STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525602	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenhaven	612 E Oak St Glenwood City, WI 54013

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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 - 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 that 1 of 3 residents (R) reviewed for pressure injuries (PI) (R2) received care consistent with professional standards of practice to prevent further deterioration and promote healing of an existing PI. R2 was at risk for PI development. The facility failed to provide adequate and consistent wound care treatments, comprehensive interventions to R2's care plan, and did not document progression of staged PI. Findings include: Facility policy titled Pressure Areas, last revised 01/22, stated in part, .1. Area in question is assessed by nurse and temporary care plan initiated with initial intervention to reduce pressure. #2. New Braden scale to be completed by nurse.#3. Area documented with size, shape, color, presence of slough or eschar, texture, odor, depth, prevalence of pain, peri-wound, drainage, location as well as any noted factors that may be causing the pressure.#4. Area staged according to National Pressure Ulcer Advisory Panel.#5. MD is notified of area and provided documentation.#8. Dietary is notified to determine if supplements are needed for wound healing. R2 was admitted to the facility on [DATE] with diagnoses including in part, urinary tract infection, klebsiella pneumoniae, parkinsonism, depression, anxiety, hyperlipidemia, type 2 diabetes, neuromuscular dysfunction of bladder, gastro esophageal reflux disease without esophagitis, and insomnia. R2's Minimum Data Set (MDS) assessment, dated 10/29/25, identified R2 required substantial maximal assistance for toileting and toilet transfer. Partial moderate assistance for bed mobility, rolling left to right, sitting to lying, and chair to bed. MDS indicated R2 was at risk for PIs.Surveyor reviewed R2's ADL care plan initiated on 11/07/25 which stated in part:-Bed mobility requires extensive assistance of 1 staff with the use of bedrail for bed mobility. Surveyor reviewed R2's skin integrity care plan. R2 has potential for pressure ulcer development related to immobility initiated on 11/10/25 which states in part:-The resident will have intact skin, free of redness, blisters or discoloration by/through review date. -Administer medications as ordered. Monitor/document for side effects and effectiveness.-Administer treatments as ordered and monitor for effectiveness.-Follow facility policies/protocols for the prevention/treatment of skin breakdown.-Monitor nutritional status. Serve diet as ordered, monitor intake and record.-Obtain and monitor lab/diagnostic work as ordered. Report results to MD [Medical Doctor] and follow up as indicated.-The resident requires supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing.-Treat pain as per orders prior to treatment/turning etc. to ensure the resident's comfort. Surveyor reviewed R2's physician orders:-On 02/27/26, Right buttock dressing, cleanse with wound cleanser, pat dry, cover with border foam every day shift every other day.-On 01/08/26, Skin assessment weekly every evening shift every Thursday. Surveyor reviewed R2's Braden and skin assessments:-On 10/22/25 at 12:31 PM, Initial admission assessment of normal skin, warm, temperature dry bilaterally equal, normal turgor, no open areas.-On 11/19/25 at 12:52 AM, Braden scale scored 16 at risk for skin breakdown.-On 02/19/26 at 4:08 PM, has no skin issues.-On 02/26/26 at 8:52 PM, Skin issue #1: An open sore to the left buttock measuring 0.5x0.5cm with purulent drainage.-On 02/28/26 at 8:40 PM, Braden scale scored 18 at risk for skin breakdown. Surveyor reviewed R2's progress notes, which stated in part, .-On 11/20/25 at 1:10 PM, Note: patient backside is reddened but intact at this time.-On 01/05/26 at 10:45 AM, (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 0686 Level of Harm - Actual harm Residents Affected - Few	Communication- With PhysicianNote Text: Nurse called with report as [R2] is returning to us from hospital. Patient also has some skin break down to his bottom which is covered with a Mepilex and has been struggling in the hospital with yeast to his groin area as well they sent him with a cream -Lotrimin to apply. Patients use 2 assists to get up and transfer. We will use sit to stand here at this time. -1/5/26 at 9:13 PM, Skilled Evaluation: Skin: Skin color is WNL. Skin warm / dry to touch. Decreased skin turgor.Skin note: Resident has redness/yeast in groin and redness to his coccyx. -1/5/26 at 9:19 PM, Skin onlySkin Evaluation: Skin color is WNL [within normal limits]. Mucous membranes are moist. Skin warm/dry to touch. Decreased skin turgor. Resident has current skin issues.Skin Issue: Pressure Ulcer / Injury. Skin issue location: Sacrum Pressure Ulcer / Injury Stage: Stage I - Non-blanchable erythema. Wound exudate: None. Peri wound condition: Erythema. Dressing saturation: None. Wound odor: No. Tunneling: No. Undermining: No. Tissue: Warm.Note / Notification / Education: Skin note: Mepilex placed on coccyx to protect against further breakdown.Provider Contacted: Already aware.Person Contacted: Already aware.-On 1/6/26 at 1:06 PM, Skin/Wound NoteNote Text: [R2] had large BM [bowel movement] today and when I was cleaning him up, I removed [R2's] Mepilex and did not have a new one available at that time. I was unable to replace it, however skin under dressing was reddened but intact without open sores. I did apply Lotrimin to [R2's] groin as ordered and have explained this to the CNAs [Certified Nursing Assistants] and also [R2's] wife that we address this area and apply new dressing net time we stand [R2] up.-On 1/7/26 at 10:28 AM, Skin/Wound NoteNote Text: Sacral Mepilex removed as it got soiled with feces, unable to apply new one as it was not available at the time. Writer did notice that right in the crack of [R2's] buttocks, [R2] had a layer of skin that appeared to have peeled off but not really an open area. It just appeared to be dry skin that flaked. Writer applied zinc barrier cream. Will monitor and pass on to next shift.-On 1/11/26 at 1:38 PM, Skin onlySkin Evaluation: Skin warm & dry, skin color WNL, mucous membranes moist, turgor normal. [R2] has current skin issues.Skin Issue: Discoloration. Skin issue location: Buttock Length: 1.5 cm red, blanchable Width: 1.0 Tissue: Painful.Note / Notification / Education: Skin note: Area on buttock measuring 1.5 x 1 cm. Red and blanchable. Put a protective coccyx Mepilex on buttock at this time.-On 1/11/26 at 2:15 PM, Health Status NoteNote Text: [R2] has a deep red, blanchable area measuring 1 cm x 1.5 cm. Recorder cleansed area and placed Mepilex. Daughter was in room when area was found, so she is aware. Recorder faxed PCP [primary care provider] for a dressing change order.-On 1/13/26 at 3:49 PM, Order NoteNote Text: Fax sent to MD that [R2] has a dark red, blanchable area measuring 1 cm x 1.5 cm on right buttock. Ok for dressing change daily, cleanse site, skin prep, Mepilex until area has resolved, returned signed ok [name of physician].-On 1/13/26 at 9:09 PM, Temporary Care Plan NoteNote Text: New dressing orders for R [right] buttock. No signs of worsening or delayed healing at this time.-On 1/14/26 AT 9:10 PM, Temporary Care Plan NoteNote Text: No new wounds or wound worsening on resident's R buttock. Continuing to follow dressing change orders.-On 1/15/26 at 9:53 PM, Skin onlySkin Evaluation: Skin warm & dry, skin color WNL, mucous membranes moist, turgor normal. Resident has current skin issues.Skin Issue: Discoloration. Skin issue location: Buttock Length: 1.5 Width: 0.6 Tissue: Painful.Note / Notification / Education: Skin note: area on buttock red, blanchable. Cleansed area, placed skin prep, placed Mepilex. Will continue to monitor per facility protocol.Resident / Responsible Party aware of diagnosis and plan of care: No. Resident education provided R/T [related to] new diagnosis: No. Resident education provided R/T new order: No.-On 1/21/2026 at 11:53 AM, Temporary Care Plan NoteNote Text: TCP for buttock wound dressing changed discontinued. Wound healed, no need for dressing.-On 1/24/2026 at 12:13 AM, Skilled EvaluationSkin: Skin warm & dry, skin color WNL and turgor is normal.Skin note: has protective dressing over sacrum, area is opportunistic for break down due to resident sliding down in recliner causing shearingSpecial Care:Safety: Call light is within reach.Functional: Able to move all extremities.-On 1/28/2026 at 1:18 PM, Skin/Wound NoteNote Text: Resident [R2] has small open area in intergluteal crest that appears to be from shearing. Writer applied zinc cream and a Mepilex to protect the area. No s/sx [signs/symptoms] of (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	infection.-On 1/28/2026 at 1:19 PM, Temporary Care Plan NoteNote Text: TCP [antiseptic] started for small wound in intergluteal crest. Will monitor site for signs and symptoms of infection as well as encouraging resident to spend less time in his recliner and more time on his bed to offload pressure. Zinc cream and Mepilex foam dressing applied and to be changed daily and PRN [as needed]. Goal for wound to heal without signs/symptoms of infection.-On 1/29/2026 12:55 AM, Braden Scale for Predicting Pressure Ulcer RiskBraden Evaluation:Result: At RiskScore: 18.0.-On 2/5/2026 at 8: 27 PM, Skin onlySkin Evaluation: Skin warm & dry, skin color WNL, mucous membranes moist, turgor normal. No current skin issues noted at this time.-On 2/19/2026 at 4: 08 PM, Skin onlySkin Evaluation: Skin warm & dry, skin color WNL, mucous membranes moist, turgor normal. No current skin issues noted at this time.-On 2/25/2026 at 7:07 AM, Order NoteNote Text: New order from Hospice [name of physician]: Wound care to right buttock cleanse with wound cleanser & pat dry, cover with border foam dressing change every other day & PRN if dressing becomes loose or soiled.-On 2/25/2026 at 10:16 AM, Temporary Care Plan NoteNote Text: TCP started for right buttock wound. Staff to cleanse wound with wound cleanser and pat dry. Cover with bordered foam dressing and change every other day and PRN if dressing becomes soiled or loose. Will monitor for signs or symptoms of infection. Goal: wound healing.-On 2/26/2026 at 8: 52 PM, Skin onlySkin Evaluation: Skin warm & dry, skin color WNL, mucous membranes moist, turgor normal. Resident has current skin issues.Skin Issue: Other skin issue. Other skin issue: open sore Skin issue location: left buttock Length: 0.5 Width: 0.5 Wound exudate: Purulent. Wound odor: No. Tunneling: No. Undermining: No.-On 2/28/2026 at 8:40 PM, Braden Scale for Predicting Pressure Ulcer RiskBraden Evaluation:Result: At RiskScore: 18.0 . Surveyor reviewed R2's Hospice progress notes, which stated in part, On 02/24/26 at 2:00 PM, Wound assessment note: Onset date of wound 02/24/26, pressure ulcer, stage 2, wound measurements1.5cm x 1cm. Treatment: Cleanse with soap and water, dress with foam dressing, every other day. Additional; care: Moisture control and turning/repositioning program. Safety measures: Risk for skin breakdown. DME/Assistive devices: Roho cushion recommended, will obtain from Hospice office. Narrative note: Facility nurse reporting skin breakdown to [R2's] buttocks, probably shear injury, area assessed, wound added to flow sheet, wound care orders provided to facility, writer to check on availability of Roho cushion. Facility nurse asking about APM, but since [R2] spends most time in recliner will reassess need if [R2] begins lying in bed frequently.-On 02/26/26 at 2:31 PM, Visit notes: Stage 2 pressure ulcer, 0.5cmx0.5cm, follow wound care per care plan, wound assessment data obtained from facility note. No new interventions, follow plan of care. On 03/03/26 at 9:15 AM-11:55 AM, Surveyor observed R2 lying in recliner at a 45-degree angle with R2's buttocks touching the recliner. Surveyor observed Certified Nursing Assistant (CNA) E transfer R2 up to wheelchair for lunch at 11:55 AM. Surveyor did not observe a pressure relief cushion in R2's chair for off-loading. On 03/03/26 at 1:32 PM, Surveyor observed CNA E come out of R2's room with EZ-stand. Surveyor observed R2 lying in recliner at a 45-degree angle with R2's buttocks touching the recliner. Call light in reach. On 03/04/2026 at 10:55 AM, Surveyor observed CNA E don Personal Protective Equipment (PPE) and enter R2's room. CNA E transferred R2 to the toilet due to an incontinent BM. Surveyor observed CNA E cleanse BM off R2's buttocks. CNA E noted that R2's dressing on buttock area had fallen off. CNA E continued cleaning R2's buttocks and then called Registered Nurse (RN) D into re-dress the wound on R2's buttocks. Surveyor observed R2 grimace and stated, My butt hurts. CNA E reported that R2 has been having some loose incontinent BMs the last few days, and that it is not normal for R2 to have so many BMs. On 03/04/2026 at 11:03 AM, Surveyor observed RN D enter R2's room with PPE and a Mepilex for R2's wound. RN D began cleaning R2's buttocks with wipes as R2 had more BM that needed to be clean. R2 stated to RN D, My back side hurts bad. RN D looked at R2's buttocks and stated, I don't know how I am going to get this big Mepilex on [R2's] buttocks. CNA E stated to RN D, Maybe just do zinc oxide since the dressings fall off all the time. RN D stated to CNA E, That is what I will do. Surveyor assessed R2's wound and noted that R2 had an open wound on the left inner buttock, the wound bed could not be visualized, and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor observed 100% slough. RN D applied zinc oxide to open wound on R2's left buttock with contaminated gloves. CNA E and RN D transferred R2 back to wheelchair. Surveyor did not observe RN D doff contaminated gloves and complete hand hygiene before applying zinc oxide to R2's open wound on buttocks. On 03/04/2026 at 11:22 AM, Surveyor observed R2 sitting in wheelchair in lounge on unit D in front of television shaking, complaining of severe pain on R2's bottom and in groin area. Surveyor interviewed CNA E and asked if R2 has pressure relieving devices in wheelchair and recliner. CNA E reported that R2 does not have any pressure relieving devices in recliner but R2 does have them in wheelchair. On 03/04/2026 at 11:27 AM, Surveyor observed RN D approach R2 to gather vitals. Upon requesting to sit forward, Surveyor observed R2 clench hold of the wheelchair and started shaking stating, I am in pain. RN D gathered vitals on R2 due to R2 being in so much pain. Vitals were within normal range, and R2 was febrile. RN D reported that RN D will be notifying R2's Hospice RN F and Hospice RN F will be at facility shortly. On 03/04/2026 at 11:34 AM, Surveyor interviewed CNA E, RN D, and Assistant Director of Nursing (ADON) C and asked what the expectation is for staff to reposition R2 as Surveyor has observed R2 sitting directly on buttocks either in recliner or wheelchair the last two days. RN D and ADON C reported expectations would be repositioning R2 at least every 2 hours. Surveyor asked ADON C for expectation of pressure relieving device in R2's recliner. ADON C reported that Hospice RN F was supposed to order this offloading device for R2 a week ago. Surveyor asked if anyone has followed up on the pressure relieving devices. ADON C reported to Surveyor that ADON C will do this now. On 03/04/2026 at 11:52 AM, Surveyor observed CNA E transfer R2 to bed to try to offload R2's buttocks. Surveyor observed CNA E complete another brief change as R2 had more BM on R2's buttocks and groin area. Surveyor observed R2 clenching and pushed against the wall when CNA E was cleaning R2's buttocks. Surveyor observed R2's buttocks to be very red and irritated. Surveyor observed no wound dressing on R2's open wound on left buttock. Surveyor observed CNA E apply a new brief on R2 but did not apply zinc oxide as ordered. Surveyor observed CNA E roll R2 back to supine position on R2's buttocks. CNA E exited R2's room. On 03/04/2026 at 12:02 PM, Surveyor interviewed CNA E and asked if R2 was lying on back in supine position with buttocks touching the mattress and was that enough to off load pressure for R2. CNA E reported to Surveyor that CNA E did not know if it was off loading or not. Surveyor never observed CNA E or any other staff go back into R2's room to reposition. On 03/04/2026 at 12:07 PM, Surveyor interviewed RN D and asked about wound dressing change and following wound care orders. RN D reported that RN D decided to just do the zinc oxide as the facility does not have small enough Mepilex to place on R2's open wound. Surveyor asked RN D if leaving an open wound is common practice. RN D reported that RN D was just doing what she could at that moment and afterward went and asked ADON C what steps should have been done. Surveyor reported to RN D that Surveyor observed RN D clean BM off R2's buttocks, and then RN D applied zinc oxide with contaminated gloves unto R2's buttocks, contaminating the open wound on R2's left buttock. RN D reported that RN D should have removed contaminated gloves and performed hand hygiene before donning a new pair of gloves, but RN D did not change contaminated gloves. On 03/04/2026 at 12:20 PM, Surveyor interviewed ADON C and asked expectation of wound dressing changes for R2. ADON C stated to Surveyor, Yes [RN D] came and spoke with me after [RN D] completed cares on [R2]. I educated [RN D] about importance of following physician orders. ADON C reported to Surveyor that RN D should have placed Mepilex on R2's buttocks as ordered. Surveyor asked ADON C for expectation of hand hygiene during wound dressing change. ADON C reported that RN D should have doffed the contaminated gloves, sanitized hands, and then donned new gloves during dressing change on R2. Surveyor asked ADON C once R2 developed open wound concerns on R2's buttocks how come interventions were not put into place on R2's care plan to decrease the chance of skin breakdown. ADON C reported to Surveyor that ADON C is unsure, but ADON C will be following up on off-loading interventions for R2 going forward. On 03/04/2026 at 1:05 PM, Surveyor observed Hospice RN arrive and enter R2's room. On 03/04/2026 at 1:43 PM, Surveyor interviewed Hospice RN F and asked (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Hospice RN F to explain when R2 was admitted to hospice and when did Hospice RN F assess R2's left buttock wound to start. Hospice RN F reported that when Hospice RN F admitted R2 on 02/24/26, R2 had an open area to left buttock. Hospice RN F documented the left buttock as a Deep Tissue Injury (DTI) of the left buttock stage 1. The stage 1 wound measured 1.5cm x 1cm. Surveyor asked Hospice RN F what kind of interventions were put into place to off-load and to minimize further breakdown. Hospice RN F reported that Hospice RN F verbally told staff to off-load, but there were no interventions put into place at that time in the medical record or care plan. Hospice RN F then reported that on 02/26/26 R2's left buttock DTI deteriorated further and opened which was assessed as a stage 2 measuring 0.5cm x 0.5cm. Hospice RN F reported there were no new interventions put into place and that interventions stayed as is. Hospice RN F reported to Surveyor that on 03/04/26, Hospice RN F assessed R2's DTI on left buttock. Hospice RN F stated to Surveyor, [R2's] DTI continues to deteriorate, measures 0.9cm x 0.7cm and is now unstageable with 100% slough, little erythema, no drainage and no odor at this time. Surveyor asked Hospice RN F what interventions are going to be put into place going forward. Hospice RN F reported that Hospice RN F is reaching out to the provider, but new interventions will be off-loading device to recliner, alternating air mattress to R2's bed, and new dressing change orders. Surveyor requested R2's hospice progress notes from Hospice RN F. On 03/09/26 at 3:40 PM, Surveyor emailed Hospice RN F for the documentation from hospice visit with R2 on 03/04/26. Surveyor is waiting for documentation. On 3/13/26 at 10:34 AM, Surveyor received via email R2's hospice progress notes. Hospice note dated 3/4/26 at 1:00 PM, PI midline inner buttocks gluteal fold Assessment states, PI stage 2, wound bed 100% slough, wound edges attached, peri wound skin-erythema, drainage-none, odor-none, wound status-deteriorating measurements are 0.9cm x 0.7 cm. Wound care/dressing change as per order: wound to right buttock. PI cleansed with wound cleanser and patted dry. PI covered with border foam dressing.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide palatable food served at safe appetizing temperatures. This has the ability to affect all 31 of the facility's residents. Review of resident council minutes and the resident council meeting reveal residents' concerns over meal temperatures. Observation at meals time revealed that foods were not held at proper holding temperatures; hot foods were not held hot, and cold liquids were not held cold. This is evidenced by: On 03/03/2026 at 2:00 PM, Surveyor reviewed Resident Council Meeting Minutes from December 2, 2025, which state in part; Food temps are cold. Resident Council Meeting Minutes from January 26, 2026, state in part: Food temps are on the colder side, and February 23, 2026, Resident Council Meeting Minutes state in part: Food temps are on the colder side. On 03/03/2026 at 9:42 AM, Surveyor interviewed R25 and asked if there were any concerns. R25 reported that R25's food is always cold. During the resident council meeting held by Surveyor on 03/04/2026 at 10:10 AM, the residents stated, Sometimes food is too cold. On 03/04/2026 at 12:05 PM, Surveyor observed the meal cart arriving to the unit. Items were placed in the hot holding area. Cranberry juice, lemonade, water, milk and other juices were passed on a cart from unit to unit without any temperature control measures. On 03/04/2026 at 12:13 PM, Dietary Aide (DA) H took temperatures of food items in the hot holding table. The cheese steak sandwich temperature was 98 degrees. Carrots' temperature was 130 degrees. The pureed food items were set on top of the counter with no temperature control in place. DA H took the temperature of the pureed potatoes; they were 70 degrees. DA H took the temperature of another pureed starch which was 47 degrees. DA H did nothing to bring the temperatures of the food items up to the proper holding temperatures prior to service. DA H continued to plate food until 12:47 PM. At 1 PM, staff began to place the fluids back into the refrigerator. Surveyor had staff take the temperature of one of the fluids; it was 71 degrees. On 03/04/2026 at 2:36 PM, Surveyor interviewed Dietary Director (DD) G. Surveyor relayed the above observations, to which DD G responded, That is not ok. Food should have been reheated to 165 degrees or higher prior to service. When asked why some of the food is just sitting on the counter with no temperature control, DD G stated, All food is supposed to be in the warmer, but with the current census there is more food than will fit. DD G stated we will be moving serving into the different households which will accommodate holding food in the warmers. When asked how long this problem of keeping things at the proper temperature has been going on, DD G stated the past 6 weeks or so. DD G stated she would provide the facility guidelines for holding temperatures. On 03/04/26 at 3:00 PM, DD G provided temperature logs with guidelines for hot holding which state, All hot foods should be held at 140 degrees or above. COLD HOLDING: All cold foods should be held at 41 degrees F or below.

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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 failed to prepare and distribute food under sanitary conditions. This has the ability to affect all 31 of the facility's residents.Staff washing dishes contaminated their uniform. Staff doing dishes were observed going between dirty and clean items with no hand antisepsis. Staff were observed to change gloves with no hand antisepsis.Staff were observed to touch ready to eat foods with contaminated gloves.Food was carried down halls and from unit to unit uncovered then delivered to residents. Food not stored in its original container was not labeled with identifying information or open date. Open food not labeled with an open or use by dates.Scoop was found in food container, increasing food's risk for contamination.This is evidenced by:Example 1 The facility policy titled Cleaning Dishes and dish machine sanitization states in part; Person loading dirty dishes should not handle clean dishes unless apron is changed and hands are washed thoroughly and wearing thoroughly clean new gloves before moving from dirty to clean dishes. The facility policy titled Handwashing states in part: Dietary staff will wash hands before starting work, when returning to work. and at other times hands have been soiled. Dishwashers should always wash their hands before handling clean dishes. On 03/03/2026 at 1:54 PM, Surveyor observed Dietary Aide (DA) H doing dishes. DA H sprayed dirty dishes, getting water and debris on the front of her uniform. DA H did not wear an apron as described in the facility policy. DA H was observed going from handling dirty dishes to clean without changing gloves or performing hand hygiene. DA I was observed to be working in the dietary department and was observed to take off her gloves and put on clean gloves with no hand hygiene. On 03/04/2026 at 11:18 AM, Surveyor interviewed Dietary Director (DD) G about the above observations. DD G stated that staff are to, Wear a disposable apron, and they need to have a dirty person and a clean person when doing dishes, or they need to stop and wash their hands prior to handling the clean dishes. Example 2 The facility policy titled Single-Use Glove Policy states in part: gloves must be worn by all dietary staff when handling ready to eat foods, Hands must be thoroughly washed and dried before putting on a new pair of gloves . Hands must be washed immediately after removing gloves to remove any moisture or bacterial build up that occurred while wearing them .Gloves are task specific and must be discarded and replaced.as soon as they become soiled.before beginning a different task .before handling ready to eat foods. On 03/04/2026 at 7:37 AM, Surveyor observed Dietary Aide (DA) H had gloves on, and DA H grabbed utensils and milk container. Surveyor then observed DA H grab cooked toast out of toaster with contaminated gloved hands and buttered the toast. DA H placed contaminated toast on R17's breakfast tray. DA H grabbed R17's breakfast tray and delivered it to R17. Surveyor observed DA H grab door of dining room with contaminated gloves and continued prepping and serving other residents' food with same contaminated gloves. On 03/04/2026 at 7:40 AM, Surveyor observed DA H pouring fluids for breakfast into cups with gloves (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	on. Surveyor observed DA H grab bread with contaminated gloves and place in the toaster. DA H waited for toast to cook then grabbed with same contaminated gloves and spread butter and jelly on toast. DA H placed contaminated toast on R25's breakfast tray and delivered breakfast tray to R25. On 03/04/2026 at 8:02 AM, Surveyor observed DA H preparing breakfast. DA H handled bread with gloved hands, got a knife from drawer, cut and plated fresh fruit, then got more bread out with the same gloved hands. DA I was observed making pancakes; at one point she changed gloves without performing hand antisepsis. On 03/04/2026 at 12:22 PM, Surveyor observed DA H making grilled cheese sandwiches. DA H reached into bag with gloved hands, got out bread, handled container of butter, and spread butter. DA H was observed to wipe the counter with a paper towel and then wiped the rim of a bowl of soup with the paper towel. DA H placed the bowl into the microwave, warmed the soup, temped the soup and put it on the plate, then she pushed over the cheese sandwich on the plate with her gloved hands. A short time later DA H carried a whole tray of individual cups of ice cream from one living unit to the C living unit uncovered. On 03/04/2026 at 9:37 AM, Surveyor interviewed DA H and asked if it was common practice to use the same contaminated gloves the entire time for prepping and serving meals to residents. DA H reported to Surveyor that DA H has only been here for couple weeks, but DA H probably should have changed gloves throughout touching utensils and other surfaces. Surveyor asked DA H if it is normal to touch food with bare hands or with contaminated gloves. DA H reported to Surveyor that the kitchen has lots of tongs and probably should have used tongs to pick up bread for breakfast. On 03/04/2026 at 11:18 AM, Surveyor interviewed Dietary Director (DD) G about the above observations. When asked about changing gloves, DD G stated any time they change tasks hands should be washed, and gloves should be changed. Example 3 On 3/3/26 at 8:55 AM, Surveyor asked for policies related to food storage, refrigeration, and leftover use. Surveyor only received the following two policies. The facility policy titled Use of Leftovers, not dated, states: 2. Leftovers will be covered, labeled, and dated; then stored appropriately. The facility policy titled Food Storage, dated 12/31/24, states: Sufficient storage facilities are provided to keep foods safe, wholesome and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination. 4. Plastic containers with tight-fitting covers must be used for storing. All containers must be accurately labeled and dated. 6. Scoops must be provided for four, sugar, cereals, dried vegetables, and spices. Scoops are not to be stored in the food containers but are kept covered in a protected area near the containers. Scoops are to be washed and sanitized on a weekly basis, or as needed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The State Operation Manual for Long Term Care titled Appendix PP, dated states: 483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Food handling risks associated with food stored.include but are not limited to:. Food left in refrigerators beyond use by dates (including, but not limited to foods that have been opened but were not labeled.) On 3/3/26 at 8:17 AM, Surveyor conducted an initial tour with the Dietary Director (DD). DD G provided a tour to Surveyor of the dry storage, refrigerator, freezers, and kitchen area. During the tour, Surveyor observed beige chunks floating in liquid in an unlabeled container in the refrigerator. DD G stated could not find a label when asked and stated they are pears. I am going to throw them away. Surveyor observed the container of salt with a scoop in it. DD G's expectation is no scoops left in the containers; it can cause cross contamination. Surveyor observed the containers of sugar, flour and brown powder. DD G was unable to find a label when asked. DD G stated I don't know what this is. They know better. I'm throwing this away. Surveyor observed a half open loaf of bread and open package of hamburger buns. DD G was unable to find a label. DD G stated we go through that daily, but they should have been labeled with an open date. In 3/3/26 at 8:52 AM, DD G stated that all things should be labeled when open. We do not have to label with a use by date if it has an expiration date. Example 4 The facility policy titled Plate Cover Policy states in part: to ensure food is served at the proper temperature, protected from environmental contamination.trays must remain covered during transport.covers should be removed just prior to placing the plate on the table to minimize heat and exposure On 03/03/2026 at 1:06 PM, Surveyor observed Certified Nurse Assistant (CNA) S walking down hallway with uncovered tray of desserts. CNA S delivered uncovered tray full of desserts to unit C. Surveyor observed CNA S set tray of desserts on table uncovered. Surveyor observed CNA S walk down hallway with uncovered tray full of desserts. On 03/03/2026 at 1:08 PM, Surveyor observed CNA S walk into R25's room with uncovered dessert tray and ask if R25 wanted dessert. CNA S walked out of R25's room down the hallway and into R28's room. CNA S exited R28's room and then walked into R35's room, which is on EBP, and asked if R35 wanted dessert. CNA S exited R35's room with uncovered dessert tray and continued down hallway with uncovered dessert tray. Surveyor observed CNA S walk down hallway and enter R33's room with uncovered dessert tray and ask if R33 wanted dessert. CNA S then exited R33's room and walked down hallway with uncovered dessert tray. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/03/2026 at 1:11 PM, Surveyor interviewed CNA S and asked if delivering uncovered dessert tray to residents on C unit is normal practice. CNA S reported to Surveyor that CNA S had to go get the desserts because the kitchen forgot to deliver the desserts to residents who already were served their lunch trays. Surveyor asked CNA S if the food tray needs to be covered. CNA S stated to Surveyor, I guess it does, but kitchen forgot to deliver desserts.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, observation, and interview, the facility did not ensure the residents remain free of possible accidental hazards. Facility did not ensure staff were applying the correct size Hoyer (mechanical full body lift) sling to prevent accidents for 3 residents (R) requiring Hoyer full body lifts. (R5, R13, R23).R13 is dependent for rolling, repositioning, and mobility and was lifted with a one person assist mechanical lift which goes against policy and Occupational Safety and Health Administration (OSHA) nursing home standards of practice. R23 was lifted with a one personal assist mechanical lift which goes against Occupational Safety and Health Administration (OSHA) nursing home standards of practice. Lack of supervision of thickened liquids for R14 who was at risk of choking. Findings include: The facility policy, titled Safe Resident Lifting and Transferring Program, dated 1/3/26, states: Purpose: 4. Safely lift a resident who is unable to assist in transfer by pivoting out of bed and into a chair, Geri-chair, or wheelchair using a gait belt. Policy: Glenhaven, Inc employees will follow the Safe Resident lifting and Transferring Program guidelines for all resident lifts and transfers. 7. Total lifts are used for resident who are non-weight bearing and who have fallen on the floor and cannot get up on their own. A one-person transfer can be performed if the lift is designed for one person operation. Ther person ca be positioned appropriately with one person. If the person is predictable and without behaviors. If the staff is trained appropriately A backup is available if needed for safety concerns. 8. Be mobility such as rolling, boosting a resident, should be performed in teams of two. At no time should a Glenhaven, Inc. employee attempt to maneuver a resident individually, unless a resident is able to assist with the process. The Occupational Safety and Health Administration (OSHA) document, Guidelines for Nursing Homes, revised March 2009, states: The standard practice for Hoyer lifts in nursing homes requires at least two trained staff members for safe transfer, ensuring the correcting sling size and type are used . Sling Application: Choose the correct sling size; too large risks slipping, while to small causes discomfort or falls. Manufacturer's guidelines for EZ Way Smart Lift state the EZ way Smart Lift was designed to be (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	operated safely by one person. However, with some patients it is best to use two people. Guidelines do not make a statement or clarify the factors that would make up some patients. Manufacturer's guidelines document. Sling Sizing Charts states: Small sling 70-100lbs, Max distance from patient's tailbone to base of neck 21inches, Medium Sling 90-220, Max distance from patient's tailbone to base of neck 24inches, Large Sling Size 190-320lbs. Max distance from patient's tailbone to base of neck 26inches, XL Sling Size 280-450lbs. Max distance from patient's tailbone to base of neck 29inches . Example 1 R13 was admitted to the facility on [DATE], and has diagnoses that include unspecified mood disorder, essential tremors, hearing loss, dementia, and high blood pressure. R13's Minimum Data Set (MDS) assessment, dated 12/8/25, indicated that R13 has unclear speech, is never understood and rarely understands the conversation. R13's Brief Interview for Mental Status (BIMS) indicated resident was unable to respond to the questions. R13 has impaired mobility bilaterally in both the upper and lower extremities. R13 is dependent for rolling left to right, and assessment did not attempt to have R13 sit up himself or try to stand. R13 is dependent of a mechanical lift for all transfers and a wheelchair for mobility. R13 is dependent for all activities of daily living (eating, hygiene, dressing). R13's Certified Nursing Assistant (CNA) Kardex (guide to care) for 3/4/26 found in CNA binder states, Ensure proper positioning in w/c. observe for signs of slouching; maintain prepositioning in bed. Transfer: dependent 1-2 assist, full body/Hoyer lift. Use size medium sling. On 3/4/26 at 7:10 AM, Surveyor observed only CNA T transfer R13 using a Hoyer (mechanical) lift and sling to transfer R13 from bed to his wheelchair. CNA T rolled R13 from side to side to place the Hoyer sling under him. R13 could not assist with the roll. Surveyor was surprised that CNA T was able to do that and made comment. CNA T stated I have to do this (roll resident) all the time. On 3/4/26 at 7:20 AM, Surveyor interviewed CNA T who stated, It was crazy when I moved here, they allow one person lifts. CNA T stated that she came from another facility and there they had assist of 2 with all Hoyer lifts. CNA T stated she thought that was standard. CNA T stated it is in the binder how to transfer residents and what sling to use. On 3/4/26 at 11:19 AM, Surveyor interviewed CNA T who stated the size of the sling used matters; it is in our book and on the care plan what is needed. CNA T stated there are extra slings in the laundry room; we wash as needed. CNA T stated slings stay with the resident, and we know the size because the edge is a different color, and it is listed on the tag. On 3/4/26 at 2:30 PM, Surveyor reviewed R13's electronic medical record for weights and height or documentation on size assessment for Hoyer sling. R13 weighed 185.4 lbs. (pounds) on 12/10/25, 189.6 lbs. on 2/4/26, and 191.2 lbs. on 3/4/26. There is no height documented in the electronic medical record. There was no progress note or assessment record for determining Hoyer sling size. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 2 R5 was admitted to the facility on [DATE] with diagnoses of aphasia (difficulty swallowing), history of stroke, cellulitis of right lower limb, hemiplegia and hemiparesis, morbid obesity, seizure disorder, type 2 diabetes mellitus, muscle weakness, hypertension (high blood pressure), dementia, and depression. R5's MDS assessment, dated 12/15/25, indicated that R5 has unclear speech and is sometimes understood but usually understands, missing part of the message but comprehends most conversation. R5 needs substantial assistance to depends on assistance for all mobility. Due to R5's communication a BIMS was not done with R5. Assessment with staff and those that know R5 indicated R5 knows where he is, recognizes faces, but cognitively is severely impaired. R5's CNA Kardex, dated 3/24/26, states: Transfers: The resident requires total assistance by 1-2 staff to move between bed and wheelchair utilizing the Hoyer lift. Use size Large Sling. Resident utilizes the EZ stand to transfer between wheelchair and toilet Bed Mobility: The resident requires extensive assistance by 1-2 staff to turn and repositioning bed . On 3/4/26 at 1:50 PM, Surveyor observed CNA V and CNA T use a Hoyer lift and transfer R5 back to bed. CNA V and CNA T used the large Hoyer sling. Example 3 R23 was admitted to the facility on [DATE] and has diagnoses that include progressive neurological condition, coronary artery disease, heart failure, high blood pressure, non-Alzheimer's dementia, anxiety, depression, and asthma. R23's MDS assessment, dated 1/27/25, indicated that R23 has unclear speech, can sometimes make self-understood and misses some part/intent of the message but comprehends most conversations and is severely cognitively impaired. R23 has no extremity impairment, requires a wheelchair for mobility, and is dependent on full assistance for transferring to the toilet, shower, and for transfers to from chair to bed and vice versa. R23 is able to roll self in bed and sit up with touching assistance. On 3/4/26 at 7:48 AM, Surveyor observed only CNA V use a Hoyer lift and sling to transfer R23 from bed to his wheelchair. Surveyor observed CNA V place Hoyer sling under R23, giving R23 a little push when R23 rolled. On 3/4/26 at 7:52 AM, Surveyor interviewed CNA V who stated that they try to use two staff when they lift residents with a Hoyer lift, but the lifts are safe to use with one and sometimes it is too busy. We use the sling size that is on the plan. On 3/4/26 at 12:32 PM, Surveyor observed sling sizes used with R5, R13 and R23 with CNA T's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance. R13 was sitting on a cross-body sling with a beige trim, R5 was sitting on a cross-body sling with burgundy trim, and R23 was sitting on a full body sling with beige trim. CNA T stated it is because R23 squirms and tries to put it out from under him and then we can't get it under him to transfer him out of his chair. On 3/4/26 at 3:33 PM, Surveyor reviewed EZ sling sizing guidelines. Surveyor noted there is overlap in weight ranges for different sizes. Residents could fit in two different slings resulting in one being too large or small. Leadership Interviews: On 3/4/26 at 10:14 AM, Surveyor interviewed Assistant Director of Nursing (ADON) C who stated that if a resident is working with therapy, they help determine the transfers. If there is a change, we usually get therapy involved. On 3/4/25 at 10:26 AM, Surveyor interviewed Physical Therapist (PT) U who stated if a resident is new, the facility gets the initial transfer status from the hospital. Then once here PT or Occupational Therapy (OT) go in and assess how much cuing is needed and strength the resident has. PT U stated that Hoyer lifts always take 2 staff to transfer in my experience. PT U stated that it is standard to have 2. PT U said R13's physical therapy deemed R13 as dependent. Per PT U's last therapy note stated R13 was dependent in all transfers and requires max assist with bed mobility. R13's orders do not say Hoyer directly but that is what dependent means. PT U states we do not determine the sling size, that is the nursing staff. On 3/5/26 at 10:52 AM, Surveyor interviewed ADON C who stated ADON C determines the sling size for residents. ADON C stated sling size is determined on weight, if overweight we would consider height and the two factors, using a larger size. Surveyor showed ADON C the manufacturer's guidelines where this is a chart for size of sling based on two factors, weight and measurement from patient's tailbone to base of neck. Guidelines state, A proper fit will depend on factors other than weight, including height and girth of a patient. ADON C stated let's be honest they have that note in there, so they are not liable. We base it off weight. If the CNA says this is not feeling right, then there is a new assessment. Example 4 R14 was re-admitted to the facility on [DATE] with diagnoses including in part, cerebral infarction, glaucoma, osteoarthritis, hypertension, edema, flaccid hemiplegia affecting ride dominant side, constipation, depression, muscle weakness, lymphedema, facial weakness following cerebral infarction, and urinary tract infection. R14's MDS assessment, dated 02/11/26, identified R14 required set up and supervision during eating. R14's BIMS dated 02/11/26 was 12/15, which indicates R14 had moderately impaired cognition. Surveyor reviewed R14's care plan for nutrition which states in part, -Provide, serve diet as ordered--Regular/Puree Texture/Honey thick liquids. -Set up and supervise meals. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Monitor intake and record q meal. -ST Evaluation and Treatment as indicated. Surveyor reviewed R14's ST order in CNA binder on unit, dated 02/18/26: Liquids MT2 (Nectar Thick) in 2 nosey cups. Continue with PU4 (Purees) for foods. Surveyor reviewed kitchen demographic sheet for R14. Surveyor observed diet IDDSI 4 (Pureed), nectar thick liquids in nosy cup, dislikes thickened water, green pureed food, and uses a divided plate. Surveyor reviewed R14's progress notes: -On 01/06/26, Nutrition/Dietary Note Late Entry:Note Text: Q3 Nutrition Assessment:Oral: Reports difficulty swallowing at times with coughing and choking during meals or when swallowing. Eating: admission Performance: Supervision or touching assistance at meals. No complaints of thirst.- Continue diet of Fluids and fluids as desired texture with honey consistency texture- Ensure appropriate pureed consistency preparation for all foods- Additional training provided to dietary staff on correct puree consistency preparation following incident- Monitor swallowing difficulties and coughing episodes during mealsWill review/update care plan. Will continue to monitor and follow closely. -On 2/5/2026, communication with Physician. Note Text: Fax sent to MD with request for ST Services following screen provided by physical therapy services.Response: OK for ST to eval and treat as indicated for dysphagia. -On 2/5/2026, Note Text: Notified resident that she has a new order for ST to eval and treat for dysphagia. -On 2/27/2026, Note Text: Fax sent to MD ST evaled & recommend nectar thick liquids with nosy cup for all liquids, continue with IDDSI 4 (puree) diet, returned signed ok with above. -On 2/27/2026, Communication with Family/POA, Note Text: Spoke with POA on the phone regarding new order for nectar thick liquids in a nosey cup rather than honey thick liquids in the nosey cup. POA agreeable to order change. Interviews/Observations: On 03/03/26 at 2:00 PM, Surveyor interviewed Family Member (FM) P and asked if FM P had any concerns with eating and diet. FM P reported that FM P feels facility is handling R14's diet correctly. FM P stated, Mom chokes a lot and sounds like Speech Therapy (ST) wants to change her diet a little to help with eating, so she is puree with thickened liquids. On 03/04/2026 at 7:43 AM, Surveyor observed Registered Nurse (RN) D administer medications for R14. Surveyor observed thickened water in a cup sitting on R14's bedside table when RN D and Surveyor entered R14's room. Surveyor observed RN D grab thickened water and hand to R14 to swallow medications. Surveyor interviewed RN D and asked if R14 is supposed to have fluids in room since R14 is on thickened liquid and puree diet. RN D stated to Surveyor, Oh, I think it is ok as long as (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	it is out of reach as [R14] does not use her arms and can't reach the glass, but I am unsure at this time. On 03/04/2026 at 8:11 AM, Surveyor observed R14 at the dining room table for breakfast. Surveyor observed R14 grab R14's spoon and feed self. On 03/04/2026 at 12:29 PM, Surveyor observed Speech Therapy (ST) assessing R14 during lunch time for swallowing. On 03/04/2026 at 12:50 PM, Surveyor interviewed ST Q and asked what R14's diet is and expectation for R14 during feeding and drinking fluids. ST Q reported that R14 should be always supervised with feeding and drinking of thickened fluids. Surveyor asked if ST Q allows fluids in room. ST Q reported that R14 can have fluids in room if supervised but never left alone with fluids. ST Q reported that ST Q's company is new with the facility, and ST Q is performing much needed education regarding diets and supervision. On 03/05/2026 at 9:06 AM, Surveyor entered R14's room and observed thickened liquids in a clear cup sitting on bedside table. On 03/05/2026 at 9:17 AM, Surveyor interviewed CNA O and asked CNA O to enter R14's room. Surveyor asked CNA O if R14 having thickened liquids in room was appropriate. CNA O reported to Surveyor that usually R14 does not have thickened water in room and that today was maybe the second time CNA O has seen water in R14's room. CNA O reported to Surveyor that R14 needs supervision with food and water. On 03/05/2026 at 9:23 AM, Surveyor interviewed RN J and asked RN J's expectation of fluids in R14's room. RN J reported that all residents should have access to fluids. Surveyor asked RN J what R14's diet and intake orders are. RN J reported there has been some confusion about what type of fluids R14 is on. RN J reported that facility has been giving her honey thickened liquids for a while, but diet says nectar is thick, so RN J is unsure. RN J reported to Surveyor that RN J has been questioning this frequently with no direct affirmative answer. On 03/05/2026 at 9:43 AM, Surveyor interviewed ADON C and asked what diet R14 is. ADON C reported there has been some confusion about diet and fluids. Surveyor showed ADON C that ST's orders were Liquids MT2 (Nectar Thick) in 2 nosey cups. Continue with PU4 (Puree's) for foods on 02/18/26 but through interviews from staff, staff are still giving honey thick to R14. ADON C stated, That is a concern and needs to be fixed. ADON C reported that since we have switched to a different ST there needs to be more education on touching base with ADON C after ST recommends diet changes. Surveyor asked ADON C if R14 is supposed to be supervised. ADON C reported to Surveyor that ADON C will need to communicate with ST if in fact she needs supervision with food and liquids. ADON C stated at this time ADON C is unsure, but expectation is for all staff to monitor residents on thickened liquids if ST ordered supervised.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525602	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenhaven	612 E Oak St Glenwood City, WI 54013

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 of 12 sampled residents' (R25) medical records clearly identified the resident's advanced directives, regarding code status.The facility did not ensure R25's medical record was clear in identifying her advanced directives, regarding code status on admission.Findings include:Facility policy titled, Advanced Directives, includes, in part: Advanced Directives is a written instruction, such as living will or durable power of attorney for health care, recognized by State law, relating to the provisions of health care when the individual is incapacitated A. Upon admission, identify if the resident has an advance directive. D. All advanced directive document copies will be obtained and located (identify the same section of the resident's medical record that would be readily retrievable by any facility staff) . E. Resident wishes will be communicated to the staff via care plan and to the resident physician.R25 was admitted to the facility following a hospitalization on [DATE]. R25's Brief Interview for Mental Status score dated [DATE] was 15/15, which indicates R25 had no cognitive impairments.Review of admission physician's orders on [DATE], R25's medical record identified no order for code status.Review of current physician's orders on R25's medical record identified on [DATE], Do Not Resuscitate (DNR) status completed.On [DATE] at 9:41 AM, Surveyor reviewed R25's medical record and found no advance directive scanned into computer and a physician order for DNR status ordered 7 days later in R25's medical record. Surveyor observed that R25 went 7 days without a code status in place.On [DATE] at 10:01 AM, Surveyor interviewed R25 about R25's wishes for CPR or code status. R25 reported to Surveyor that R25 is a DNR. On [DATE] at 9:23 AM, Surveyor interviewed Registered Nurse (RN) J and asked where RN J would find code status and the process for new admissions. RN J reported that the floor nurse that receives the new admission will make sure code status is addressed within 24 hours of R25 being in facility. RN J reviewed R25's record and could see that R25 was admitted on [DATE] but did not have a code status then. RN J reviewed physician orders that stated R25 is DNR on [DATE]. RN J looked at top of screen in medical record and stated R25 is DNR but when you click on advance directives there is no documentation to show the signed document for DNR status. On [DATE] at 10:21 AM, Surveyor interviewed Director of Nursing (DON) B and asked the expectation of time and accuracy of code status for R25. DON B reported to Surveyor that the process begins on admission by Administrative Assistant K who completed the admission paperwork, then the document is printed and given to DON B, Assistant Director of Nursing (ADON) C, or Health Unit Coordinator L and the document is then given to the provider to sign. DON B stated, One of us 3 will place a heart on resident's name on door to show Full Code status. DON B stated to Surveyor, I screwed up and was under the impression [R25] was a Full Code. It wasn't until [DATE] when [Health Unit Coordinator L] returned from vacation that staff realized [R25] was a DNR status. Surveyor asked DON B why there was no scanned documentation in R25's medical record pertaining to R25's code status. DON B reported that DON B would need to search for the code status document.On [DATE] at 10:45 AM, DON B brought Surveyor the advance directive document clarifying R25's code status of DNR but admitted that the document was not scanned into R25's medical record yet but would do this right away.

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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 interview and record review, the facility did not report 1 of 1 (R2) potential misconduct incidents to the State Agency (SA) via the State's Misconduct Incident Reporting (MIR) system immediately upon learning of the incident.R2 reported to facility staff that a male Certified Nurse Assistant (CNA) M had inappropriately touched R2's penis. Findings include:Facility policy titled Abuse Prevention Policy, last revised 04/07/25, stated in part,-F. Protection: Immediately upon receiving a report of alleged abuse, the Administrator, and or designee will coordinate delivery of appropriate medical/and or psychological care and attention. a. vii. Notification of law enforcement and/or State agency, Crisis Response, Poison Control, etc.as indicated.-G. Reporting and Response: Abuse policy requirements indicate any abuse allegations are reported per Federal and State Law. Facility will ensure that all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility .R2 was admitted to the facility on [DATE] with diagnoses including in part, Urinary tract infection, Klebsiella pneumoniae, parkinsonism, depression, anxiety, hyperlipidemia, type 2 diabetes, neuromuscular dysfunction of bladder, gastro esophageal reflux disease without esophagitis, and insomnia. R2's Minimum Data Set (MDS) assessment, dated 10/29/25, identified R2 required substantial maximal assistance for toileting and toilet transfer. Partial moderate assistance for bed mobility, rolling left to right, sitting to lying, and chair to bed. R2's Brief Interview for Mental Status (BIMS) dated 10/22/25 was 8/15, which indicates R2 had mild to moderate cognitive impairments.Surveyor reviewed R2's progress notes in R2's medical record, which states in part, On 01/29/26 at 10:01 PM, CNA informed recorder that resident has complained about inappropriate sexual touching from another CNA. Recorder asked resident about the incident, resident stated CNA came into room last night and touched his penis while he was sleeping. Recorder asked clarifying question, Was it on top of the brief or under it? Resident stated, it was on top, and he slid his hand up and down. Recorder asked if it was possible that he was trying to see if resident was dirty? Resident stated no and he was going to call his son and be out of here by morning. Recorder notified DON of conversation, DON advised to get statements from everyone and obtained statement from POA. Recorder called POA and told her of resident sexual accusation. POA said residents have made these statements before and they are not true. He just doesn't like him. He doesn't like anyone. He said that CNA gets in bed and lays with him and I know that doesn't happen. POA then said when she was there CNA took him to the bathroom and was working with him while having good conversations. I just don't want him getting in trouble, he didn't do anything wrong. Recorder relayed this information to DON. DON she will make a note in care plan that resident makes false accusations and to not have this CNA go into residents' room anymore. Recorder relayed that information to POA. POA is okay with this plan and will discuss it at the next care conference. Recorder had both CNAs from D unit write statements and put under DONs door.Surveyor reviewed facility Analysis and Action Plan Worksheet, dated 01/29/26, which stated in part, Notification of law-Na and Notification of MD-Na. On 03/05/2026 at 1:38 PM, Surveyor interviewed Director of Nursing (DON) B about investigation of R2's sexual abuse concerns that were reported to facility staff on 01/29/26. Surveyor asked DON B if R2's accusation of CNA M inappropriately sexually touching R2 was reported to law enforcement or to the State OCQ division. DON B reported that DON B did not report to state or law enforcement as DON B was supposed to.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interview, policy review and record review, the facility did not ensure allegations of sexual abuse were thoroughly investigated or prevent further potential abuse from occurring while the investigation was in progress for resident (R) (R2) and other undocumented residents, which has the potential to affect all 11 residents on the D unit. Facility did not protect R2 when allowing Certified Nursing Assistant (CNA) M to continue to work with R2 when accused of sexual abuse.Facility did not complete a thorough investigation of R2's accusation against CNA M.Findings include:Facility policy titled Abuse Prevention Policy, last revised 04/07/25, stated in part,-E. Investigation: The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed.Investigation of abuse: i. Who was involved. ii. Residents statements. iv. Involved staff and witness statements of events. v. A description of the resident's behavior and environment at the time of the incident. vi. Injuries present including a resident assessment. vii. Observation of residents and staff behaviors during the investigation. viii. Environmental considerations.e. More investigative protocols: The results of the investigation will be recorded and attached to the report.-G. -F. Protection: Procedures must be in place to provide the residents with a safe, protected environment during the investigation. i. The alleged perpetrator will immediately be removed and residents protected. Employees accused of alleged abuse will be immediately removed from facility and will remain removed pending the results of a thorough investigation. iv. Examine, assess, and interview the residents and other residents potentially affected immediately to determine any injury and identify any immediate clinical interventions necessary. Notify resident physician. vii. Notification of law enforcement and/or State Agency as indicated. viii. A medical, evidentiary, or sexual assault exam should be completed as soon as possible, as appropriate .R2 was admitted to the facility on [DATE] with diagnoses including in part, urinary tract infection, Klebsiella pneumoniae, parkinsonism, depression, anxiety, hyperlipidemia, type 2 diabetes, neuromuscular dysfunction of bladder, gastro esophageal reflux disease without esophagitis, and insomnia. R2's Minimum Data Set (MDS) assessment, dated 10/29/25, identified R2 required substantial maximal assistance for toileting and toilet transfer. Partial moderate assistance for bed mobility, rolling left to right, sitting to lying, and chair to bed. R2's Brief Interview for Mental Status (BIMS) dated 10/22/25 was 8/15, which indicates R2 had mild to moderate cognitive impairments.Surveyor reviewed R2's progress notes in R2's medical record, which states in part,On 01/29/26 at 10:01 PM, CNA informed recorder that resident has complained about inappropriate sexual touching from another CNA. Recorder asked resident about the incident, resident stated CNA came into room last night and touched his penis while he was sleeping. Recorder asked clarifying question, Was it on top of the brief or under it? Resident stated, it was on top, and he slid his hand up and down. Recorder asked if it was possible that he was trying to see if resident was dirty? Resident stated no and he was going to call his son and be out of here by morning. Recorder notified DON of conversation, DON advised to get statements from everyone and obtained statement from POA. Recorder called POA and told her of resident sexual accusation. POA said residents have made these statements before and they are not true. He just doesn't like him. He doesn't like anyone. He said that CNA gets in bed and lays with him and I know that doesn't happen. POA then said when she was there CNA took him to the bathroom and was working with him while having good conversations. I just don't want him getting in trouble, he didn't do anything wrong. Recorder relayed this information to DON. DON she will make a note in care plan that resident makes false accusations and to not have this CNA go into residents' room anymore. Recorder relayed that information to POA. POA is okay with this plan and will discuss it at the next care conference. Recorder had both CNAs from D unit write statements and put under DONs door.Surveyor reviewed facility Analysis and Action Plan Worksheet, dated 01/29/26, which stated in part, .Actions: -On 01/29/26, Notification of POA, administration, and DON. -On 01/29/26-02/01/26, Staff interview and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident interviews completed. -On 01/30/26, ID care team monitoring.Statement from CNA incidence was reported to completed.Statement from POA completed.Statement from [CNA M] completed.Conclusion: In light of POA stating that [R2] has made comments/accusations previously to her and that she knows they are not true, no state report is being submitted. [R2] will be care-planned as having history of false accusations, and [CNA M] will no longer be assigned to care for resident per residents' preference.Out of precaution, all residents were questioned regarding any inappropriate touching. Those unable to answer were assessed for any changes to behaviors that may suggest any inappropriateness is occurring.Surveyor reviewed CNA M's timecard that states in part, .Worked 01/29/26 from 6:00 PM-6:23 AM, 01/30/26 from 6:01 PM-6:31 AM, 01/31/26 from 5:59 PM-6:36 AM.On 03/05/2026 at 1:10 PM, Surveyor interviewed R2's POA about incident with accusation of CNA M inappropriately touching R2's penis. POA N felt that R2 was hallucinating so POA N told facility not to worry about the accusation. Surveyor asked if there were any other steps facility might have taken to protect R2 from any potential sexual abuse concerns. POA reported to Surveyor that POA is unsure at this time.On 03/05/2026 at 1:38 PM, Surveyor interviewed CNA O and asked CNA O to explain how CNA O knew about R2's accusation of CNA M inappropriately touching R2's penis. CNA O stated, I came on day shift next morning and in report from [CNA M], [R2] had accused [CNA M] of a sexual concern. Surveyor asked CNA O if CNA M continued to work with R2 for the rest of CNA M's nightshift. CNA O reported that CNA M continued to take care of R2 that night as CNA M reported off to CNA O about cares completed for R2 through the night. CNA O stated, [CNA M] continued to care for all other residents on D unit. Surveyor asked if CNA O has heard any other concerns with CNA M's performance while working at facility and if any residents reported any sexual abuse concerns to CNA O. CNA O reported that CNA O has not heard any other complaints at this time. On 03/05/2026 at 1:51 PM, Surveyor interviewed Director of Nursing (DON) B about investigation of R2's sexual abuse concerns. DON B reported that DON B completed an investigation, and facility felt the accusation was not accurate. Surveyor asked how DON B investigated R2's accusation of CNA M inappropriately touching R2's penis. DON B reported that R2 hallucinates a lot, so facility had called POA N with updated hallucination, and POA N told facility that it was probably not accurate. DON B reported to Surveyor that DON B revised R2's care plan with intervention that R2 hallucinates. Surveyor asked if DON B interviewed all other potential sexual abuse concerns with other residents and were head to toe assessments completed for R2 and all other residents CNA M provided cares to. DON B reported that most residents were interviewed. DON B reported that DON B could not provide a head-to-toe assessment on R2 for any potential physical concerns of sexual abuse nor could DON B provide any other assessments for cognitively impaired residents who were cared for by CNA M. Surveyor asked DON B if CNA M was removed from providing immediate cares of residents until full investigation was performed and completed. DON B reported that DON B was unsure. Surveyor requested CNA M's timecard that showed CNA M continued to work the rest of 01/29/26 and then the next 2 days. Surveyor asked DON B if any further action was taken to protect R2 from potential sexual abuse concerns and if DON B provided education to CNA M after the incident. DON B reported to Surveyor that DON B did not perform education to CNA M. Surveyor reported to DON B that during interviews, CNA M is still providing care to R2 presently. DON B reported that DON B should have completed a more thorough investigation.

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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 staff and resident interview and record review, the facility did not ensure 2 residents/resident representative (R) (R2 and R30) of 2 residents reviewed for hospitalization received the proper notice of transfer, reason for transfer, or name and address with telephone number of the Office of the State Long-Term Care Ombudsman.Transfer Discharges Notices do not contain a specific reason for transfer.Findings include: On 3/12/26 at 2:32 PM, when completing offsite work, Surveyor identified there was no discharge/transfer policy in the pile of papers. Surveyor reached out to Assistant Director of Nursing (ADON) C and provided an opportunity to supply a policy. On 3/12/26 at 3:13 PM, ADON C sent email with documented titled Notice of Transfer or Discharge 2016 attached. Surveyor opened attachment and found a blank copy of the Notice of Transfer or Discharge form, Resident's Rights to Appeal a Transfer or Discharge document, Contact Numbers sheet and Notice of Bed-Hold Policies. These are blank versions of the forms used during the following listed hospitalizations. Per the Long-Term Care State Operations Manual (SOM), dated 7-23-25, regulation 483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. 483.15(c)(5) Content of Notice. The facility's notice must include all the following at the time notice is provided: The specific reason for the transfer or discharge. Example 1 R30 was admitted to the facility on [DATE], and has diagnoses that include high blood pressure, high cholesterol, chronic fatigue, squamous cell carcinoma of skin, type 2 diabetes with chronic kidney disease, communication disorder, bipolar disorder, dementia, and Alzheimer's disease. R30's Minimum Data Set (MDS) assessment, dated 2/28/26, identified R30 is cognitively impaired and unable to make her own decisions. R30 requires substantial assistance with personal hygiene, bathing and dressing and partial assist with transferring to sit to lying position required substantial maximal assistance for toileting and toilet transfer. Partial moderate assistance for bed mobility, rolling left to right, sitting to lying, and chair to bed. On 3/4/26 at 1:32 PM, Surveyor reviewed notice of transfers for R30's hospitalizations on 1/7/26 and 4/12/25 which showed no specific reason for transfer to a higher level of care. Form had the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following non specific reasons as option for discharge transfer: Resident choice. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. The resident's health has improved sufficiently that the resident no longer needs the services provided by this facility. The safety of individuals in the facility is endangered by the resident being here. The health of individuals in the facility would be endangered by the resident being here. The resident has failed, after appropriate notice, to pay for a stay in this facility. Immediate transfer/discharge as required by the resident's urgent medical need. On 3/5/26 at 3:43 PM, Surveyor interviewed ADON C who stated the forms tell families why they are being transferred. Surveyor reiterated that the regulation states specific reasons, and listed reasons are vague. The form should provide specific information to the family representative and ombudsman in writing. The options on the form of immediate transfer/discharge as required by the resident's urgent medical need, resident choice, necessary for the resident's welfare and the resident's needs cannot be met in the facility are not specific. ADON C stated I guess, I see. Example 2 R2 was admitted to the facility on [DATE] with diagnoses including in part, urinary tract infection, Klebsiella pneumoniae, parkinsonism, depression, anxiety, hyperlipidemia, type 2 diabetes, neuromuscular dysfunction of bladder, gastro esophageal reflux disease without esophagitis, and insomnia. R2's Minimum Data Set (MDS) assessment, dated 10/29/25, identified R2 required substantial maximal assistance for toileting and toilet transfer. Partial moderate assistance for bed mobility, rolling left to right, sitting to lying, and chair to bed. R2's Brief Interview for Mental Status (BIMS) dated 10/22/25 was 8/15, which indicates R2 had mild to moderate cognitive impairments. On 03/03/26 at 12:20 PM, Surveyor reviewed notice of transfers for R2's hospitalization on 11/10/25 and 12/27/25 which showed no reason for transfer to a higher level of care.

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility did not complete and submit Minimum Data Set Assessments (MDSAs) in the required time frames for 2 of 2 sampled residents for hospitalizations. (R2, R30)R30's MDS assessment was completed late on 1/12/25, 11/19/24, 218/25, 4/23/25, and 8/19/25. R30's MDS dated [DATE] transmission timeframe was greater than the 14 days from due date. 1/12/26 MDS transmission to the Centers for Medicare & Medicaid Services (CMS) national database was 51 days late.R2's MDS assessment was completed late on 10/29/25, 1/12/26, and 2/6/26.R2's MDS dated [DATE] transmission timeframe was more than 14 days from due date. 10/22/25 MDS transmission to the CMS national database was 19 days late.Findings include:The RAI (Resident Assessment Instrument) 3.0 User's Manual, dated October 2024, states in regard to the timing for completing the MDSAs in Section 5.2: - For all non-admission MDSAs, the MDS Completion Date must be no later than 14 days after the previous ARD (Assessment Reference Date). This would include Annual Assessments.- For all admission Assessments, the MDS Completion Date must be no later than 13 days after the Entry Date (Date of admission plus 13 days)- Quarterly Assessments: The Assessment Reference Date and MDS Completion Dates must be no later than 92 days from previous ARD and the Transmission Date must be no later than 14 days from the Completion Date.Example 1R30 was admitted to the facility on [DATE], and has diagnoses that include high blood pressure, high cholesterol, chronic fatigue, squamous cell carcinoma of skin, type 2 diabetes with chronic kidney disease, communication disorder, bipolar disorder, dementia, and Alzheimer's disease.On 3/5/26 at 2:22 PM, Surveyor conducted a review of R30's MDSs submitted for R30 during this survey period; 12/11/24 to 3/5/36. Surveyor noted the following late MDS assessment and record submission.Comprehensive - Completed on 1/12/26 and submitted on 1/23/26 with assessment completed 1/19/26.The admission assessment is more than 13 days after admission 1/5/26.Annual Comprehensive: Completed on 11/19/24 and submitted on 12/20/24 with assessment completed 12/10/24. Assessment late; the assessment completion date of 12/10/24 is more than 14 days after 11/19/24 assessment reference date. Quarterly Assessment: Completed on 2/18/25 and submitted on 3/24/25 with assessment completed 3/13/25. Assessment late; the assessment completion date of 3/13/25 (assessment completion date) is more than 14 days after 2/18/25 assessment reference date.PPS Assessment: Completed on 4/23/25 and submitted on 5/15/25 with assessment completed 5/14/25.Assessment late; the assessment completion date of 5/14/25 is more than 14 days after 4/23/25 assessment reference date.Quarterly Assessment: Completed on 8/19/25 and submitted on 9/16/25 with assessment completed 9/15/25.Assessment late; the assessment completion date of 9/15/25 is more than 14 days after 8/19/24 assessment reference date.Tracking (entry/death record) completed on 1/12/26 and submitted on 3/4/26.Record submitted late; the submission is more than 14 days after 1/12/26. Example 2R2 was admitted to the facility on [DATE] with diagnoses including in part, urinary tract infection, Klebsiella pneumoniae, parkinsonism, depression, anxiety, hyperlipidemia, type 2 diabetes, neuromuscular dysfunction of bladder, gastro esophageal reflux disease without esophagitis, and insomnia. On 3/5/26 at 2:22 PM, Surveyor conducted a review of R2's MDS submitted for R2 during this survey period; 12/11/24 to 3/5/36. Surveyor noted the following late MDS assessment and record submission.Tracking (entry/death record): admitted on [DATE] and submitted on 11/10/25.Record submitted late: the submission date is more than 14 days after admission: [DATE].Comprehensive: Admission/Medicare 5 days: Completed on 10/29/25 and submitted on 11/10/26 with assessment completion on 11/7/25.The assessment completion date 11/7/25 is more than 13 days after 10/22/25 admission date.Discharge return anticipated/end of PPS Part A stay: Completed on 12/28/25 and submitted on 1/12/26. Accurate timing.Tracking (entry/death record): Completed on 01/05/26 and submitted on 1/12/26. Accurate timing. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenhaven	612 E Oak St Glenwood City, WI 54013

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Admission/Medicare 5 day - Comprehensive - Completed on 1/12/26 and submitted on 1/23/26 with assessment completed 1/19/26.The admission assessment is more than 13 days after admission 1/5/26.PPS/Part A Discharge (End of Stay) - Completed on 2/6/26 and submitted on 3/4/26 with assessment completed 2/26/26.The assessment completion date of 2/26/26 is more than 14 days after 2/6/26.On 3/4/26 at 7:46 AM, Surveyor interviewed Assistant Director of Nursing (ADON) C, who is also the MDS coordinator, regarding R30, who was not in the system when surveyors entered the facility on 3/3/26. Facility had readmitted R30 at the facility on 1/12/2026. ADON C stated they caught that yesterday. ADON C realized something wasn't clicked and it did not go through on 1/12/26. For this reason, R30 would not have been in the system to be pulled for this recertification survey. On 3/5/26 at 3:30 PM, Surveyor interviewed ADON C regarding MDS. ADON C is the MDS coordinator and the lead for completion and submission. ADON C was made aware of late assessment and records submissions found. ADON C was surprised to learn that there were late assessments. ADON C also stated that she did not realize that reentry MDSs are to be completed within 7 days of being readmitted . Surveyor referred her to the timeline chart found in the RAI manual. ADON C wrote a note regarding the reference.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility did not ensure a resident who required substantial assistance for repositioning and toileting received timely assistance for 1 of 1 resident (R) reviewed for Activities of Daily Living (ADLs) (R13).R13, who is dependent for cares and incontinent of urine, did not have his brief changed for about 7 hours; prior to 7:10 AM until 2:02 PM. Findings include:On 3/4/26 at 2:22 PM, Surveyor asked for policies regarding incontinence care, ADL dependency and repositioning, whether it was all in one policy or individual polices. At 3:33 PM, Director of Nursing (DON) B came back to Surveyor and said DON B could not find a policy on incontinence care and repositioning. The National Institute of Health states, Best practice for changing incontinence briefs in nursing homes requires checking every 2 hours, with changes occurring immediately upon soiling to prevent skin breakdown . High absorbency products may last 5-12 hours, but active monitoring is required for quality of care.R13 was admitted to the facility on [DATE], and has diagnoses that include unspecified mood disorder, essential tremors, hearing loss, dementia, and high blood pressure. R13's Minimum Data Set (MDS) assessment, dated 12/8/25, indicated that R13 has unclear speech, is never understood and rarely understands the conversation. R13's Brief Interview for Mental Status (BIMS) indicated resident was unable to respond to the questions. R13 has impaired mobility bilaterally in both the upper and lower extremities. R13 is dependent for all mobility and on a mechanical lift for all transfers and a wheelchair for mobility. R13 is dependent for all activities of daily living (eating, toileting hygiene, personal hygiene, dressing).R13's Kardex (certified nursing assistant plan of care), states R13 is incontinent. Check and change every two hours and as needed.R13 incontinence care plan, printed 3/4/26 states:FOCUS:INCONTINENCE The resident has bowel and bladder incontinence r/t immobility and cognitive loss. Date initiated 1/12/25 revision on: 6/11/25.Goal:Resident will not have skin breakdown related to incontinence. Date initiated: 1/12/25 Target date: 3/1/26.Interventions: Check resident every two to three hours for incontinence Date Initiated:1/12/25 Revision 1/12/25. Provide peri care after each incontinent episode Date Initiated: 1/12/25.On 3/4/26 at 7:10 AM, Surveyor observed Certified Nursing Assistant (CNA) T transfer R13 to his wheelchair using a Hoyer lift. CNA T stated R13's cares had been previously done. Surveyor continuously observed R13 from 7:10 AM to 10:02 AM. During this time R13 was sitting out in the great room, sitting in front of the fireplace before breakfast, and by window after breakfast. From 8:36 AM to 9:28 AM, R13 was at breakfast table.On 3/4/25 at 10:02 AM, Surveyor observed R13 start coughing and making noises. CNA T came over by R13, greeted him and wheeled him back to his room. CNA T pulled his blanket off his lap, pulled the waist band away from his waist, looked in R13's pants, stated there was no marking, he is dry, let waist band go, and put blanket back on his lap. CNA T did not change R13's brief.At 10:03 AM, R13's wheelchair was pushed from his room back in front of the fireplace. At 10:08 AM, CNA T pushed R13 out to the activities area where he stayed while BINGO was going on.On 3/4/26 at 11:17 AM, Surveyor observed R13, sitting out at BINGO in the middle of the U shape formation of tables, sleeping. R13 had not left the area.On 3/4/26 at 11:46 AM, Surveyor observed BINGO was over and R13 was sitting out in activity area with 3 other residents. Residents were being brought back to their units. At 11:48 AM, Surveyor observed CNA T take R13 from Registered Nurse (RN) R who had started to push R13 back to the unit. CNA T pushed R13 back into the unit and pushed R13 directly to great area and parked R13 wheelchair in front of the fireplace. R13's brief was not checked. R13 was at his lunch table from 12:08 PM to 1:26 PM. At 1:26 PM, R13 was placed back in front of the fireplace. At 1:39 PM, RN R pushed R13 back to his room because he started coughing and making noises and resident next to him was getting agitated. RN R pushed R13 just into his room, visible through the open door. Surveyor stood in hall where Surveyor could continue to observe residents in great room and R13 in R13's room.On 3/4/26 at 1:54 PM, Surveyor interviewed CNA V and CNA T about repositioning, changing (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	briefs and the brief products used. CNA V stated that the rep for the briefs said until about 75% they are good, you watch the lines. Surveyor was unclear what she meant and asked CNA V for clarification. CNA V took a clean brief and showed Surveyor the yellow markings. CNA V pointed at the middle of brief and said that would be 50% so about here is 75%. The yellow markings will change to blue to indicate the brief is wet. CNA T stated normally we don't wait; we change if we see the lines and they are wet. CNA T stated nonverbal residents should be changed every 2 hours unless they are dry. We check every two hours. Surveyor asked if a resident can communicate, how long do they go without being checked. CNA T stated we ask after breakfast, and when we come to get them for lunch. On 3/4/26 at 2:02 PM, Surveyor observed CNA V and CNA T transfer R13 back to bed via Hoyer. CNA V and CNA T rolled resident and removed Hoyer sling from under R13, then changed R13's brief and provided peri-care. R13's brief was saturated and ready to break. CNA V took off brief, and Surveyor observed that all markings were blue indicating full saturation. CNA V held up brief to look at it, and CNA T stated when CNA T saw R13 this morning he had no lines. He was dry. On 3/4/26, Surveyor continuously observed R13 from 7:10 AM until 2:02 PM. CNA T took resident back to his room at 10:02 AM; in one minute, she allegedly checked R13 for dryness. At 10:03 AM, she was pushing him back out on floor. R13 was not checked for incontinence again until 2:02 PM. On 3/4/26 at 2:22 PM, Surveyor interviewed Assistant Director of Nursing (ADON) C who stated that R13 should have been checked before lunch if R13 was checked at 10. Generally, it is a 2-hour check. Our continence products are good for quite some time. We don't push it here. If checked and dry, we would not check again for 2 hrs. If it was bowel that's a different situation. Usually there is an odor and change them then, otherwise we would check at the two-hour limit. On 3/4/26 at 3:33 PM, DON B brought in requested paperwork to Surveyor. DON B stated we would expect them to be changed and repositioned every 2 hours or as care planned.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure 2 of 2 residents (R13 and R5) received necessary care and treatment. R13 and R5 are dependent on assistance for repositioning and mobility. R13 and R5 were not repositioned per care plan and standards of care.Findings include:On 3/4/26 at 2:22 PM, Surveyor asked for policies regarding incontinence care, ADL dependency and repositioning, whether it was all in one policy or individual polices. At 3:33 PM, Director of Nursing (DON) B came back to Surveyor and said DON B could not find a policy on incontinence care and repositioning. Example 1R13 was admitted to the facility on [DATE], and has diagnoses that include unspecified mood disorder, essential tremors, hearing loss, dementia, and high blood pressure. R13's Minimum Data Set (MDS) assessment, dated 12/8/25, indicated that R13 has unclear speech, is never understood and rarely understands the conversation. R13's Brief Interview for Mental Status (BIMS) indicated resident was unable to respond to the questions. R13 has impaired mobility bilaterally in both the upper and lower extremities. R13 is dependent for all mobility and on a mechanical lift for all transfers and a wheelchair for mobility. R13 is dependent for all activities of daily living (eating, toileting hygiene, personal hygiene, dressing).R13's Kardex (certified nursing assistant plan of care), states: INCONTINENT: check and change every two hours and as needed.BED MOBILITY: dependent on 1-2 staff. Nurse Aide- anticipate needs as resident is no longer able to make them known, assist with repositioning.Kardex does not provide any guidance of frequency to reposition R13.On 3/4/26 at 7:10 AM, Surveyor observed Certified Nursing Assistant (CNA) T transfer R13 to his wheelchair using a Hoyer lift. On 3/4/26, Surveyor continuously observed R13 in his wheelchair from 7:10 AM to 2:02 PM. R13 was not repositioned or placed back into bed, or in his recliner to offload pressure to his buttocks.On 3/4/26 at 2:02 PM, Surveyor observed CNA V and CNA T lift R13 by Hoyer lift, provide peri-care and lay resident in bed on his back. Example 2R5 was admitted to the facility on [DATE] with diagnoses of aphasia (difficulty swallowing), history of stroke, cellulitis of right lower limb, hemiplegia and hemiparesis, morbid obesity, seizure disorder, type 2 diabetes mellitus, muscle weakness, hypertension (high blood pressure), dementia, and depression.R5's MDS assessment, dated 12/15/25, indicated that R5 has unclear speech and is sometimes understood but usually understands, missing part of the message but comprehends most conversation. R5 needs substantial assistance to depends on assistance for all mobility. Due to R5's communication a BIMS was not done with R5. Assessment with staff and those that know R5 indicated R5 knows where he is, recognizes faces, but cognitively is severely impaired. R5's skin assessment in MDS reports R5 has history of one pressure injury and is at risk of developing others. R5's CNA Kardex, dated 3/24/26, states: Reposition: Resident for comfort Ensure resident is transferred to bed between meals (following exercise bike if applicable) in order to offload from buttock.Turn and repositioned every 2 hours and PRN, Keep body in good alignment.Bed Mobility: The resident requires extensive assistance by 1-2 staff to turn and reposition in bed . On 3/4/26, Surveyor continuously observed R5 from 8:36 AM to 1:50 PM. R5 was not repositioned or placed back into bed, or in his recliner to offload pressure to his buttocks.On 3/4/26 at 1:52 PM, Surveyor interviewed CNA T who stated R5 is repositioned every 2 hours. CNA T stated she asked R5 after breakfast if R5 wanted to use the bathroom. CNA T said R5 said no. Surveyor asked if that was about 9:45 AM. CNA T said I think so. Surveyor asked if R5 had been up in his chair all day, if this was his first time back in bed. CNA T stated yes. We should have asked him again.On 3/4/26 at 2:00 PM, Surveyor interviewed CNA T while she waited for CNA V and the Hoyer lift. CNA T stated that the residents unable to move themselves should be repositioned every 2 hours. Surveyor asked if R5 and R13 can move themselves. CNA T stated R5 shifts his weight, but I suppose that is not repositioning. R13 can't move himself. Surveyor asked should they have been repositioned today. CNA T was hesitant but stated, yes, they should have been. On 3/4/26 at 2:22 PM, Surveyor interviewed Assistant Director of Nursing (ADON) C who stated the expectation (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is that someone who is not able to reposition themselves should be checked every couple hours, that is just baseline. If there is an issue we put it in the CNA tasks. R5 requires assistance but is not always a willing participant. He prefers to be one way and does not want to be other way. R5 can shift around in his chair. They should be offering to move him. They should not have gone 8-10 hours in one position. R13 needs assistance with repositioning. On 3/4/26 at 3:33 PM, Director of Nursing (DON) B stated we would expect them to be changed and repositioned every 2 hours or as care planned.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility did not ensure that residents with an indwelling catheter received the appropriate care and services for 1 of 2 residents (R2) reviewed for catheters.Findings include:Facility policy titled Indwelling catheter insertion and care, last revised 04/07/25, stated in part,-5. t. Secure the catheter to the client's thigh using the securement device.u. Secure the urine collection bag lower than the client's position.-6. f. Maintain unobstructed urine flow by: i. Keeping the catheter and collection tubing free from kinking.ii. Always keep collection bag below the level of the bladder.R2 was admitted to the facility on [DATE] with diagnoses including in part, urinary tract infection, Klebsiella pneumoniae, parkinsonism, depression, anxiety, hyperlipidemia, type 2 diabetes, neuromuscular dysfunction of bladder, gastro esophageal reflux disease without esophagitis, and insomnia. R2's Minimum Data Set (MDS) assessment, dated 10/29/25, identified R2 required substantial maximal assistance for toileting and toilet transfer. Partial moderate assistance for bed mobility, rolling left to right, sitting to lying, and chair to bed. R2's Brief Interview for Mental Status (BIMS) dated 10/22/25 was 8, which indicates R2 had mild to moderate cognitive impairments.Surveyor reviewed R2's indwelling catheter care plan:The resident has an Indwelling Catheter due to Neurogenic bladder.History of failed voiding trials and ongoing UTI's due to not being able to fully empty bladder.-Catheter: The resident has 16f coude tip catheter with 20cc balloon. Position catheter bag and tubing below the level of the bladder and away from entrance room door.-Monitor and document intake and output as per facility policy.-Monitor for signs and symptoms of discomfort.-Monitor/document for pain/discomfort due to catheter.-Monitor/record/report to MD for signs and symptoms of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns.On 03/04/2026 at 10:55 AM, Surveyor observed Certified Nurse Assistant (CNA) E don Personal Protective Equipment (PPE) and enter R2's room. CNA E transferred R2 to the toilet due to an incontinent Bowel Movement (BM). Surveyor observed R2 had a leg bag in place but was sitting above R2's knee, kinked and wrapped around R2's knee. Surveyor observed the catheter was pulling tight from R2's cornea of penis. Surveyor did not observe catheter stabilization to R2's thighs. Surveyor observed R2 to have hematuria in the leg bag. On 03/04/2026 at 11:22 AM, Surveyor observed R2 sitting in wheelchair in lounge on unit D in front of TV shaking, complaining of severe pain on bottom and in groining area. Surveyor interviewed CNA E and asked about R2's catheter and why it was kinked with the leg bag and no stabilization to R2's thigh to keep R2's catheter tubing from pulling at R2's penis. CNA E reported that the hospice CNA is the one who got R2 up this morning and provided cares for the day. CNA E reported that CNA E is unsure why the leg bag is so short and has no stabilization on thigh. On 03/04/2026 at 11:27 AM, Surveyor observed Registered Nurse (RN) D approach R2 to gather vitals. Upon requesting to sit forward Surveyor observed R2 clench hold of the wheelchair and started shaking stating, I am in pain. RN D gathered vitals on R2 due to R2 being in so much pain. Vitals were within normal range, and afebrile. RN D reported that RN D will be notifying R2's Hospice RN F and Hospice RN F will be at facility shortly. On 03/04/2026 at 1:54 PM, Surveyor interviewed Hospice RN F and asked for information pertaining to R2's catheter, hematuria, and the stabilization of catheter. Hospice RN F reported to Surveyor that R2 has a history of ESBL in urine, was admitted to hospital in December of 2025 for sepsis, and Urinary Tract Infection (UTI) but has not had hematuria and that is a new symptom today. Hospice RN F reported that R2's catheter should be secured to the thigh as well as proper tubing for the leg bag during the day so that it isn't kinked. Hospice RN F reported that when Hospice RN arrived at facility she was assessing R2 and noticed that R2's catheter was pulling at R2's penis. Hospice RN F applied thigh stabilization to R2's catheter and reported to Surveyor the (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expectation is that the catheter is always secured. On 03/04/2026 at 2:21 PM, Surveyor interviewed Assistant Director of Nursing (ADON) C and asked ADON C for expectation of securement of catheterization for R2. ADON C reported that R2's catheter should be secured to the thigh as well as proper tubing for the leg bag during the day so that it isn't kinked.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility did not ensure all drugs and biologicals were stored and labeled in accordance with currently accepted professional principles. This occurred for 1 of 3 medication carts/storage rooms observed. During the recertification survey, 1 of 3 observations were made of R15's liquid Morphine bottle open with no open date label in medication cart on unit E. Surveyor observed controlled medication Lorazepam not double locked on unit E.Findings include:Facility policy titled Controlled Substance Medication Storage, last revised 05/2018, stated in part,B. Schedule II-V medications and other medications subject to abuse or diversion are stored in a permanently affixed double locked compartment sperate from all other medications or per state regulation .Example 1On 03/04/26 at 9:10 AM, Surveyor observed medication cart on unit E with Registered Nurse (RN) R. Surveyor observed a bottle of morphine sulfate oral concentration 100mg/5ml, give 0.25ml by mouth every 2 hours as needed, opened with no open date label. The morphine was dispensed on 12/26/25 and R15 used 2 doses on 02/14/26 and 02/17/26. The bottle was in a bag with R15's identification but no open date label. On 03/04/26 at 9:33 AM, Surveyor interviewed Assisted Director of Nursing (ADON) C and asked if ADON C is aware that R15 has morphine concentration located in medication cart on unit E that has been opened with no open date label. ADON C reported to Surveyor that all liquid medications should be labeled with open date as soon as they are opened. ADON C reported that ADON C will discard the morphine and obtain a new bottle with correct labeling. Example 2On 03/04/26 at 9:12 AM, Surveyor observed a locked cabinet on unit E with RN R. In the locked cabinet was a fridge that RN R opened. Surveyor observed Lorazepam vial located in the fridge with insulin pens and flu vaccinations. Surveyor interviewed RN R and asked if Lorazepam is supposed to be double locked. RN E reported that RN E was unsure and would need to ask ADON C. On 03/04/26 at 9:33 AM, Surveyor interviewed ADON C and asked if Lorazepam is supposed to be double locked. ADON C reported that Lorazepam should be locked and thought that it was double locked over the years but would fix immediately.