of 07/23/25, states: Actual deficit with ADLs with interventions of cleanse left palm and then apply palm guard.R28's care plan, dated 06/27/25, with a target date of 07/23/25, states: Functional maintenance program: passive range of motion to upper extremities with interventions to focus on elbow, fingers, thumb, and shoulder every shift.R28's CNA care task record for 07/2025, noted PROM was not completed on: 07/01, 07/07, 07/11, 07/12, 07/15, 07/18, 07/23, and 07/28.R28's CNA care task record for 07/2025, noted cleansing of left palm and wrist guard placement was not completed on: 07/01, 07/11, 07/15, and 07/28.On 07/29/25 at 11:13 AM, Surveyor interviewed Certified Nursing Assistant (CNA) D regarding PROM and palm guard. CNA D stated staff try to complete PROM exercises with residents, but do not always have the time. CNA D stated a dedicated restorative nursing aide was established about a month ago to help with PROM. Surveyor asked about R28's palm guard. CNA D stated it is supposed to be applied in the morning, but not all staff follow the care plan.On 07/30/25 at 7:02 AM, Surveyor interviewed Director of Nursing (DON) B regarding PROM exercises and application of R28's palm guard. DON B stated that a dedicated restorative nurse aide was established about 3-4 weeks ago to complete PROM exercises for residents. DON B stated these cares should have been completed for R28.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications for 2 of 2 residents (R)(R28 and R5) reviewed.R28 was not given enteral feeding as ordered and assessment was not completed per current standard of care.R5's assessment was not completed per standard of care. This is evidenced by: Facility policy titled, “Gastrostomy Tube – Administration of Medications,” with a revision date of 10/2022, states: “Medications administered via tube will be done following current standards of practice and with a physician’s order. Procedure: 5. Check for correct placement of tube.” The National Institute of Health, 2023, recommends the position of a feeding tube be checked by measuring the visible tube length and comparing it to the length documented during x-ray verification. Older methods, including observing aspirated GI contents or the administration of air with a syringe while auscultating are unreliable and should no longer be used to verify placement. Example 1 R28 was admitted to the facility on [DATE], with pertinent diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia, gastrostomy status, and mild protein-calorie malnutrition. R28’s most recent quarterly Minimum Data Set (MDS) assessment, dated 07/17/25, noted a Brief Interview for Mental Status (BIMS) score of 00, indicating severely impaired cognition. R28 has a feeding tube in place. R28’s care plan, dated 05/02/24, with a target date of 07/23/25, states: “Feeding tube: at risk for complications with interventions to check for tube placement & gastric contents/residual volume per facility protocol and record.” R28’s orders: 02/24/25 Enteral Feed four times a day Nutren 1.5 liquid 200 ml via PEG tube, via gravity through syringe. Do not push. Flush with 60 ml water before and after each feed. 06/05/25 Check G tube placement every shift prior to medications/feedings. On 07/29/25 at 10:37 AM, Surveyor observed Licensed Practical Nurse (LPN) C administer R28’s enteral feeding. Prior to feeding, Surveyor observed LPN C place stethoscope on R28’s abdomen and connect syringe to the feeding tube. Surveyor asked LPN C what was being done. LPN C stated she was verifying placement of feeding tube by pushing air in and listening for air entering the stomach. Surveyor asked LPN C if this was the facility’s current practice for verifying placement. LPN C stated yes. Surveyor observed LPN C pour the enteral nutrition formula into a graduate container and measured out 240 ml. Surveyor asked LPN C if all 240 ml would be administered. LPN C stated yes. Surveyor observed LPN C pour approximately 60 ml of formula, (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attached the plunger, and connected syringe to R28’s feeding tube. LPN C then began to push the formula into R28’s feeding tube. Surveyor asked LPN C if R28’s enteral feeding was supposed to be pushed. LPN C stated yes. Surveyor informed LPN C the order stated to give by gravity and do not push. LPN C stopped the feeding and stated, “It does? Well then I guess I just made an error. I just reviewed this order with the nurse before coming in here.” Surveyor asked LPN C what the ordered feeding amount was. LPN C stated 240 ml. Surveyor showed LPN C the order noted in R28’s electronic medical record (EMR) stating 200 ml. LPN C stated she thought it said 240 ml. LPN C then removed the plunger and fed remaining formula via gravity for a total of 200 ml. On 07/30/25 at 7:02 AM, Surveyor interviewed Director of Nursing (DON) B regarding tube feeding observation. DON B stated nursing staff were trained to verify feeding tube placement by auscultating for air and was unaware the current standard of practice had changed regarding this. DON B stated she had been made aware by LPN C regarding the error in administering the formula via push instead of gravity. DON B stated that nursing staff would be educated to verify orders prior to tube feeding to ensure this error did not occur again. Example 2 R5 admitted to the facility on [DATE]. Diagnoses included dysphagia after stroke with gastrostomy tube (G-tube) for feeding purposes. MDS assessment, completed on 05/08/25, confirmed R5 scored 07/15 during BIMS, indicating a cognitive impairment. R5’s care plan included: NUTRITION/HYDRATION: Actual/At Risk and/or Potential for Complications with Nutrition/Hydration due to recent CVA (stroke) with need for tube feeding. 03/22/2024 -Pleasure feeding: nectar liquids by spoon or pureed diet with cold textures such as applesauce or pudding with safe swallow strategies; small bites (1/2 spoonful), single bites; sit up 90° for oral intake; supervision and assistance with eating; cue for double swallows; if cough noted, instruct to clear throat or wet voice; wait 30 minutes prior to laying down after oral intakes. 01/03/2025 -Tube Feedings / Flushes Per Facility Protocol Registered Dietician/MD orders: Elevate head of bed during and after tube feeding administration. Check residuals before tube feeding administration. Observe / Monitor / Document signs and symptoms of tube feeding intolerance. Observe / Monitor / Document S&S of dehydration. Notify MD/RD of concerns as needed. 03/22/2024 FEEDING TUBE: Potential for Complications with tube feeding. Tube Feeding Placed due to recent CVA. 01/21/2025 -Check for tube placement & gastric contents/residual volume per facility protocol and record. Hold feeding if >200 cc aspirated. 03/22/2024 -Keep HOB elevated 45° during and at least 30 minutes after tube feed. 03/22/2024 R5’s physician orders included: -Flush tube with 20ml of water between each medication. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Flush G-Tube with 75 ml of water before feeding. -Nutren 1.5 liquid; 275cc each feeding, four times a day provide feeding via gravity. On 07/30/25 at 8:26 AM, R5 was lying in his bed. RN G told R5 she was going to administer his tube feeding and medications. R5 nodded his head yes. RN G elevated R5’s head of bed to 45°. R5 stated he was doing well, and he had no complaints of pain. R5 told Surveyor RN G was, “great.” Surveyor observed RN G place her stethoscope on R5’s abdomen near his G-tube and insert air into the tube with a syringe. Surveyor asked RN G if it was the facility’s policy to auscultate to verify placement a G-tube, RN G stated, “Yes.” Surveyor asked RN G if the facility had provided education that auscultating to determine placement of a G-tube was no longer a standard of practice. RN G stated she was not aware.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not recognize and manage pain for 1 of 1 resident reviewed (R53) in order to help attain or maintain highest practicable level of well-being and to prevent or manage pain.The facility failed to recognize and treat R53's pain and implement pain interventions.Findings include:Facility policy titled, Pain Management, last revised May 2025, reads in part: The community will identify, monitor, and evaluate residents' pain .residents are screened for pain regularly through observing the resident during daily care and/or observing for signs and symptoms of pain.for the resident who has difficulty communicating, physical signs such as grimacing, restlessness, moaning/groaning.will be monitored.any identified pain issues at the time of admission will be addressed on the baseline care plan. Facility policy titled, Person-centered Plan of Care-Comprehensive, last revised January 2023, reads in part: The community will develop a person-centered plan of care for each resident. This care plan includes measurable objectives and timetables designed to meet the resident's medical, nursing, mental, and psychosocial needs. Identify needs, problems. of resident based on.past history.R53 was admitted to the facility on [DATE], with diagnoses including dementia, repeated falls, other specified fracture of right pubis, and chronic pain.Minimum Data Set (MDS) on 07/22/25 documented a Brief Interview for Mental Status (BIMS) score of 3/15 indicating severe cognitive impairment.On 07/28/25 at 2:08 PM, Surveyor observed Certified Nursing Assistant (CNA) D enter R53's room and immediately ask CNA O to grab a Hoyer lift and bring it in R53's room. Surveyor heard resident yelling ow repeatedly from across the hall from her room. On 07/28/25 at 2:12 PM, Surveyor interviewed CNA D. CNA D stated resident had been sliding out of her wheelchair but did not have a fall. CNA D stated R53 yells out like when transferred with the Hoyer lift and that it wasn't new for R53.On 07/29/25 at 9:06 AM, Surveyor heard R53 yelling ow repeatedly once again from across the hall. Surveyor knocked, introduced self, and entered room for observation. CNA D and CNA J were completing lower body dressing. Surveyor observed with permission. Surveyor observed CNA D and CNA J pulling R53's jeans on the rest of the way and placing the sling under R53. Each time R53 was moved from side to side, R53 would yell out ow, ow, ow and had facial grimacing. R53 was guarding her left hip area with left hand. Surveyor observed R53 saying Oh and Ok in response to CNA D's instructions. CNA D informed R53 of everything they were going to do, but when counting to 3 before rolling R53, CNA D started to roll resident with the drawsheet prior to getting to 3. R53 flailed, stiffened their body, pushed back against CNA D, and continued to say ow. Surveyor asked CNA D if R53 always cries out in pain like that. CNA D stated, We aren't entirely sure it's pain or maybe just the act of moving scares her. CNA D stated R53 was admitted to facility for weakness and history of falls at home. CNA D stated they were not aware of any fractures or anything. CNA D showed Surveyor care plan sheets that are in each resident room and stated they follow the information on those sheets. Surveyor reviewed the care sheet for R53 which stated, Impulsive. History of falls. Record review indicated a pain assessment was completed on 07/21/25 indicating no pain present.Surveyor reviewed pain charting history. All but 1 day since admission was marked 0/10 pain and 07/28/25 showed 2/10 pain. Some days the verbal number scale was utilized, while other days the visual dementia scale was used to assess R53 for pain. R53 has physician order for Tylenol as needed for pain but has not been administered since admission.On 07/30/25 at 9:09 AM, Surveyor interviewed Licensed Practical Nurse (LPN) C. LPN C stated some residents are able to verbalize pain. Others that cannot, use the dementia scale and staff watch residents for grimacing and moaning. LPN C stated if the resident is on scheduled pain medication an initial assessment is done right away in the morning and then as needed. If a new case of pain is reported, an as needed pain assessment is completed. LPN C stated if a CNA reports someone is having pain, she would enter the resident room to assess. If there is a frequency of pain, she would report it to the provider, update family, and write it on the report sheet for the next shift. LPN C (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525567	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Lights Hcc	706 Bratley Dr Washburn, WI 54891

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated more frequent assessments would also be completed. LPN C stated no one has reported R53 having pain to LPN C.On 07/30/25 at 9:30 AM, Surveyor interviewed Director of Nursing (DON) B. DON B stated her expectations for staff regarding pain management includes completing an assessment anytime a pain medication is administered and follow up with pain level. DON B stated with episodes of new reported pain the provider should be called. DON B stated a pain care plan with interventions for pain should also be in place. DON B stated care plans are created with each new admission and the initial/baseline care plan is on paper. DON B stated the MDS generates the new care plan, and it is modified with changes as needed. The care plan is then reviewed quarterly and as needed. Surveyor informed DON B that R53's care plan did not address pain interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	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 written notice of transfer to include 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 for 3 residents of 3 residents (R)(R4, R28, R32) reviewed. The facility did not have a system in place to provide a written notice of transfer. This had the potential to affect all 43 residents that reside in the facility.R4 was transferred to the hospital on [DATE]. No written notice of transfer was documented.R28 was transferred to the hospital on [DATE]. No written notice of transfer was documented.R32 was transferred to the hospital on [DATE] and 07/11/25. No written notice of transfer was documented.This is evidenced by:R4 was admitted to the facility on [DATE], with pertinent diagnoses of cerebral infarction, asthma, Todd's Paralysis, diabetes mellitus type 2, and acute embolism and thrombosis of deep vein of right lower extremity.On 07/15/25, R4 was transferred to the hospital via ambulance with shortness of breath and fever. R4 was admitted to the hospital. R4 has an anticipated return date to the facility on [DATE]. Bed hold notice completed and Ombudsman notified. No documentation of written transfer notice documented.R28 was admitted to the facility on [DATE] with pertinent diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, atrial fibrillation, and congestive heart failure.On 01/22/25, R28 was transferred to the hospital via ambulance for fever, altered level of consciousness, and change in blood pressure and pulse. R28 was admitted to the hospital. R28 returned to the facility on [DATE]. Bed hold notice completed and Ombudsman notified. No documentation of written transfer notice documented.R32 was admitted to the facility on [DATE], with pertinent diagnoses of diabetes mellitus type 2, chronic obstructive pulmonary disorder (COPD), and atrial fibrillation.On 10/07/24, R32 was transferred to the hospital via ambulance for nosebleed and shortness of breath. R32 was admitted to the hospital. On 10/18/24, R32 returned to the facility. Bed hold notice completed and Ombudsman notified. No documentation of written transfer notice documented.On 07/11/25, R32 was transferred to the hospital via ambulance for shortness of breath. R32 was admitted to the hospital. On 07/15/25, R32 returned to the facility. Bed hold notice completed and Ombudsman notified. No documentation of written transfer notice documented.On 07/30/25 at 10:46 AM, Surveyor interviewed Director of Nursing (DON) B regarding written notice of transfers. DON B stated being unaware of a requirement to provide a written notice of transfer and the facility did not have a process in place to do so. Surveyor asked how residents were informed of their appeal rights and Ombudsman contact information. DON B did not know for sure, but thought it was included with the bed hold form. DON B stated this process would be reviewed by Quality Assurance Performance Improvement (QAPI).