STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525645	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindengrove Mukwonago	837 E Veterans Way Mukwonago, WI 53149

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility did not ensure that food was prepared, distributed, and served in accordance with professional standards for food service safety in 2 of 3 kitchens. *Food Services Manager-U was observed in the main kitchen preparing and handling food without wearing a hair restraint to cover facial hair. *The blender blade was observed not to be thoroughly cleaned and sanitized in the main kitchen between preparation of two puree foods. *Food debris was observed over several days on the main kitchen floor and underneath kitchen equipment in the main kitchen. *A jug of salsa with an open date labeled 6/4/25 was observed with other ready-to-serve condiments in a refrigerator in the main kitchen and was not discarded timely manner. *The refrigerator in a satellite kitchen serving residents was observed to be at 67 degrees Fahrenheit with food and drink items inside of the refrigerator. This deficient practice has the potential to affect all 36 residents who receive food from the main kitchen. Findings include:On 12/8/25 at 8:50 AM, Surveyor conducted an initial tour of the facility's main kitchen with Food Services Manager (FSM)-U. FSM-U stated food for the nursing facility is prepared and stored in the main kitchen then transported to two satellite kitchens classified as rehab kitchen and west kitchen for serving to nursing facility residents. FSM-U stated the facility follows Wisconsin Food Code for safe food practices. The Wisconsin Food Code documents: .food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens.equipment . and utensils shall be clean to sight and touch.facilities shall be cleaned as often as necessary to keep them clean.time/temperature control for safety food shall be maintained . at 41 degrees Fahrenheit or less.1. Hair RestraintsOn 12/8/25 at 8:50 AM, during the initial kitchen tour, Surveyor observed FSM-U walk around the main kitchen while not wearing a hair restraint for exposed facial hair. On 12/8/25 at 11:21 AM, Surveyor observed FSM-U preparing and handling food near the stove in the main kitchen while not wearing a hair restraint for exposed facial hair. On 12/9/25 at 2:03 PM, Surveyor informed FSM-U that Surveyor had several observations of FSM-U not wearing a hair restraint over exposed facial hair. FSM-U stated FSM-U was under the impression no restraint was needed if the facial hair was less than an inch in length. No additional information as to why food was not prepared, distributed, and served in accordance with professional standards for food service safety. 2. Food PreparationOn 12/8/25 at 11:21 AM, Surveyor observed Cook-V prepare puree recipes for cooked pork and cooked squash. After completing the pureed squash, Cook-V stated Cook-V rinsed the blender blade in soap and water. Surveyor observed several bits of squash still present on the blender blade before Cook-V began using the same blender blade to prepare the cooked pork puree. On 12/9/25 at 2:03 PM, Surveyor interviewed FSM-U regarding the expectation for cleaning the blender blade in between preparation of two pureed foods. FSM-U stated the blender blade should be run through the dishwashing machine between preparation of two foods. Surveyor shared concern with FSM-U that Surveyor observed bits of squash still present on the blender blade prior to pork puree being prepared and that Cook-V stated the blender blade was rinsed in soap and water. No additional information as to why food was not prepared, distributed, and served in (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	accordance with professional standards for food service safety.3. Food StorageOn 12/8/25 at 8:50 AM, during the initial kitchen tour, Surveyor observed food debris all over the main kitchen floor and underneath the stove and steamer. On 12/8/25 at 9:00 AM, Surveyor observed an opened jug of salsa in a walk-in cooler in the main kitchen with the opened date documented as 6/4/25 on a label. The jug of salsa was stored with other ready-to-serve condiments. On 12/9/25 at 10:45 AM, Surveyor observed food debris all over the main kitchen floor and underneath the stove and steamer. Surveyor observed the jug of salsa still present in the walk-in cooler in the main kitchen.Surveyor notes the FoodKeeper application by the United States Department of Agriculture Food Safety and Inspection Service, version 9.0.0, build 68, documents for freshness and quality, salsa should be consumed within 1 month if refrigerated after opening.On 12/9/25 at 11:36 AM, Surveyor observed the thermometer on the outside and the inside of the refrigerator in the rehab satellite kitchen read 67 degrees Fahrenheit. Surveyor observed there was no alarm or other alert system indicating the temperature was above the standard temperature of 41 degrees Fahrenheit. Surveyor observed the following contents inside the refrigerator: milk, coffee creamer cups, pudding, Jello, pre-prepared grapes and cut up cantaloupe. Surveyor observed the pudding cups, Jello cups, and coffee creamer cups inside of the refrigerator were not cold to the touch. On 12/9/25 at 11:40 AM, Cook-W arrived at the rehab kitchen and was unaware the refrigerator temperature was 67 degrees Fahrenheit. Surveyor shared concern with Cook-W that the refrigerator temperature was 67 degrees Fahrenheit. Cook-W stated Cook-W checked the temperature in the morning of 12/9/25 and it was documented as 36 degrees Fahrenheit and Cook-W did not know how long the refrigerator was not at the proper temperature. On 12/9/25 at 2:03 PM, Surveyor interviewed FSM-U regarding how long condiments should be stored in the refrigerator or walk-in cooler. FSM-U stated condiments are stored in the cooler and portioned out as needed, and they are typically stored up to 3 months but are usually used before then. Surveyor shared concern with FSM-U that a jug of salsa with opened date 6/4/25 was observed in the walk-in cooler in the main kitchen over several days. FSM-U stated the salsa would be discarded. Surveyor shared concern with FSM-U regarding the rehab kitchen refrigerator being at 67 degrees Fahrenheit, and FSM-U confirmed all contents that were inside of the refrigerator were discarded and maintenance was contacted to work on the refrigerator. Surveyor shared concern with FSM-U that food debris was observed over several days on the main kitchen floor and underneath the stove and steamer. FSM-U stated the daily cleaning list would be revisited and updated as needed. On 12/9/25 at 3:03 PM, Surveyor shared the above concerns with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B.No additional information as to why food was not prepared, distributed, and served in accordance with professional standards for food service safety.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 4 (R1, R2, R50, & R3) of 4 residents reviewed for hospitalizations were notified of the reason for transfer/discharge and bed hold policy in writing to the resident & their representative. The facility's notice of transfer and bed hold form does not include the Ombudsman's email address. *R1 was admitted to the hospital on [DATE]. R1 and R1's POA did not receive in writing the reason for transfer/discharge and bed hold policy. The Ombudsman was not notified of R1 discharge to the hospital on 9/4/25. *R2 was discharged to the hospital on [DATE] & 10/30/25. R2 and R2's representative did not receive in writing the reason for transfer/discharge and bed hold policy. *R50 was discharged to the hospital on [DATE]. R2 and R2's representative did not receive in writing the reason for transfer/discharge and bed hold policy. *R3 was discharged to the hospital on 5/15/25. R3 and R3's representative did not receive in writing the reason for transfer/discharge and bed hold policy. Findings include: The facility's policy dated as last reviewed 5/2/25 and titled, Individual Transfer and Discharge documents under the Policy section: Ensure the discharge planning process addresses each resident's discharge goals and needs. Under the Procedure section it documents: A. Acceptable conditions for transfer or discharge from the facility includes 4. For medical reasons as ordered by a physician. The facility's policy dated as last reviewed 5/2/25 and titled, Individual Bed Hold documents under the Policy section: The individual, guardian, and/or individual representative will be informed upon admission and/or hospital/therapeutic leave of their bed hold options at the facility. Under Procedure B. Upon transfer to hospital and/or therapeutic leave documents 1. Individual will be informed and receive a copy of the bed hold procedure and letter. 1.) R1's diagnoses includes end stage renal disease (kidneys permanently have lost almost all their ability to function), chronic respiratory failure with hypoxia (low levels of oxygen in body tissues), chronic obstructive pulmonary disease (group of lung disease that block airflow and make it difficult to breath), congestive heart failure (heart doesn't pump enough blood to meet the body's needs), atrial fibrillation (irregular and rapid heartbeat), dementia (loss of cognitive function that interferes with a person's daily life and activities), and anxiety (emotional response involving feelings of worry, dread, and tension often accompanied by physical symptoms like a racing heart or sweating). R1's power of attorney for healthcare was activated on 12/24/23. R1's significant change MDS (minimum data set) with an assessment reference date of 9/18/25 documents a BIMS (brief interview mental status) score of 6, which indicates that R1 has severe (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitive impairment. R1's nurses note dated 9/4/25, at 23:24 (11:24 p.m.), documents: After left shoulder x-ray report confirmed by [Physician's name], new order to send to ER (emergency room) for evaluation of left hip and complete series. POA [Name] notified, request to send to [Hospital initials], [Name] ambulance notified, resident left facility at 16:00 (4:00 p.m.). Daughter notified facility of admit for possible surgery tomorrow. DON (Director of Nursing) and NP (Nurse Practitioner) [Name] notified. R1 was hospitalized from [DATE] to 9/11/25. Surveyor noted a notice of transfer and bed hold for R1 dated 9/4/25. This form included the Ombudsman's phone number and address but did not include their email address. Surveyor noted that R1's bed hold documents under verbal authorization given in person section it indicates: 2. Resident Representative. Surveyor noted that there is no evidence R1 and R1's POA were provided the notice of transfer and bed hold policy in writing. On 12/9/25, at 3:28 p.m., Surveyor interviewed Social Worker-N. Surveyor asked SW-N if she is involved with the bed hold policy when a resident is transferred/discharged to the hospital. SW-N explained that usually when a resident is on their way out the door to the hospital, its nursing who provides transfer/discharge documentation. SW-N informed Surveyor if the resident has been out over midnight, then either herself or admissions will call the family to see what they want. SW-N informed Surveyor the nurse sending the resident to the hospital does the notice of transfer and bed hold form and prints it off. SW-N informed Surveyor they will send the notice of discharge and bed hold form in the mail, the family can come in and get the form and if the resident is their own person they will send one with the resident to the hospital. A Surveyor asked if the Ombudsman is notified. SW-N replied yes, via email. On 12/9/25, at 3:50 p.m., Surveyor asked Registered Nurse (RN)-K what the process is if a resident needs to be transferred to the hospital. RN-K informed Surveyor she would contact the MD (Medical Doctor), update the POA (power of attorney) if required. Surveyor asked RN-K if she completes the notice of transfer and bed hold form. RN-K informed Surveyor RN-K does, usually makes a copy and sends this with the resident. Surveyor asked RN-K if the resident has a power of attorney does she send the form to the resident's POA. RN-K informed Surveyor she doesn't know if she is able to do that. RN-K informed Surveyor it would be verbal and doesn't know if they have any means of receiving it. On 12/10/25, at 8:11 a.m., Surveyor asked RN-J what the process is if a resident needs to be transferred to the hospital. RN-J explained she would assess the patient, ask the patient if they are their own person if she can send them to the hospital, let the doctor and NP (Nurse Practitioner) know. RN-J informed Surveyor if the patient has a POA she will call the POA to ask if it's okay to send to the hospital. Surveyor asked RN-J what paperwork she has to do. RN-J informed Surveyor a medication list, MAR/TAR (medication administration record/treatment administration record), a change in condition form is filled out in the computer, face sheet, code status, sometimes a H & P (history and physical) and any recent labs. Surveyor asked RN-J if she completes the notice of transfer and bed hold form. RN-J replied yes and if they have a POA we have to ask them what they prefer and sometimes the admission staff will help if they know the family. RN-J informed Surveyor she makes a copy of this form and places it with the other paperwork and sends it with the patient if (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the family hasn't decided whether to hold the bed. Surveyor asked RN-J if this form is sent to the resident's POA to provide this form in writing. RN-J if someone has their email sometimes admissions will help, or they will come in and sign it or give us a verbal saying to hold the bed. On 12/10/25, at 9:02 a.m., a Surveyor interviewed Admissions-O regarding the transfer notice & bed hold policy. Admissions-O informed the Surveyor nursing would complete the notices when a resident goes out to the hospital. Admissions-O stated that Admissions-O usually don't get involved but occasionally if a family has questions or if the social worker calls me and the family has questions about the bed rate or options. On 12/10/25, at 11:37 a.m., Surveyor reviewed the September 2025 discharge list which was emailed to the Ombudsman. Surveyor was unable to locate R1's name on this list. On 12/10/25, at 11:54 a.m., Surveyor showed SW-N the September 2025 discharge list and asked if this was the list sent to the Ombudsman. SW-N replied [Name of Ombudsman] yes. Surveyor asked why R1 who was admitted to the hospital on [DATE] wasn't on the list. SW-N informed Surveyor because she lives here. On 12/9/25, at 3:08 p.m., Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B there is no evidence R1's notice of transfer and bed hold form was provided to R1 and R1's POA when R1 was transferred/discharged to the hospital on 9/4/25. No additional information was provided. 2). R2 was admitted to the facility on [DATE] with diagnoses including displaced bimalleolar fracture of right lower leg (ankle fracture), chronic diastolic (congestive) heart failure, chronic kidney disease stage 3, and depression. R2 was hospitalized on [DATE] until 10/20/25 for revision surgery to the right ankle. Surveyor reviewed R2's electronic health record (EHR) and could not locate a notice of transfer or bed hold notice that was provided to R2 or R2's representative on 10/17/25. Surveyor noted that at the time of transfer, R2 was R2's own person. R2 was hospitalized on [DATE] until 11/3/25 for abnormal vitals and difficulty breathing. Surveyor reviewed R2's EHR and located an electronic version of a notice of transfer and bed hold dated 10/30/25 with verbal consent documented, but no evidence that this information was conveyed in writing to R2 at the time of transfer. Surveyor noted at the time of transfer, R2 was R2's own person. On 12/9/25 at 3:29 PM, Surveyor interviewed Social Worker (SW)-N regarding the process of providing written notice of transfer and bed hold when a resident is transferred to the hospital. SW-N stated the nurse on duty would be responsible for getting the notice of transfer and bed hold to the resident or their representative when a resident is sent to the hospital. SW-N stated the nurse on duty would print the notice and give it to the resident, or if the resident had an activated power of attorney (POA), the notice would be sent in the mail. Surveyor requested evidence that written notice of transfer and bed hold was provided to R2 on 10/17/25 and 10/30/25. On 12/10/25 at 8:43 AM, SW-N informed Surveyor that no bed hold notice or notice of transfer was provided to R2 on 10/17/25, as it was a planned surgery, and the resident was able to return to the facility following the surgery. SW-N stated the electronic notice of transfer and bed hold is in R2's (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EHR on 10/30/25. Surveyor shared concern with SW-N that the form dated 10/30/25 only documents verbal notification to R2 regarding the bed hold and transfer, and there is no evidence this information was provided to R2 in writing. SW-N did not provide any additional information. On 12/10/25 at 2:18 PM, Surveyor interviewed Director of Nursing (DON)-B regarding the process of providing written notice of transfer and bed hold when a resident is transferred to the hospital. DON-B stated the nurse on duty would start the notice and send the paperwork to the hospital with the resident. DON-B stated if the resident has an activated POA, the facility contacts the POA to let them know of the bed hold rate and confirm if the POA agrees to hold the bed. Surveyor asked DON-B if a notice of transfer and bed hold is provided for a planned hospital stay. DON-B stated a notice of transfer and bed hold would not be issued in this instance. Surveyor shared concern with DON-B that there is no evidence R2 was provided a written notice of transfer or bed hold upon being hospitalized on [DATE], and only verbal notification was provided to R2 upon being hospitalized on [DATE]. No additional information was provided. 3.) R50 was admitted to the facility on [DATE] with diagnoses including encephalopathy (a disturbance of brain function), severe protein-calorie malnutrition, and vascular dementia (dementia caused by reduced blood flow to the brain) with behavioral disturbance. R50 had an activated power of attorney (POA). R50 was hospitalized on [DATE] due to poor intake. Surveyor reviewed R50's electronic health record (EHR) and did not locate a notice of transfer or bed hold notice on 10/14/25. On 12/9/25 at 3:29 PM, Surveyor interviewed Social Worker (SW)-N regarding the process of providing written notice of transfer and bed hold when a resident is transferred to the hospital. SW-N stated the nurse on duty would be responsible for getting the notice of transfer and bed hold to the resident or their representative when a resident is sent to the hospital. SW-N stated the nurse on duty would print the notice and give it to the resident, or if the resident had an activated power of attorney (POA), the notice would be sent in the mail. Surveyor requested evidence that written notice of transfer and bed hold was provided to R50's representative on 10/14/25. On 12/10/25 at 8:43 AM, SW-N informed Surveyor that no written bed hold notice or notice of transfer was located for R50 on 10/14/25. On 12/10/25 at 2:18 PM, Surveyor interviewed Director of Nursing (DON)-B regarding the process of providing written notice of transfer and bed hold when a resident is transferred to the hospital. DON-B stated the nurse on duty would start the notice and send the paperwork to the hospital with the resident. DON-B stated if the resident has an activated POA, the facility contacts the POA to let them know of the bed hold rate and confirm if the POA agrees to hold the bed. Surveyor shared concern with DON-B that there is no evidence R50's POA was provided a written notice of transfer or bed hold upon being hospitalized on [DATE]. No additional information was provided. 4.) R3 was admitted to the facility on [DATE] with diagnoses of History of Urinary Tract Infections, Retention of Urine, and Presence of Urogenital Implants (medical devices or injectable materials used to restore urinary or sexual function). R3's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(BIMS) score of 10, indicating that R3 had moderate cognitive impairment and decision making. The MDS documents that: R3 requires set up assistance to eat and perform oral hygiene; R3 is completely dependent with all cares: toileting, showering, dressing, all other hygiene, changing positions (sit to lay, roll left and right in bed, and sit to stand.); R3 is incontinent of bowel and has a urinary catheter. R3's POAHC (Power of Attorney of Health Care) was activated on 2/24/25. On 5/15/25, at 6:18 PM, a nursing note written by RN-S documented: Patient still lethargic and sleepy. Blood sugar prior to dinner 391 and temperature 101.8. Prn tylenol given and staff attempted to feed patient. Patient ate one bite of dinner and fell back asleep. Updated POA (power of attorney) on patient's status and request to [NAME] hospital. POA in agreement and stated to seen patient to Hospital for evaluation. MD-Q updated and gave order to go to ER. On 5/15/25, at 11:07 PM, a nursing note written by RN-S documented: Ambulance called and report given to RN (registered nurse) at ER (emergency room). DON (Director of Nursing)-B notified. Patient left facility at 2000. Interact transfer form and all paperwork given to EMT's (emergency medical technicians). Surveyor could not located a bed hold and transfer notice in R3's medical record for when R3 was transferred to the hospital on 5/15/25. On 12/9/25, at 3:28 PM, Surveyor interviewed Social Worker (SW)-N who stated that nursing is responsible for sending the behold notice with the patient to the hospital. SW-N stated that she was unaware of where bed hold electronic assessment and hard copies of bed hold goes as it is the nursing department's job to issue the documents. SW-N stated the facility does not send out written bed hold notices to patients who have Medicaid as those patients will have Medicaid automatically pay for the bed hold for 15 days. SW-N stated a written copy of the bed hold notice was not completed or given to R3. On 12/9/25, at 3:49 PM, Surveyor interviewed RN-K who stated nurses send a written copy of the bed hold notice with the patient to the hospital and will get verbal confirmation from the resident or the resident's representative if they would like a bed hold. On 12/10/25, at 9:02 AM, a surveyor interviewed Admissions-O who stated Nursing would complete the bed hold notices when a resident goes out to the hospital, Admissions-O doesn't get involved unless the family has questions. On 12/10/25, at 2:17 PM Surveyor shared the concern of R3 and R3's representative not receiving a written bed hold notice with DON-B and Regional Nurse Consultant (RNC)- Q. No additional information was provided.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility did not ensure 1 (R1) of 1 resident was clinically appropriate to self-administer medications.R1 was observed with a white pill on R1's breakfast tray and approximately four pills in a medication cup on R1's breakfast tray located on the over bed table next to R1. R1 does not have a self-administration assessment. Findings include:The facility's policy dated May 2018 and titled, Self-Administration of Medications documents under the Policy section: In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer. Under Procedures documents A. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process.R1's diagnoses includes end stage renal disease (kidneys permanently have lost almost all their ability to function), chronic respiratory failure with hypoxia (low levels of oxygen in body tissues), chronic obstructive pulmonary disease (group of lung disease that block airflow and make it difficult to breath), congestive heart failure (heart doesn't pump enough blood to meet the body's needs), atrial fibrillation (irregular and rapid heartbeat), dementia (loss of cognitive function that interferes with a person's daily life and activities), and anxiety (emotional response involving feelings of worry, dread, and tension often accompanied by physical symptoms like a racing heart or sweating).R1?s significant change MDS (minimum data set) with an assessment reference date of 9/18/25 documents a BIMS (brief interview mental status) score of 6, which indicates severe cognitive impairment.On 12/8/25, at 9:24 a.m., Surveyor observed R1 sitting on the edge of the bed with R1's left leg extended and resting on top of the wheelchair cushion. To the right of R1 is an overbed table with R1's breakfast tray. Surveyor observed laying directly on the breakfast tray is a large white tablet and a medication cup containing approximately 4 tablets. Surveyor asked R1 about the medication on the breakfast tray. R1 stated she (the nursing staff) just left them; I take the big one first.R1's nurses note dated 4/12/25, at 17:05 (5:05 p.m.) and written by Licensed Practical Nurse (LPN)-I documents: Found several meds (medication) in room from this afternoon that resident did not take.R1's physician orders does not include an order for R1 to self-administer medication.Under the assessment section of R1's medical record there is an Assessment for Resident Self-Administration of Medications dated 4/20/25 that is documented as in progress. Surveyor reviewed this assessment and noted this assessment was not started and the entire assessment is blank. Surveyor was unable to locate any other self-administration of medication assessment in R1's medical record.On 12/9/25, at 11:12 a.m., Surveyor asked Registered Nurse (RN)-M where Surveyor would be able to find a self-administration assessment. RN-M informed Surveyor this is something the nurse practitioner may have to do. RN-M informed Surveyor she has asked the nurse practitioner in the past if it's okay for R1 to self administer medication. RN-M informed Surveyor she doesn't think there is one, referring to a resident's self-administration of medication assessment. LPN-H, who was also in the vicinity, informed Surveyor she thinks there is a medication administration assessment for R1. On 12/9/25, at 11:14 a.m., Surveyor asked RN-M if R1 can self-administer her medication. RN-M replied R1 does not.On 12/9/25, at 11:27 a.m., Surveyor asked Director of Nursing (DON)-B if self-administration of medications assessments are completed on residents who request to administer their own medication. DON-B replied we do for specific indications. Surveyor asked DON-B what she means by specific indications. DON-B explained if there is a new admission who wants to take their own medication, they would do an assessment, but assessments aren't done for every single patient. Surveyor asked DON-B if R1 can self-administer her own medication. DON-B replied no. DON-B informed Surveyor once in a while R1 asks the nurse to leave the bigger white pill and that R1 will take a few bites of her food and take the medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON-B informed Surveyor the nurse will go back to make sure she has taken the medication. Surveyor informed DON-B of Surveyor's observation of a large white tablet on R1'breakfast tray along with a medication cup containing four pills. Surveyor informed DON-B there is not a self-administration assessment for R1 to self-administer her own medication.After Surveyor spoke with DON-B, Surveyor noted an order with an order date of 12/9/25 that documents: Do not leave residents medication at the bedside, continue to reproach resident until she is willing to take medications. Every shift for consistent med management.No additional information was provided.

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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 (R2) of 16 residents reviewed for advanced directives had wishes clearly documented in the medical record.R2 did not have a current physician's order clarifying code status and R2's electronic medical record did not specify code status. Findings include:The facility policy titled Code Status with initial approval date of 2/8/17 and review date 5/8/25 documents: Policy: facilities will discover, maintain, and execute a (sic) individual's code status by following the documented wishes of each individual. if an individual wishes to be a Do-Not-Resuscitate (DNR), the individual's wishes will be maintained: provider signed DNR order, within the medical record, on a State DNR form, by wearing a facility approved DNR bracelet. if a (sic) individual does not wish to maintain their DNR bracelet, the Risk Agreement will be reviewed with the individual and/or individual representative. This choice will be documented in the care plan. staff will identify a (sic) individual's code status by: identification of a DNR bracelet on the individual, documentation within the medical record. the individual's medical record will be the primary reference in case of an emergency to verify code status. R2 was admitted to the facility on [DATE] with diagnoses including displaced bimalleolar fracture of right lower leg (ankle fracture), chronic diastolic (congestive) heart failure, chronic kidney disease stage 3, and depression. R2 had an activated power of attorney (POA). Surveyor reviewed R2's electronic medical record (EMR) and located a signed State DNR form by R2's POA dated 11/8/25 in the documents section. Surveyor noted the top portion of R2's EMR did not indicate code status as Surveyor had noted in other residents' EMR. Surveyor noted under the order tab in R2's EMR, R2's physician orders did not include a current order for DNR. On 12/9/25 at 3:25 PM, Surveyor interviewed Registered Nurse (RN)-S regarding how a resident's code status is determined in the event of an emergency. RN-S stated the resident should have a bracelet on their wrist, otherwise the code status should be written in their medical record under their name and there should be a physician order confirming the resident's code status. Surveyor reviewed R2's medical record with RN-S, and RN-S confirmed R2's medical record does not list R2's code status under R2's name, and there is no physician order confirming R2's code status. On 12/9/25 at 3:41 PM, Surveyor interviewed Social Worker (SW)-N regarding resident code status. SW-N stated upon admission, nursing staff asks a resident their preferred code status, a facility and state form is filled out and scanned into the resident's EMR, and a physician order is obtained. Surveyor shared concern with SW-N that R2's medical record did not specify R2's code status and no physician order was located stating R2 is DNR status. SW-N stated SW-N would look into this concern. On 12/9/25 at 3:47 PM, Surveyor shared concern with Director of Nursing (DON)-B that R2's medical record did not specify R2's code status and no physician order was located stating R2 is DNR status. DON-B reviewed R2's medical record and confirmed R2's code status is not specified underneath R2's name and there is no current physician order stating R2 is DNR status. DON-B located a discontinued physician order in R2's EMR documenting DNR status and confirmed this order was discontinued on 11/27/25. DON-B stated DON-B was not sure why this order was discontinued and would put in a new order. No additional information was provided.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents with a pressure injury, or those at risk for pressure injuries, received necessary treatment and services consistent with professional standards of practice to prevent the development of pressure injuries and to promote healing for 2 (R8, R21) of 4 residents reviewed for pressure injuries from a sample of 12. *R8 developed a pressure injury to the right inner ankle on 1/31/25, which progressed to a stage 3 pressure injury and became infected on 11/19/25 resulting in R8 having pain at the wound and requiring 2 antibiotics to treat the infection. R8 was assessed to be a high risk for developing pressure injuries. R8's care plan was not revised with alternative interventions when R8's right inner ankle wound progressed to an unstageable pressure injury. R8's ankle pressure injury was not always accurately assessed to identify the correct staging. *R21 developed a pressure wound to the right gluteus on 11/27/25, which was not comprehensively assessed by a Registered Nurse (RN) until 12/7/25, and R21's care plan was not revised to include interventions relating to the new pressure wound. Findings include: The facility's policy and procedure titled, Pressure Injury Prevention and Managing Skin Integrity with initial approval date 2/8/17 and reviewed date 5/8/25 documents . I. Policy: prevention measures are put in place to reduce the occurrence of pressure injuries. II. Procedure:1. Risk Assessmenta. Upon admission: Braden Scale will be completed to evaluate individual's risk for developing a pressure injury at admission, and weekly for four weeks for all new admissions. b. Re-evaluation: Braden Scale will be completed upon change of condition and quarterly.c. Based on the individual's Braden Scale score, pressure reduction interventions will be implemented by nursing and documented in the individual's medical record. 2. Identify Interventions and Care [NAME]. Identify interventionsi. The care and intervention for any identified skin breakdown or wound is intended to prevent any further advancement of the wound or additional skin breakdown .b. Care Plani. In developing a plan of care, the following will be considered:1. Individual pressure injury history .5. risk for pressure ulcer development (Braden Scale)3. Skin Checksa. Skin check will be done upon admission, readmission or as clinically indicated.b. While providing routine care, a licensed nurse is to monitor the skin condition of each individual weekly and document the Skin Check in the medical record. 4. Weekly Wound Roundsa. Upon identification of abnormal skin findings, a licensed nurse will complete a skin assessment. Individual with abnormal skin concern(s) will be added to weekly wound rounds. b. Registered Nurse (RN) or designee will:i. Conduct weekly skin evaluation.ii. Update the (PCP) (Primary Care Physician) with any decline in wound appearance, or as necessaryiii. Update the Care Plan with any new interventions as applicableiv. Update Individual Representative as indicated . The National Pressure Injury Advisory Panel (NPIAP) document titled, NPIAP Staging for Lightly Pigmented Skin dated 2/14/2020 defines a pressure injury as localized damage to the skin and underlying soft tissue usually over a bony prominence . the injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The document defines the following stages:Stage 2: partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough (yellowish/tan stringy or moist tissue) and eschar (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(hard, dead scab or crust of tissue) are not present. Stage 3: full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location . if slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.Unstageable Pressure Injury: full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. 1) R8 was admitted to the facility on [DATE] with diagnoses including other specified disorders of brain, unspecified dementia, anemia (a blood condition with lack of healthy red blood cells to carry oxygen to body tissues), hypertensive heart disease with heart failure (long-term high blood pressure leading to heart weakness), other chronic pain, nonrheumatic aortic (valve) stenosis (narrowing of the heart's main exit valve leading to the heart working harder to push blood through the body), adult failure to thrive, and unspecified diastolic (congestive) he R8's admission skin assessment dated [DATE] documents bruising at the right and left antecubital (elbow) region, redness at the coccyx (tailbone), and a scab at the front left lower leg. R8's admission Minimal Data Set (MDS) dated [DATE] documents no current pressure ulcers and R8 is at risk for pressure ulcers. R8 has been enrolled in hospice services since 7/4/24. R8's potential for impairment to skin integrity care plan with an initiated date of 6/30/2024 documents the following interventions initiated 6/30/24:-Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. -Educate resident/family/caregivers of causative factors and measures to prevent skin injury. -Encourage good nutrition and hydration in order to promote healthier skin.-Follow facility protocols for treatment of injury. -Identify/document potential causative factors and eliminate/resolve where possible. -Keep skin clean and dry. Use lotion on dry skin.-Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Surveyor notes there are no pressure injury prevention interventions addressing turning, repositioning, or offloading R8's heels. The pressure injury Care Area Assessment (CAA) dated 7/11/24 documents CAA triggered for potential pressure ulcer due to need for extensive assistance with bed mobility, refer to ADL documentation. Further complicated by incontinent of urine and bowel. [R8] does not currently have a pressure ulcer or history of pressure ulcers, refer to admission assessment and weekly skin assessment documentation. [R8] is at risk for skin breakdown. R8's Braden Scale assessment dated [DATE] documents a score of 12.0 indicating high risk for pressure injury developmentR8's Braden Scale assessment dated [DATE] documents a score of 12.0 indicating high risk for pressure injury development. The physician order dated 7/5/24 documents Magic Cup in the evening for weight support, please provide Thrive. The physician order dated 9/22/24 documents Ensure Clear three times a day for supplement. A skin note dated 7/19/24 documents no reported skin issues, air mattress for skin protection. Surveyor notes there was no physician order for use of an air mattress and R8's care plan was not revised to include this intervention. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician order dated 10/9/24 documents apply heel boots to right heel for protection. Chart refusals every shift. This order documents a discontinue date 1/5/25. Surveyor notes the physician ordered right heel boot was not added to the care plan at this time. R8's Treatment Administration Record (TAR) for December 2024 documents R8 refused to wear heel boot to the right heel 6 times between the dates of 12/1/24-12/31/24. R8's TAR for January 2025 documents R8 refused to wear heel boots the right heel 1 time between the dates of 1/1/25 and 1/5/25. The physician order dated 1/5/2025 documents apply heel boots for protection. Chart refusals. Surveyor notes this order does not specify when the heel boots should be applied such as in bed and when up in broda chair, or duration the heel boots should be applied. R8's TAR for January 2025 documents R8 refused to wear heel boots 6 times between the dates of 1/5/25-1/31/25. R8's quarterly MDS dated [DATE] documents R8 does not have a pressure ulcer/injury and is at risk for pressure ulcers. The MDS documents R8 does not have any range of motion impairments in the upper or lower extremities, and R8 is dependent for activities of daily living, bed mobility, and transfers. The MDS documents R8 has a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. A nursing progress note dated 1/11/25 documents [R8] is alert and oriented x1-2, able to make occasional needs known. Appetite fair and accepts protein supplements. On scheduled Tylenol, lidocaine patch, and fentanyl patch for pain. Requests PRN (as needed) morphine occasionally for additional pain. Heel boots and skin prep orders for protection, has air mattress for protection. R8's care plan for risk for malnutrition related to low Body Mass Index (BMI) for population, variable/low intake, unintended weight changes was revised 1/17/25 to include a new goal for [R8] to maintain adequate nutritional status as evidenced by maintaining weight within usual baseline weight of 110 pounds, no signs/symptoms of malnutrition, and consuming at least 50% of meals daily. A nursing progress note dated 1/31/25 documents: noted to have red intact fluid filled blister to right inner foot. Pain with assessment. Skin prep applied. Heel boots on in bed. Had gripper socks on when in Broda (a specific type of wheelchair); the wound is described as length 0.9 centimeters (cm), width 1.2 cm, tissue: painful and mushy. A new treatment order with start date of 1/31/25 documents apply skin prep every evening to intact blister to right inner foot. R8's TAR documents this treatment was administered on 2/1/25, 2/2/25, 2/3/25, 2/4/25, 2/5/25, 2/6/25, 2/7/25, 2/8/25, 2/9/25, 2/10/25, 2/12/25, and 2/13/25 until the order was discontinued on 2/14/25. Surveyor notes R8's care plan was not revised to include interventions of turning, repositioning or offloading R8's heels to promote healing. R8's weekly wound assessment dated [DATE] documents a blister to R8's right inner ankle measuring 15 millimeters (mm) (1.5 cm) long x 15 mm (1.5 cm) wide and is described as 100% scab. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor notes there is no change to R8's right inner ankle treatment or changes to the care plan to promote healing when the area was assessed to be 100% scabbed. A new treatment order with start date 2/15/25 documents apply skin prep every evening to right inner foot scabbed blister. R8's TAR documents this treatment was administered on 2/15, 2/16, and 2/17 until the order was discontinued on 2/18/25. Surveyor notes this is the same treatment ordered on 1/31/25 when the right ankle blister was identified. A nurses note dated 2/15/25 documents [R8's] appetite varies but generally adequate, accepts supplements. Pain is controlled with lido (lidocaine), Fentanyl, scheduled Tylenol. At times takes PRN MSO4 (morphine) and/or Ativan. R8's weekly wound assessment dated [DATE] documents a blister to R8's right inner ankle measuring 15 mm (1.5 cm) long x 10 mm (1.0 cm) wide and is described as 100% scab. R8's potential for impairment to skin integrity care plan with an initiated date of 6/30/2024 and revised date of 2/19/25 documents the following interventions were added 2/19/25:-air mattress on bed-Broda chair for comfort, elevate BLE (bilateral lower extremities)-prevlon (sic) boots on feet when in bed Surveyor notes heel boots were ordered on 1/5/25 and the air mattress was documented as being in place on 1/11/25 with R8's care plan revision occurring on 2/19/25. R8's TAR for February 2025 documents R8 refused to wear heel boots 13 times between the dates of 2/1/25-2/28/25. Surveyor notes an additional order was added to R8's TAR with a start date of 2/18/25 documenting heel boots to be worn in bed and in Broda every shift for protection of pressure areas. R8's TAR documents 1 refusal between the dates of 2/1/25-2/28/25. No refusals were documented under this treatment in the months of March or April and this treatment order was discontinued on 4/3/25. A new treatment order with start date of 2/21/25 documents apply skin prep every evening shift every 3 days to right inner mid-foot scabbed blister, monitor for s/sx (signs/symptoms) of infection. R8's TAR documents this treatment was administered as ordered with no refusals between the dates of 2/21/25-3/25/25 when the order was discontinued. R8's weekly wound assessment dated [DATE] documents the wound to R8's right inner foot is a stage 2 pressure injury, 100% scab, and measures 10 mm long x 8 mm in size wide. Surveyor notes this is the first instance the wound is classified as a stage 2 pressure injury instead of a blister. On 12/10/25 at 12:48 PM, Surveyor interviewed Wound RN (Registered Nurse)-C regarding why R8's wound was classified as a stage 2 pressure injury on 2/23/25. Wound RN-C replied it was classified as a stage 2 pressure injury since it was more significant than a stage 1 Wound RN-C did not state why the wound would not be considered unstageable as the area was assessed with 100% scab Wound RN-C confirmed R8's wound was considered a pressure injury due to its location over a bony prominence. Surveyor asked Wound RN-C what interventions are typically implemented for a resident at risk for developing a pressure injury. Wound RN-C replied heel boots would typically be utilized for (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a resident at risk of pressure injury even if there are no current open areas and risk would be determined by a resident assessment and Braden Scale score. Surveyor shared concern with Wound RN-C that R8's care plan did not have the intervention for heel boots until 2/19/25, after the initial blister developed on R8's right inner foot. Wound RN-C was not sure why those interventions were not in the care plan when the boots had been ordered prior to this date. A nursing note dated 3/1/25 documents [R8] refused bath today, skin checked over, no new skin issues identified. Pain is controlled with lido, Fentanyl, scheduled Tylenol. At times takes PRN MSO4 (morphine) and/or Ativan. Air mattress for skin protection, heel boots in bed. R8's weekly wound assessment dated [DATE] documents a stage 2 pressure injury to R8's right inner ankle measuring 5 mm (0.5 cm) long x 8 mm (1.5 cm) wide and is described as 100% scab. R8's weekly wound assessment dated [DATE] documents a stage 2 pressure injury to R8's right inner ankle measuring 5 mm (0.5 cm) long x 8 mm (1.5 cm) wide and is described as 100% scab.R8's weekly wound assessment dated [DATE] documents the wound to R8's right inner foot is a stage 2 pressure injury, has granulation tissue and scant serosanguinous (pinkish, watery fluid) drainage, and measures 10 mm long x 10 mm wide in size. Surveyor notes the percentage of granulation tissue was not specified in this assessment and the pressure injury has doubled in size. In an interview on 12/10/25 at 12:48 PM, Wound RN-C confirmed R8's wound first opened on 3/25/25 resulting in drainage and a new treatment was started. A physician order dated 3/25/25 documents apply Medihoney Wound & Burn Dressing External Paste to right medial (inner) foot topically in the evening every 3 days for pressure area, cover with foam dressing, monitor for s/x (signs/symptoms) of infection. R8's TAR documents this treatment was administered as ordered between the dates of 3/25/25-8/12/25 and no refusals of this treatment were documented during this timeframe. R8's TAR for March 2025 documents R8 refused to wear heel boots 11 times between the dates of 3/1/25-3/31/25. R8's care plan was updated 3/28/25 to include care area: [R8] has a behavior problem, often refuses to wear heel boots related to comfort or being too hot. The following interventions initiated 3/28/25: -if reasonable, discuss the resident's behavior. Explain/reinforce why heel boots are needed for wound healing and skin protection as appropriate. Surveyor notes R8 has a diagnosis of dementia and a BIMS score of 00 indicating R8 is severely cognitively impaired. R8's weekly wound assessment dated [DATE] documents a stage 2 pressure injury to R8's right inner ankle measuring 8 mm (0.8 cm) long x 10 mm (1.0 cm) wide and is described as small intact scab. R8's weekly wound assessment dated [DATE] documents a stage 2 pressure injury to R8's right inner ankle measuring 4 mm (0.4 cm) long x 5 mm (0.5 cm) wide and is described as 100% scab but lists granulation tissue is present. Surveyor notes the percentage of granulation tissue is not specified in this assessment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8's weekly wound assessment dated [DATE] documents a stage 2 pressure injury to R8's right inner ankle measuring 4 mm (0.4 cm) long x 5 mm (0.5 cm) wide and is described as 100% scab but lists granulation tissue is present. Surveyor notes the percentage of granulation tissue is not specified in this assessment. R8's weekly wound assessment dated [DATE] documents the wound to R8's right inner foot as a stage 3 pressure injury, noted to be worsening with 80% slough present, scant serosanguinous drainage, and measures 6 mm (0.6 cm) long x 6 mm (0.6 cm) wide. Surveyor notes this is the first instance the wound is classified as a stage 3 pressure injury. In an interview on 12/10/25 at 12:48 PM, Wound RN-C stated Wound RN-C is not sure why the wound worsened to a stage 3 and confirmed R8 did not typically refuse any treatments. Surveyor notes no care plan revisions or new interventions were added after the progression of R8's wound to a stage 3 pressure injury. R8's TAR for April 2025 documents R8 refused to wear heel boots 12 times between the dates of 4/1/25-4/30/25. A physician order dated 5/3/25 documents check placement of right medial foot dressing each shift. Change dressing if missing or soiled with a discontinued date 6/13/25. An updated order dated 6/13/25 documents monitor right medial foot dressing each shift for intactness, monitor for s/sx (signs/symptoms) of infection. R8's TAR documents this task administered as ordered with no documented instances of the dressing not being intact or any signs or symptoms of infection. R8's weekly wound assessment dated [DATE] documents a stage 3 pressure injury to R8's right inner ankle with 50% slough, granulation tissue present but no percentage specified, with scant serosanguinous drainage, measuring 6 mm (0.6 cm) long x 6 mm (0.6 cm) wide. R8's weekly wound assessment dated [DATE] documents a stage 3 pressure injury to R8's right inner ankle with slough in center of wound but no percentage specified, granulation tissue present but no percentage specified, measuring 5 mm (0.5 cm) long x 5 mm (0.5 cm) wide. R8's weekly wound assessment dated [DATE] documents a stage 3 pressure injury to R8's right inner ankle with 40% slough, granulation tissue present but no percentage specified, with scant serosanguinous drainage, measuring 6 mm (0.6 cm) long x 6 mm (0.6 cm) wide. R8's weekly wound assessment dated [DATE] documents a stage 3 pressure injury to R8's right inner ankle with 40% slough, scant serosanguinous drainage, measuring 5 mm (0.5 cm) long x 5 mm (0.5 cm) wide. R8's TAR for May 2025 documents R8 refused to wear heel boots 5 times between the dates of 5/1/25-5/31/25. R8's weekly wound assessment dated [DATE] documents a stage 3 pressure injury to R8's right inner ankle with 100% slough, small serous drainage, measuring 8 mm (0.8 cm) long x 8 mm (0.8 cm) wide. The wound was noted with bright red periwound and to be tender to the touch. A medical professional note dated 6/2/25 documents no calf tenderness, no edema (swelling), right (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindengrove Mukwonago	837 E Veterans Way Mukwonago, WI 53149

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medial ankle wound with slough at base, mild periwound erythema, no odor or purulent drainage. Continue topical treatment and monitor. R8's weekly wound assessment dated [DATE] documents a stage 3 pressure injury to R8's right inner ankle with 90% slough, scant serous drainage, measuring 8 mm (0.8 cm) long x 8 mm (0.8 cm) wide. No signs/symptoms of infection documented. R8's TAR for June 2025 documents R8 refused to wear heel boots 2 times between the dates of 6/1/25-6/13/25. A new physician order dated 6/13/25 documents heel protector boots BLE (bilateral lower extremities) when in bed. Chart refusals, if refuses float heels on pillows. R8's TAR for June 2025 documents R8 refused to wear heel boots 1 time between the dates of 6/13/25-6/30/25. Surveyor notes the order now offers an alternative to float the heels on a pillow if R8 refuses the heel protector boots. Surveyor notes R8's care plan is not revised to include this intervention. R8's weekly wound assessment dated [DATE] documents a stage 3 pressure injury to R8's right inner ankle with 90% slough, small serous drainage, measuring 6 mm (0.6 cm) long x 6 mm (0.6 cm) wide. R8's weekly wound assessment dated [DATE] documents a stage 3 pressure injury to R8's right inner ankle with epithelial tissue, granulation tissue, and slough but no percentages specified of each tissue type, measuring 5 mm (0.5 cm) long x 3 mm (0.3 cm) wide. R8's risk for malnutrition care plan was revised on 7/13/25 to include focus area pressure area to right ankle, healing potentially impacted by decline in condition and variable poor PO (by mouth) intake. The following intervention was initiated on 7/15/25:-provide and serve supplements as ordered: 240 ml (milliliters) Boost Breeze TID (three times per day) and Thrive Gelato (or Magic Cup) QD (daily). A nutrition/dietary note dated 7/14/25 documents stage 3 pressure are to right inner ankle showing improvement per 7/7/25 weekly skin report, area measures 0.5 cm x 04 cm, treatment in place. Continues to receive Ensure Clear TID (three times per day) and Magic Cup one time per day for added calories and protein. Healing and weight impacted by end of life/hospice care and primary goal of comfort. R8's TAR for July 2025 documents R8 refused to wear heel boots 4 times between the dates of 7/1/25-7/31/25. There is no documentation to support if R8 agreed to float her heels when she refused to wear the heel boots. R8's weekly wound assessment dated [DATE] documents a stage 3 pressure injury to R8's right inner ankle with 80% slough, scant serosanguinous drainage, measuring 4 mm (0.4 cm) long x 3 mm (0.3 cm) wide. R8's weekly wound assessment dated [DATE] documents a stage 3 pressure injury to R8's right inner ankle with 80% slough, scant serous drainage, measuring 5 mm (0.5 cm) long x 4 mm (0.4 cm) wide. A new treatment order with a start date of 8/15/25 documents apply Medihoney Wound and Burn Dressing External Paste to right medial foot topically in the evening every 3 days for pressure area, cover with foam dressing, monitor for s/x (signs/symptoms) of infection. R8's TAR documents this (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment was administered as ordered through 9/22/25 with no documented refusals of this treatment in this timeframe. R8's weekly wound assessment dated [DATE] documents R8's right inner foot as a stage 2 pressure injury with 80% slough present, scant serous (clear) drainage, and measures 5 mm (0.5 cm) long x 3 mm (0.3 cm) wide. Surveyor notes the facility back staged R8's right ankle pressure injury to a stage 2. In an interview on 12/10/25 at 12:54 PM, Wound RN-C confirmed a wound with slough present should be staged at a stage 3 and confirmed R8's wound assessment dated [DATE] did not have the accurate staging. A new physician order with start date of 8/20/25 documents maintain enhanced barrier precautions for wound. R8's weekly wound assessment dated [DATE] documents a stable stage 3 pressure injury to R8's right inner ankle measuring 1.3 cm long x 1.1 cm wide. Surveyor notes no percentage of tissue present specified. R8's TAR for August 2025 documents R8 refused to wear heel boots 2 times between the dates of 8/1/25-8/31/25. There is no documentation to support if R8 agreed to float her heels when she refused to wear the heel boots. R8's weekly wound assessment dated [DATE] documents a stable stage 3 pressure injury to R8's right inner ankle measuring 1.4 cm long x 1.2 cm wide. Surveyor notes no percentage of tissue present specified. A medical professional note dated 9/2/25 documents nursing staff noted redness around right ankle wound. Pt (patient) complaining of pain to the area with dressing changes, other pain is under control. Skin: right medial ankle wound with slough, periwound with erythema, tender to palpation. Continue topical treatment, start Keflex 500 mg (milligrams) PO (by mouth) BID (twice daily) for 7 days for wound infection. Surveyor notes R8's right ankle wound is now infected. A nursing note dated 9/4/25 documents resident continues oral antibiotic for right ankle wound. Erythema to wound with dressing C/D/I (clean/dry/intact). [R8] tolerating oral antibiotic well without adverse effects. Denies acute pain at rest and remains afebrile. R8's weekly wound assessment dated [DATE] documents an improved stage 3 pressure injury to R8's right inner ankle measuring 0.6 cm long x 0.6 cm wide. Surveyor notes no percentage of tissue present specified. A nutrition note dated 9/10/25 documents per 9/8/25 skin report, pressure are to right inner ankle is showing improvement, area measures 0.6 cm x 0.6 cm, antibiotic recently started. No recommendations at this time as skin integrity is improving with current plan. A nursing note dated 9/13/25 at 15:43 (3:43 PM) documents [R8] is alert and oriented to self, heel boots worn, wound to right inner foot with dressing intact. Currently on antibiotic for wound, no adverse effects. Complains of pain to wound and telling writer not to touch. Takes scheduled Tylenol, Fentanyl patch, and daily lido patch to neck. Appetite is fair, accepts supplements. A nursing note dated 9/13/25 at 20:41 (8:41 PM) documents antibiotic for foot wound has been (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed. Dressing is C/D/I. R8's weekly wound assessment dated [DATE] documents an improved stage 3 pressure injury to R8's right inner ankle measuring 0.9 cm long x 0.9 cm wide. Surveyor notes no percentage of tissue present specified. R8's weekly wound assessment dated [DATE] documents an improved stage 3 pressure injury to R8's right inner ankle measuring 0.7 cm long x 0.9 cm wide. Surveyor notes no percentage of tissue present specified. A new treatment order with a start date of 9/22/25 documents apply Hydrocol External Pad to right inner ankle topically in the morning every 5 days for pressure area, cover with foam dressing, and monitor for s/sx (signs/symptoms) of infection. The Medication Administration Record (MAR) documents this treatment was administered as ordered with no documented refusals of this treatment, and no signs or symptoms of infection were documented. A new treatment order with a start date of 9/26/25 documents apply Hydrocol External Pad to right inner ankle topically every 5 days at bedtime for pressure area, cover with foam dressing, and monitor for s/sx (signs/symptoms) of infection. R8's TAR documents this treatment was administered as ordered with no documented refusals of this treatment in this timeframe. R8's TAR for September 2025 documents R8 refused to wear heel boots 4 times between the dates of 9/1/25-9/30/25. There is no documentation to support if R8 agreed to float her heels when she refused to wear the heel boots. R8's weekly wound assessment dated [DATE] documents a stable stage 3 pressure injury to R8's right inner ankle measuring 0.8 cm long x 0.8 cm wide. Surveyor notes no percentage of tissue present specified. R8's weekly wound assessment dated [DATE] documents a stable stage 3 pressure injury to R8's right inner ankle measuring 0.6 cm long x 0.7 cm wide. Surveyor notes no percentage of tissue present specified. R8's weekly wound assessment dated [DATE] documents a stable stage 3 pressure injury to R8's right inner ankle measuring 0.9 cm long x 0.9 cm wide. Surveyor notes no percentage of tissue present specified. R8's weekly wound assessment dated [DATE] documents a stable stage 3 pressure injury to R8's right inner ankle measuring 0.9 cm long x 0.7 cm wide. Surveyor notes no percentage of tissue present specified. R8's weekly wound assessment dated [DATE] documents a stable stage 3 pressure injury to R8's right inner ankle measuring 0.8 cm long x 0.8 cm wide x 0.1 cm deep. Surveyor notes no percentage of tissue present specified. Surveyor notes this is the first time R8's right inner ankle is described as having depth present. R8's weekly wound tool provided after the survey exit dated 10/27/25 documents and unchanged stage 3 pressure injury to the right inner ankle that measures 8 mm x 8 mm x 01 mm, with epithelial tissue and 80% slough tissue present, scant serous drainage, with no odor. No changes to the treatment plan was documented, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8's Medication Administration Record (MAR) for October 2025 documents R8 was administered PRN morphine 0.5 milliliters (ml) by mouth on 10/4/25, 10/7/25, 10/15/25, and 10/20/25. R8's MAR documents R8 was administered PRN morphine 1 ml by mouth on 10/4/25, 10/8/25, and 10/12/25. R8's weekly wound assessment dated [DATE] documents a stage 3 pressure injury to R8's right inner ankle measuring 1.0 cm long x 0.7 cm wide x 0.1 cm deep. Surveyor notes no percentage of tissue present specified. In an interview on 12/10/25 at 12:50 PM, Wound RN-C stated Wound RN-C was not sure why the weekly wound assessments were not available in R8's EMR because Wound RN-C remembered completing the electronic forms weekly and has a system to check off her paper weekly assessment when the electronic record is updated. Wound RN-C stated the electronic wound assessment would have been updated to include tissue descriptions, but Wound RN-C's paper wound assessments only document the measurements and stages of the wound. Wound RN-C stated the facility's IT (information technology) department was looking into why the electronic wound assessments were missing from R8's EMR. R8's weekly wound tool provided after the survey exit dated 11/5/25 documents a worsening stage 3 pressure injury to the right inner ankle with 80% slough, scant serous drainage, measuring 10 mm X 7 mm x 1, red blanchable peri wound and wound progress is stable and no change to the treatment. R8's weekly wound assessment dated [DATE] documents R8's right inner ankle wound is a unchanged stage 3 pressure injury with 100% slough, scant serous drainage, and measures 8 mm (0.8 cm) long x 8 mm (0.8 cm) wide x 1 mm (0.1 cm) deep. No signs or symptoms infection or inflammation were documented. A nursing progress note dated 11/15/25 documents resident received bed bath due to increased pain, combative. Dressings C/D/I (clean/

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility did not ensure 1 (R40) of 2 residents received adequate supervision and assistance devices to prevent accidents.* R40's fall on 11/16/25 was not thoroughly investigated and a root cause was not determined to help prevent further falls. On 12/9/25 & 12/10/25, Dycem was not observed on R40's wheelchair per R40's falls plan of care.Findings include:The facility's policy titled, Falls and last reviewed 5/8/25 documents under the policy section: Prevention measures are put in place to reduce the occurrence of falls and risk of injury from falls.R40's diagnoses include dementia (loss of cognitive function that interferes with a person's daily life and activities), hypertension (high blood pressure), and anxiety (emotional response involving feelings of worry, dread, and tension often accompanied by physical symptoms like a racing heart or sweating).R40's annual MDS (minimum data set) with an assessment reference date of 8/27/25 has a BIMS (brief interview mental status) score of 7 which indicates severe cognitive impairment. The MDS documents that: R40 is assessed as being dependent for rolling left and right & toileting hygiene and requiring substantial/maximal assistance for bed/bed to chair transfer and toilet transfer. R40 is frequently incontinent of urine and occasionally incontinent of bowel. R40 has fallen since prior assessment with one fall no injury.R40's fall CAA (care area assessment) dated 9/3/25 documents under the care plan consideration section: CAA triggered for falls due to risk factors resulting from balance problems: Not steady, needs assistance for moving from seated to standing position, moving on and off toilet and surface-to-surface transfer; Resident receives physician ordered anti-depressant medications, Refer to MAR (medication administration record). Resident has fall history. Resident has had one fall without injury during this assessment period, refer to DQI documentation. Nursing staff assists resident with ADLs (activities daily living) as needed according to facility policy. Resident is at risk for fall related injury. No referrals at this time, will proceed to care plan with goal to have no fall related injuries.R40's resident is moderate risk for falls care plan initiated 12/21/23 & revised 8/27/25 documents the following interventions:*Anticipate and meet the resident's needs. Initiated 8/23/24.*Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Initiated & revised 8/23/24.*Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Initiated 8/23/24.*PT/OT (physical therapy/occupational therapy) evaluate and treat as ordered or PRN (as needed). Initiated 8/23/24.*Provide reminders for resident to call for assist with transfers from w/c. Lock w/c brakes for resident. Initiated 8/27/24.*Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Initiated 3/21/25.*Ensure that the resident is wearing appropriate footwear\describe correct client footwear i.e. brown leather shoes, tartan bedroom slippers, black non-skid socks) when ambulating, transferring or mobilizing in w/c (wheelchair). Initiated 3/21/25 & revised 3/28/25.*The resident needs activities that minimize the potential for falls while providing diversion and distraction. Initiated 3/21/25 and revised 3/28/25.*The resident needs a safe environment with: (even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; personal items within reach). Initiated 3/21/25 and revised 3/28/25.*Reminder signs placed in bathroom for resident to call for assist with toilet transfers. Initiated 3/28/25.*Offer recliner after dinner. Initiated 9/10/25.*The resident needs to be evaluated for and supplied\adaptive equipment or devices as needed). And as needed for continued appropriateness and to ensure least restrictive device or restraint. Initiated and revised 9/10/25*Dysem on w/c cushion. Initiated 11/17/25.R40's Visual/Bedside Kardex Report as of 12/10/25 under the resident care section includes Dysem on w/c cushion.R40's fall risk evaluation dated 8/27/25 has a score of 17 which indicates at risk. R40's fall risk evaluation has a score of 13 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which indicates at risk.R40's nurses note dated 11/16/25, at 2012 (8:12 p.m.), and written by Licensed Practical Nurse (LPN)-E documents Resident found on floor in-between bed and window leaning up against wheelchair. Call light within reach proper footwear worn. Resident stated: I was trying to sit up and I slipped. No noted injury VSS (vital signs stable) denies pain. Writer CNA (Certified Nursing Assistant) RN (Registered Nurse) assisted resident off floor into wheelchair. [Name] RN nurse supervisor aware updated stated will call POA (Power of Attorney) [Name] to update. [Physician's name] updated.On 12/8/25, at 9:44 a.m., Surveyor observed R40 sitting in a wheelchair in her room. Surveyor observed there is a cushion in R40's wheelchair and R40 is wearing gripper socks on her feet. Surveyor asked R40 how she was doing. R40 stated trying to get warm. Surveyor observed a blanket on R40's recliner chair and asked R40 about the blanket. R40 stated that's for my baby. Surveyor observed a small stuffed dog wrapped in the blanket. On 12/8/25, at 12:55 p.m., Surveyor observed R40 propelling herself in the wheelchair by moving her feet out of the lounge area by the dining room.On 12/8/25, at 3:38 p.m., Surveyor observed R40 propelling herself in the wheelchair by moving her feet out of her room. R40 stated she wants a gown. R40 then stated to Surveyor you want a warm one? I'll look at her boxes another time. On 12/9/25, at 7:17 a.m., Surveyor observed R40 sleeping in bed on her back. Surveyor observed R40's bed is in the low position and the call light is within reach. Surveyor checked R40's wheelchair for Dycem. Surveyor did not observe Dycem on top or under the cushion in R40's wheelchair.On 12/9/25, at 8:07 a.m., Surveyor observed R40 propelling herself in the wheelchair by moving her feet. R40 is wearing gripper socks on her feet. R40 asked Surveyor if she should go down for dinner.On 12/9/25, at 9:48 a.m., Surveyor observed R40 sitting in a wheelchair in her room wearing gripper socks on her feet. R40 informed Surveyor she's waiting for her brother to call.On 12/9/25, at 10:57 a.m., Surveyor observed R40 sitting in a wheelchair facing R40's bed wrapping up items in napkins. Surveyor asked R40 what she was doing. R40 informed Surveyor she's wrapping up two tablespoons, started talking nonsensical, and then stated to Surveyor I haven't' seen my boyfriend since spring.On 12/9/25, at 1:02 p.m., Surveyor observed R40 sitting in the wheelchair in the dining room eating lunch.On 12/10/25, at 8:08 a.m., Surveyor observed R40 sitting in a wheelchair at the dining room table with her head down and appears to be sleeping.On 12/10/25, at 12:38 p.m., Surveyor reviewed the facility's investigation for R40's fall on 11/16/25 which consisted of a three-page incident report dated 11/16/25 20:15 (8:15 p.m.) and neurological flow sheet. The incident report dated 11/16/25 under the incident description section for nursing description documents Resident found on floor in-between bed and window leaning up against wheelchair. Call light within reach proper footwear worn. For resident description documents Resident stated: I was trying to sit up and I slipped. Under notes documents 11/17/25 IDT (interdisciplinary team) met to assess fall; resident slid from w/c. Dysem placed on seat of W/C. Surveyor noted the facility did not conduct a thorough investigation as the facility investigation does not include any staff statements or evidence staff were interviewed, there is no root cause, and there is no evidence prior interventions were in place to prevent this fall from occurring.On 12/10/25, at 1:10 p.m., Surveyor observed R40 sitting in a wheelchair in the area where the medication carts are along the wall outside the dining area.On 12/10/25, at 1:27 p.m., Surveyor asked Certified Nursing Assistant (CNA)-L what she does for R40. CNA-L informed Surveyor she gets her cleaned up, sometimes it takes two staff depending on R40, toilets R40, gets her to the dining room, and R40 goes back on her own to her room to watch TV. CNA-L informed Surveyor R40 needs reminders, we toilet, get R40 ready for bedtime and ready for during the day. Surveyor asked CNA-L how often R40 is toileted. CNA-L replied three times a shift, get up, before and after lunch. Surveyor informed CNA-L Surveyor knows R40 has a cushion in the wheelchair and inquired if she has Dycem. CNA-L replied I think she has a cushion and nothing underneath it. Surveyor asked CNA-L when she would be toileting R40. CNA-L informed Surveyor she will take her now. At 1:30 p.m. Surveyor observed CNA-L inform R40 she's going to take her to her room and to the bathroom. At 1:31 p.m. CNA-L wheeled R40 into her room asking R40 if she wants to try going onto the toilet. R40 asked CNA-L what's that? CNA-L asked (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	do you have to go potty. At 1:33 p.m. CNA-L placed gloves on, removed the foot pedal, and locked the brakes on R40's wheelchair. CNA-L placed a gait belt around R40, asked R40 if she was ready stating going to get on the toilet, ready one, two, three, and stood R40 up. R40 slowly turned with CNA-L's encouragement, CNA-L stated to R40 wait I need to pull down your drawers but R40 sat on the toilet. CNA-L stated to R40 before you go need to stand up, you're on the toilet. CNA-L stood R40 up, pulled down pants & product and R40 sat on the toilet. At 1:37 p.m. CNA-L asked Surveyor if Surveyor wants to look under the cushion and lifted up R40's cushion. Surveyor did not observe dycem on top or under R40's wheelchair cushion per the plan of care.On 12/10/25, at 1:45 p.m., Surveyor informed Director of Nursing (DON)-B the facility did not conduct a thorough investigation as the facility investigation does not include any staff statements or evidence staff were interviewed, there is no root cause, and there is no evidence prior interventions were in place to prevent this fall from occurring. DON-B informed Surveyor she's sure there are staff statements and will look for the staff statements. Surveyor informed DON-B of Surveyor's observations of R40 not having Dycem either on top or under R40's wheelchair cushion. DON-B informed Surveyor she placed the Dycem in R40's wheelchair herself. Surveyor informed DON-B Surveyor did not observe the Dycem and when Surveyor asked CNA-L about the Dycem Surveyor was informed there is a cushion but nothing under.On 12/10/25, at 2:12 p.m., DON-B provided Surveyor with two staff statements. Surveyor reviewed the statements provided. Although the facility obtained staff statements the facility did not conduct a thorough investigation as there is no evidence prior interventions were in place and the facility did not determine a root cause.No additional information was provided as to why R40 did not have Dycem under his wheelchair cushion per R40's plan of care or why the facility did not conduct a thorough investigation as there is no evidence prior interventions were in place and the facility did not determine a root cause for R40's fall on 11/16/25.

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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, interview and record review, the facility did not ensure that 2 (R54, R3) of 2 received urinary catheter care in accordance with standards of practice. *R54's foley catheter bag was observed directly on the floor without a protective barrier. R54's foley catheter order did not specify the proper size of catheter or the proper balloon inflation size. *R3's foley catheter order did not specify the proper size of catheter or the proper balloon inflation size. Findings include: 1.) R54 was admitted to the facility 12/5/2025 with diagnoses including Bladder Cancer, Obstructive Sleep Apnea (a sleep disorder which causes one to stop breathing for periods of time) and Diabetes Mellitus. On 12/8/2025 at 9:45 AM, Surveyor observed R54 in a reclining chair in their room. Surveyor observed R54's foley catheter bag on the floor without a protective cover or barrier. On 12/08/2025 at 11:54 AM, Surveyor observed R54 in a reclining chair in their room. Surveyor observed R54's foley catheter bag on the floor without a protective cover or barrier. On 12/08/2025 at 1:05 PM, Surveyor observed R54 in a reclining chair in their room. Surveyor observed R54's foley catheter bag on the floor without a protective cover or barrier. On 12/9/2025 at 1:25 PM, Surveyor conducted interview with Licensed Practical Nurse (LPN)- T. Surveyor asked LPN-T if a resident with a foley catheter bag should have some sort of protective cover over it. LPN-T responded that foley catheter bags should always be covered and kept off the floor. On 12/9/2025, Surveyor reviewed R54's electronic medical record. R54's Minimum Data Set (MDS) admission Assessment and Comprehensive Care plans had not yet been completed. Surveyor noted a physician's order documenting the following: Catheter Care- every shift, provide catheter care. Surveyor did not observe any physician order for R54's foley catheter specifying the proper size of the catheter or the proper balloon inflation size. On 12/09/2025 at 3:10 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B regarding observations of R54's foley catheter without a cover or protective barrier on 12/8/2025. Surveyor shared concern that they did not observe any physician order for R54's foley catheter specifying the proper size of the catheter or the proper balloon inflation size. No additional information was provided at this time. 2.) R3 was admitted to the facility on [DATE] with diagnoses of History of Urinary Tract Infections, Retention of Urine, and Presence of Urogenital Implants (medical devices or injectable materials used (continued on next page)

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	525645	A. Building B. Wing	12/10/2025

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Lindengrove Mukwonago	837 E Veterans Way Mukwonago, WI 53149

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to restore urinary or sexual function). R3's Quarterly Minimum Data Set (MDS) dated [DATE] documented R3 had a Brief Interview of Mental Status (BIMS) score of 10, which indicated R3 had moderate cognitive impairment and decision making. R3 requires set up assistance to eat and perform oral hygiene. R3 is completely dependent with all cares: toileting, showering, dressing, all other hygiene, changing positions (sit to lay, roll left and right in bed, and sit to stand.) R3 is incontinent of bowel and has a urinary catheter. R3's Annual MDS on 6/13/25 CAA (Care Area Assessment) Triggered Urinary incontinence and indwelling catheter due to R3 being dependent on toilet hygiene, toilet transfer and patient having an indwelling catheter. The CAA also documents CAA triggered due to resident has indwelling Foley catheter. Requires extensive assist of one person for toileting. Is that a risk for skin rashes, skin breakdown, falls, isolation, urinary infection. No referrals at this time. Will proceed to care plan. R3's Physician orders document: Catheter – care every shift provide catheter care start 5/22/25; May irrigate foley catheter with 60ML of normal saline as needed PRN for occlusion start date 9/22/25; Monitor catheter output every shift start date 5/22/25; Change drainage bag every night shift every two weeks on Friday date bag when changing start date 10/17/25. R3's Comprehensive care plan documented: The resident has indwelling catheter: pressure ulcer coccyx neurogenic bladder. Date initiated 9/12/25. Under the intervention section it documents: Monitor for signs and symptoms of discomfort on urination and frequency. Date initiated 5/22/25; Monitor and document for pain and discomfort due to catheter. Date initiated 5/22/25.; Monitor and record and 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, changing behavior, changing eating patterns. Date initiated 5/22/25. Surveyor noted R3 does not have an order stating what size foley or how much to inflate the foley balloon in R3's orders or care plan. On 12/9/25, at 11:35 AM, Surveyor interviewed RN-M who stated when inserting a new foley catheter, RN-M would look at R3's physician orders to know what size catheter to use and how much fluid to inflate the foley catheter balloon to. RN-M went to review R3's orders and was not able to locate an order for balloon amount and foley size. RN-M stated I don't know what to tell you, it's (the balloon amount and foley size) usually in the MAR (medication administration record). RN-M also checked R3's paper charting and was unable to locate the information. On 12/9/25 at 12:01 PM, Surveyor interviewed LPN-T who stated when inserting a new foley catheter, LPN-T would look at R3's physician orders to know what size catheter to use and how much fluid to inflate the foley catheter balloon to. LPN-T stated if there is not an order then it would be based on policy what size catheter to use and how much to fill the catheter balloon. LPN-T does not know what they policy states for what size foley and balloon amount on the facility's policy. Surveyor noted that foley size and balloon amount is not listed in the facility's policy for urinary catheters. On 12/9/25 at 12:08 PM, Surveyor interviewed LPN-H who stated when inserting a new foley catheter, LPN-H would look at R3's physician orders to know what size catheter to use and how much (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fluid to inflate the foley catheter balloon to. LPN-H stated that to their knowledge there is not a policy that indicates what foley size or balloon amount to use if there is no order. LPN-H stated that the facility does not just make things up, the facility goes off of the physician orders. On 12/10/25, at 8:55 AM Surveyor noted R3 had a new physician order that documented: - Indwelling Foley catheter_changed on 12/3/25 with 16F5CC balloon. Start date 12/9/25 5:47 PM. - Foley catheter change PRN for signs and symptoms of not functioning. Start date 12/9/25 5:47 PM. These orders were placed by DON-B on 12/9/25. On 12/10/25 at 10:48 AM, Surveyor interviewed RN-J who stated when inserting a new foley catheter, RN-J would look at R3's physician orders to know what size catheter to use and how much fluid to inflate the foley catheter balloon to. RN-J stated the facility will mirror whatever the hospital's orders are for the foley size and balloon amount. If a new order is needed, RN-J stated RN-J would call MD-Q or NP-D to place a new order for the foley size and balloon amount. On 12/10/25 at 2:17 PM, Surveyor interviewed DON-B who stated when inserting a new foley catheter, DON-B expects nurses to look at the patient's foley that is currently inserted to know what size catheter to use and how much fluid to inflate the foley catheter balloon to. Surveyor informed DON-B that the nurses interviewed stated they would look for the physician orders to verify correct foley size and balloon amount. DON-B and Regional Nurse Consultant (RNC)- P both stated they have never seen an order that stated foley catheter size and balloon amount and DON-B and RNC-P personally have always looked at the foley that is currently inserted in the patient for that information. On 12/10/25, at 2:17 PM Surveyor shared the concern of R3 not have foley catheter size and balloon inflation amount in an order for the nurses to reference when placing a new foley catheter with DON-B and RNC-P. No additional information was provided.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, the facility did not ensure that 2 of 2 (R54, R1) received respiratory treatment in accordance with standards of practice. *R54's Continuous Positive Air Pressure (CPAP) device did not have physician's orders in place regarding proper settings or maintenance of their CPAP device. *R1 did not receive oxygen therapy in accordance with their physician's orders. Findings include: The facility's policy and procedure titled Standard Respiratory Protocol with no listed date documents: Problem: Impaired or potential impairment of gas exchange r/t (related to) chronic respiratory disease.Apply oxygen, CPAP as ordered. 1.) R54 was admitted to the facility 12/5/2025 with diagnoses including Obstructive Sleep Apnea (a sleep disorder which causes one to stop breathing for periods of time), Bladder cancer and Diabetes Mellitus. On 12/8/2025 at 10:04 AM, Surveyor observed R54 to have a CPAP machine at their bedside. Surveyor asked R54 if they receive assistance with their CPAP machine at hours of sleep. R54 responded that the nurses take care of that for them. On 12/9/2025 at 1:25 PM, Surveyor interviewed Licensed Practical Nurse (LPN)- T. Surveyor asked LPN-T what procedures would be followed for a resident who admits to the facility with a CPAP machine. LPN-T responded that the CPAP orders and settings should be put into the electronic medical record so nursing staff would know how the CPAP machine should be set up. Surveyor asked LPN-T if there should be orders in place for the cleaning and maintenance of a CPAP machine. LPN-T responded that there should be orders for each CPAP to be cleaned routinely. On 12/9/2025, Surveyor reviewed R54's electronic medical record. R54's Minimum Data Set (MDS) admission Assessment and Comprehensive Care plans had not yet been completed. Surveyor noted a physician's order documenting the following: CPAP, assist with placement and function QHS (at bedtime). Surveyor could not identify any physician's orders regarding cleaning or maintenance of R54's CPAP machine. On 12/09/2025 at 3:10 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B regarding missing physician's orders regarding the proper settings and cleaning and maintenance of R54's CPAP machine. No additional information was provided. 2.) R1's diagnoses includes chronic respiratory failure with hypoxia (low levels of oxygen in body tissues), chronic obstructive pulmonary disease (group of lung disease that block airflow and make it difficult to breath), congestive heart failure (heart doesn't pump enough blood to meet the body's needs), dementia (loss of cognitive function that interferes with a person's daily life and activities), and anxiety (emotional response involving feelings of worry, dread, and tension often accompanied by physical symptoms like a racing heart or sweating). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's oxygen therapy care plan initiated 12/28/23 & revised 11/23/25 documents the following interventions: *Encourage or assist with ambulation as indicated. Initiated 12/28/23. *Give medications as ordered by physician. Monitor/document side effects and effectiveness. Initiated 12/28/23. *Monitor for s/sx (signs/symptoms) of respiratory distress and report to MD (medical doctor) PRN (as needed): Respirations, Pulse oximetry, increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. Initiated 12/28/23. *OXYGEN SETTINGS: O2 (oxygen) via nasal prongs @ (at) 2L (liters) continuous. Humidified. Initiated & revised 12/28/23. *Resident has her own portable concentrator. Initiated 12/28/23. R1's significant change MDS (minimum data set) with an assessment reference date of 9/18/25 has a BIMS (brief interview mental status) score of 6 which indicates severe cognitive impairment. The MDS documents: Yes, is marked for oxygen while a resident for R1. R1's physician orders include an order with an order date of 9/19/25 of O2 (specify liter) per NC (nasal cannula) prn to keep sats (saturations) > (greater) 88% every shift. R1's physician orders include an order with an order date of 9/19/25 of check pulse ox monthly (every 4 weeks) on Sunday evening. Surveyor reviewed R1's TAR (treatment administration record) & under the weight/vital tab and noted R1's pulse ox was not checked according to physician orders on 10/19 & 10/26. R1's physician orders include an order dated 10/17/25 which documents: Change humidifier air canister every night shift every Friday. On 12/8/25, at 9:24 a.m., Surveyor observed R1 sitting on the edge of the bed with R1's left leg extended and resting on the cushion in R1's wheelchair. R1 is receiving oxygen via nasal cannula. Surveyor observed R1's oxygen is set at 2.5 liters and there is not a humidifier bottle. On 12/9/25, at 7:13 a.m., Surveyor observed R1 sitting on the edge of the bed drinking coffee. R1 has oxygen via nasal cannula which is set at 2.5 liters. Surveyor did not observe a humidifier bottle on the concentrator. On 12/9/25, at 8:10 a.m., Surveyor observed R1 sleeping on the left side with her knees bent. R1's head of the bed is elevated high and is receiving oxygen at 2.5 liters via nasal cannula. Surveyor did not observe a humidifier bottle on the concentrator. On 12/9/25, at 9:50 a.m., Surveyor observed R1 sleeping on the left side. R1 is receiving oxygen via nasal cannula at 2.5 liters. Surveyor observed there is not a humidifier bottle on the oxygen concentrator. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/25, at 10:55 a.m., Surveyor observed R1 awake in bed with the head of the bed up high. R1's nasal cannula is on the bridge of R1's nose. Surveyor observed R1's concentrator is set at 2.5 liters and there is not a humidifier bottle. On 12/9/25, at 12:56 p.m., Surveyor observed R1 sitting on the edge of the bed. R1 is receiving oxygen via nasal cannula at 2.5 liters. Surveyor observed there is not a humidifier bottle on the oxygen concentrator. On 12/9/25, at 11:14 a.m., Surveyor asked Registered Nurse (RN)-M if R1 should have a humidifier bottle on R1's oxygen. RN-M replied I don't think so but let me look, maybe she does. RN-M then checked R1's orders and stated to Surveyor there is an order to change it so I would say yes. On 12/9/25, at 11:16 a.m., RN-M accompanied Surveyor to R1's room to check R1's oxygen concentrator. RN-M stated it's not there, referring to the humidifier bottle, and then showed Surveyor the humidifier bottle which is located on a piece of furniture in R1's bathroom. Surveyor asked RN-M how many liters should R1's oxygen be set at. RN-M replied I think 2. Surveyor asked RN-M what is R1's oxygen set at. RN-M replied 2.5. On 12/9/25, at 11:20 a.m., Surveyor asked Director of Nursing (DON)-B if a resident's physician orders document the liters of oxygen a resident is to receive. DON-B asked Surveyor like a specific liter flow and informed Surveyor it's a range whatever the physician says it should be. DON-B stated facility staff would have to check oxygen saturation and titrate oxygen administration. Surveyor informed DON-B R1's physician order documents specify liter and R1's care plan documents 2 liters. DON-B informed Surveyor R1 is pretty independent with her oxygen. Surveyor informed DON-B Surveyor has noted R1's oxygen set at 2.5 liters. Surveyor asked DON-B how often is R1's oxygen saturation is checked. DON-B informed Surveyor that R1 does not have routine monitoring like every four hours. Surveyor informed DON-B Surveyor has not observed a humidifier bottle on R1's oxygen concentrator according to R1's physician orders. On 12/10/25, at 8:18 a.m., Surveyor observed R1 sitting on the edge of the bed eating breakfast. Surveyor observed R1 is receiving oxygen at 2.5 liters via nasal cannula. Surveyor did not observe a humidifier bottle on the oxygen concentrator. On 12/10/25, at 8:22 a.m., DON-B informed Surveyor the night nurse said R1 refused the humidifier bottle. Surveyor informed DON-B Surveyor did not note any documentation in R1's medical record regarding R1 refusing the humidifier bottle and there isn't a care plan regarding refusals. DON-B informed Surveyor she's going to care plan the refusal. No additional information was provided.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review the facility did not ensure 1 (R1) of 1 resident have consistent pre & post dialysis communication and are monitored for complications for residents whom receive dialysis treatments. Findings include:The facility's policy dated as last reviewed 8/7/25 and titled, Dialysis documents under the Policy section: The care for a individual receiving dialysis will be coordinated and communicated between the Skilled Nursing Facility (SNF) and the relevant dialysis staff. Under the Procedure section it documents: A. An individual Care Plan will be developed/revised in the SNF in collaboration with information provided by the relevant dialysis facility. Individual record will reflect up to, and including: 1. Identified of individualized risk factors and potential complications related to dialysis; 2. Choices or preferences including advanced directives if any; 3. Medical status including status of comorbid conditions, frequency of vital signs, weights, and monitoring of fluids as ordered:.B. Individual record will reflect the coordination and collaboration with the relevant dialysis facility including exchange of pertinent information before, during, and post dialysis including emergency protocol contaction sic (contact) information.R1's diagnoses includes end stage renal disease (kidneys permanently have lost almost all their ability to function), dependence on renal dialysis, dementia (loss of cognitive function that interferes with a person's daily life and activities), and anxiety (emotional response involving feelings of worry, dread, and tension often accompanied by physical symptoms like a racing heart or sweating).R1?s significant change MDS (minimum data set) with an assessment reference date of 9/18/25 has a BIMS (brief interview mental status) score of 6 which indicates severe cognitive impairment.R1's resident needs dialysis hemodialysis r/t (related to) renal failure care plan initiated 12/21/23 and revised 11/23/25 documents the following interventions:*Do not draw blood or take B/P (blood pressure) in arm with graft. Initiated 12/21/23.*Encourage resident to go to the scheduled dialysis appointments. Resident receives dialysis M-W-F (Monday-Wednesday-Friday), chair time 1200 (12:00 p.m.). Initiated & revised 12/21/23.*Monitor dry skin and apply lotion as needed. Initiated 12/21/23.*Monitor labs and report to doctor as needed. Initiated 12/21/23.*Monitor/document/ report PRN (as needed) for s/sx (signs/symptoms) of renal insufficiency: changes in level of consciousness, changes in skin tugor, oral mucosa, changes in heart and lung sounds. Initiated 12/21/23.*Monitor/document/report PRN new/worsening peripheral edema. Initiated 12/21/23.Surveyor noted R1's dialysis care plan does not include an intervention to monitor R1's access site for complications such as bleeding.R1's physician orders include an order with an order date of 9/11/25 of Resident has dialysis M-W-F (Monday-Wednesday-Friday), make sure dialysis binder is sent with resident. In the morning every Mon, Wed, Fri.Surveyor reviewed R1's November 2025 & December 2025 TAR (treatment administration record) and noted on each dialysis day R1's physician order to make sure dialysis binder is sent with resident is checked & initialed as being completed.R1's physician orders date of 9/12/25 document: Send a bag lunch with resident on dialysis days, chart refusals if resident declines to take the lunch with her. In the morning every Mon, Wed, Fri send bag lunch to dialysis, M-W-Fri, chart refusals.On 12/8/25, at 9:24 a.m., Surveyor observed R1 sitting on the edge of the bed with R1's left leg extended and resting on top of the wheelchair cushion. Surveyor asked R1 if she has any plans for today. R1 informed Surveyor she has dialysis.On 12/8/25, at 10:04 a.m., Surveyor observed R1 being wheeled out of her room by a Certified Nursing Assistant (CNA). R1is wearing a coat & an blanket is covering R1's lap & legs.On 12/8/25, at 3:45 p.m., Surveyor observed R1 sitting in a wheelchair with her coat on outside the nursing office by the counter.On 12/9/25, at 9:53 a.m., Surveyor asked Registered Nurse (RN)-M where Surveyor would be able to locate R1's dialysis binder. RN-M informed Surveyor she's not sure and then went to ask Licensed Practical Nurse (LPN)-H. On 12/9/25, at 9:54 a.m., RN-M stated to Surveyor I'll check her room as I don't see it in here, referring to the nursing office. Surveyor observed LPN-H checking the cabinets where the counter is.On 12/9/25, at 9:55 a.m., LPN-H informed Surveyor she not finding R1's binder and saw it a couple weeks ago.On (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/9/25, at 9:56 a.m., RN-M provided Surveyor with R1's dialysis binder informing Surveyor the binder was in R1's room.On 12/9/25, at 9:57 a.m., Surveyor reviewed the white dialysis binder provided by RN-M. Surveyor noted the outside of the binder is labeled 2024 [R1's name] Dialysis Communication Binder. Surveyor noted there are multiple blank dialysis/nursing facility communication forms in the binder. The top portion has instructions which indicates the nursing facility completes the top portion of the form prior to resident's dialysis treatment and sends with resident for each treatment. The top portion includes name of facility, facility address, facility telephone number, weight, vital signs, labs, etc. The bottom portion is completed by the dialysis unit at the end of treatment. A copy is for the dialysis record and the original is sent back to the nursing facility. Surveyor noted there are no forms for 2025. There are two sheets for 2024. For one sheet the top portion was not completed by the nursing facility and the bottom portion of the form was completed by the dialysis center with a date of 11/13/24. The second sheet has only the facility name, address, and phone number completed on the top portion of the form and the bottom section was completed by the dialysis center with a date of 1/17/24.On 12/9/25, at 10:10 a.m., Surveyor asked RN-M where R1's dialysis communication sheets for 2025 would be as R1's dialysis binder only has two sheets from 2024. RN-M informed Surveyor she didn't know. Surveyor asked RN-M if there is a nursing manager for the unit. RN-M informed Surveyor the first name of Director of Nursing (DON)-B.On 12/9/25, at 10:13 a.m. Surveyor asked RN-M how they communicate with the dialysis center for R1. LPN-H, who was with RN-M, stated sometimes the dialysis center gives us a call. If we need to give an update, we call the dialysis center like when R1 was hospitalized . RN-M informed Surveyor they also call for any medication changes. LPN-H informed Surveyor they don't call the dialysis center every Monday, Wednesday, and Friday. Surveyor asked where Surveyor would be able to locate monitoring for complications with R1's fistula. LPN-H replied probably progress notes. RN-M stated there isn't a specific place so probably nurses notes.During R1's record review, Surveyor did not note monitoring for complications of R1's fistula in the nurse's notes.On 12/9/25, at 10:16 a.m., Surveyor asked DON-B how the facility communicates with the dialysis center for R1. DON-B informed Surveyor R1 has a binder that goes back and forth with R1 and by phone call. The dietitian communicates with the dialysis center for weights. Surveyor asked DON-B what's in the binder. DON-B replied pretty much charting by exception explaining there is a place where the nurses can write vitals and labs. DON-B informed Surveyor this is only completed if there is something out of the ordinary, they (the dialysis center) need to know about. Surveyor asked DON-B where Surveyor would be able to locate monitoring for complications of R1's fistula such as bleeding. DON-B informed Surveyor it would be in R1's TAR. Surveyor asked DON-B if she could look at R1's TAR to see if the monitoring is documented. DON-B reviewed R1's TAR and stated to Surveyor it's not in the TAR. DON-B informed Surveyor she doesn't have an answer right this minute and she's trying to see if it fell off when R1 went to the hospital. DON-B informed Surveyor she will put it in right now. Surveyor informed DON-B R1's dialysis binder Surveyor was provided with only had two communication sheets from 2024. Surveyor informed DON-B Surveyor is unable to locate communication between the facility and the dialysis center for R1. There is no monitoring of R1's fistula for complications such as bleeding in R1's MAR/TAR (medication administration record/treatment administration record) or any where else in R1's medical record. R1's care plan does not address complications of R1's fistula. After Surveyor spoke with DON-B, Surveyor noted an order with an order date of 12/9/25 of Monitor dialysis site for s/sx (signs/symptoms) of infection or bleeding daily left arm every shift for bruit and thrill. R1's dialysis care plan was also revised to include an intervention to Monitor/document/report PRN any s/sx of infection to access site: Redness, Swelling, warmth or drainage initiated 12/9/25.On 12/10/25, at 9:45 a.m., DON-B informed Surveyor the binder Surveyor asked about is not how they communicate with the dialysis center. DON-B informed Surveyor they email them, they call, we call, that is the most preferred method. DON-B informed Surveyor their dietitian meets with dialysis once a month. DON-B informed Surveyor the binder has the risk to get lost and a phone call is the best outcome when they need to talk about (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1. DON-B informed Surveyor she did print some communication the facility did with the dialysis center and provided these to Surveyor. Surveyor reviewed the information provided by DON-B and noted a nurses notes dated 10/20/25, 9/23/25, & 9/12/25. Nutrition/Dietary notes written by the dietitian with communication to the dialysis center dated 11/11/25, 10/14/25, 9/25/25, 9/22/25, 8/26/25, 7/14/25, 7/10/25, 7/8/25, 4/22/25, 6/7/24, 3/25/23, and 3/16/23. There is a nutritional note from the dialysis center dated 11/10/25 & a home medication reconciliation from the dialysis center dated 11/17/25.Surveyor informed DON-B prior to providing Surveyor with this information Surveyor did note multiple notes from the dietitian. Surveyor informed DON-B there is a physician order regarding a binder and the communication sheets inside this binder if completed provide assessment prior to and after treatment. Surveyor informed DON-B the facility was not monitoring for complications for R1's fistula.No additional information was provided.