STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525654	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Lakeside	1016 Lakeshore Dr Rice Lake, WI 54868

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident receives treatment and care in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) for 1 of 12 residents (R) reviewed (R46.) Beginning 03/03/26, R46 presented with a change of condition including shortness of breath, difficulty breathing, and continuous use of a Continuous Positive Airway Pressure (CPAP) machine. The facility failed to assess R46 with the change in condition, failed to notify the provider of R46's change in condition, failed to complete respiratory assessments as per provider order, and failed to implement new care plan interventions. These failures resulted in R46 being transferred to a higher level of care and being diagnosed with a Pulmonary Embolism (PE) requiring a pulmonary artery thrombectomy (an invasive or surgical procedure to remove blood clots from the pulmonary arteries.) The facility's failure to provide care consistent with standards of practice for R46 by not performing comprehensive assessments when R46 had a change in condition with shortness of breath, difficulty breathing, and continuous all-day use of the CPAP machine created a finding of immediate jeopardy that began on 03/03/26. Nursing Home Administrator (NHA) A and Director of Nursing (DON) B were informed of the immediate jeopardy on 04/06/26 at 3:57 PM. The immediate jeopardy was removed on 04/07/26, however the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan.Findings include:According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process:(a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis.(b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis.(c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants.(d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. Website on AskMayoExpert. Pulmonary embolism (adult). Mayo Clinic; 2022. https://www.mayoclinic.org/diseases-conditions/pulmonary-embolism/symptoms-causes/syc-20354647) that states, . A pulmonary embolism is a blood clot that blocks and stops blood flow to an artery in the lung. In most cases, the blood clot starts in a deep vein in the leg and travels to the lung. Rarely, the clot forms in a vein in another part of the body. When a blood clot forms in one or more of the deep veins in the body, it's called a deep vein thrombosis (DVT).Because one or more clots block blood flow to the lungs, pulmonary embolism can be life-threatening. However, prompt treatment greatly reduces the risk of death. Common symptoms include:Shortness of breath. This symptom usually appears suddenly. Trouble catching your breath happens even when resting and worsens with physical activity.Chest pain. You may feel like you're having a heart attack. The pain is often sharp (continued on next page)

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

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and felt when you breathe in deeply. The pain can stop you from being able to take a deep breath. You also may feel it when you cough, bend or lean over.Fainting. You may pass out if your heart rate or blood pressure drops suddenly. This is called syncope.Other symptoms that can occur with pulmonary embolism include:A cough that may include bloody or blood-streaked mucusRapid or irregular heartbeatLightheadedness or dizzinessExcessive sweatingFeverLeg pain or swelling, or both, usually in the back of the lower legClammy or discolored skin, called cyanosisWhen to see a doctorA pulmonary embolism can be life-threatening. Seek urgent medical attention if you experience unexplained shortness of breath, chest pain or fainting.) Facility policy titled, Notification of Changes, reviewed 10/5/25 and revised on 04/06/26 states: .#2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status.This may include:a. Life-threatening conditions, or b. Clinical complications.#3. Circumstances that require a need to alter treatment.This may include:a. New treatment. b. Discontinuation of current treatment due to i. Adverse consequences. ii. Acute conditions. iii. Exacerbation of a chronic condition.#7. Change in Condition: Any new symptoms, abnormal findings, or adverse reactions must be documented immediately. A comprehensive assessment, including completion of the eINTERACT Change in Condition assessment, will be initiated to identify, evaluate and communicate the resident's status. Provider notification must follow the established escalation process below:Primary Provider: [on-call service] system1st contact: [xxx-xxx-xxx]2nd contact: [xxx-xxx-xxx]If no provider is reached and the concern is urgent or timeˆsensitive, staff must contact:[on-call service] system NP direct line [xxx-xxx-xxx]If the conditions remain urgent or timeˆsensitive and provider contact cannot be established, staff must contact:[local hospital] - [xxx-xxx-xxx]ManagerˆOnˆCall to collaboratively establish a plan of careFamily or resident representative notification must occur as indicated, and all assessments, notifications, interventions, and followˆup actions must be clearly documented in the medical record. R46 was admitted on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia, obstructive sleep apnea, morbidly obese due to excess calories, cardiomegaly, atherosclerotic heart disease with atherosclerosis of arteries of extremities with intermittent claudication of bilateral legs, essential hypertension, stage 3 kidney disease, type 2 diabetes mellitus, and fracture of the lower end of right femur. R46's Minimum Data Set (MDS) assessment, dated 10/15/25, identified R46 had impairment on one lower side and was dependent on assistance for bed mobility, taking on and off footwear, rolling left to right, sitting to lying, chair to bed, toileting, and for transfers. MDS documented R46's Brief Interview for Mental Status (BIMS) score was 13/15, which indicated R46 had intact cognition. Surveyor reviewed R46's ADL (Activities of Daily Living) care plan which indicated:-Bed Mobility: The resident is extensive assistance of 2.-Transfer: The resident requires mechanical Hoyer lift with 2 staff assist for transfers.-PT/OT evaluation and treatment as per provider orders. Surveyor reviewed R46's care plan which included:R46 has altered cardiovascular status related to hypertension, myocardial infarction, and hypokalemia initiated on 04/23/25:-Monitor/document/report as needed any changes in lung sounds on auscultation (i.e. crackles), edema and changes in weight. -Monitor/document/report as needed any signs/symptoms of coronary artery disease (CAD): chest pain or pressure especially with activity, heartburn, nausea and vomiting, shortness of breath, excessive sweating, dependent edema, changes in cap refill, color/warmth of extremities. R46's coronary artery disease care plan related to atherosclerosis, hypertension, myocardial infarction, hyperlipidemia, and stroke initiated on 04/23/25 states:-Encourage routine physical exercise. May need physical therapy (PT) consultation to set up individualized programs. Encourage walking daily. -Monitor/document/report as needed any signs/symptoms of CAD: chest pain or pressure especially with activity, heartburn, nausea and vomiting, shortness of breath, and excessive sweating. R46's Peripheral Vascular Disease (PVD) care plan related to diabetes, lower extremity edema, lymphedema, and on diuretics initiated on 04/23/25 states:- Encourage residents to change position frequently, not sitting in one position for long periods of time. -Give medications for improved blood (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	flow or anticoagulants as ordered. R46's chronic obstructive Pulmonary Disorder (COPD) and use of continuous positive air pressure (CPAP) machine care plan, initiated on 08/05/25, states:-Monitor for difficulty breathing (Dyspnea) on exertion. Remind resident [R46] not to push beyond endurance. -Monitor/document/report as needed any signs and symptoms of respiratory infection: Fever, Chills, increase in sputum (document the amount, color and consistency), chest pain, increased difficulty breathing (dyspnea), increased coughing and wheezing. -Head of bed elevated to alleviate shortness of breath when lying flat to decrease episodes of difficulty breathing. R46's physician order with a start date of 01/25/26:Complete Respiratory Assessment in the evening, Document under Assessment. Surveyor reviewed R46's last hospitalization history and physical (H&P) discharge note from 02/17/26-02/23/26 which states: .She presented to the emergency room with severe left quadrant pain. CT [computerized tomography-diagnostic imaging procedure using rotating x-rays and computer software to create detailed 3D cross-sectional images of soft tissues, bones, and blood vessels] imaging without abdominal pathology but with incidental right femoral vein filling defect. There was concern for possible DVT [blood clot in a deep vein] and lower extremity venous doppler ultrasound later confirmed extensive new DVT despite ongoing Pradaxa therapy. She was admitted for evaluation of UTI [urinary tract infection,] renal involvement, correction of electrolyte abnormalities, and evaluation of anticoagulation need. She eventually started on a heparin drip for anticoagulation given new acute on chronic extensive DVT. Vascular surgery/cardiology were consulted for guidance on long-term anticoagulation since she developed a new DVT on Pradaxa [blood thinning medication]. It was recommended to continue dabigatran [Pradaxa] 75 mg twice daily. She was medically cleared to discharge back to facility on 02/23/26. Respiratory: normal respirations, unlabored breathing, lungs are clear to auscultation bilaterally with no crackles, wheezes, or rhonchi. Labs/Diagnostics: Imaging: CT of abdomen and pelvis with contrast only. Findings: Limited exam due to motion artifacts. Questionable filling defect of the right common femoral vein cannot exclude underlying thrombus. Recommend venous doppler [non-invasive painless imaging test used to visualize veins and evaluate blood flow] study of the bilateral lower extremities. R46's progress notes include: .On 03/02/26 at 9:00 AM, Resident complained of abdominal pain, inability to have bowel movement, and shortness of breath. Resident continued to yell out. Writer went in. Bowel sounds present x4. Oxygen saturation is 95% on room air. Respirations even and unlabored, no signs of acute respiratory distress observed, Will continue to monitor.-On 3/3/26 at 10:09 AM, Change of Condition-Note Text: Resident complains of Shortness of Breath (SOB) and experienced coughing episode. Oxygen was 82% on room air. Resident placed on 2L oxygen via nasal cannula. Oxygen improved to 90%. VS: BP 135/68, respirations 20, Pulse 106, temp 98.0. Resident appeared anxious during episode but remained responsive. Writer remained with resident and assisted with slow, deep breathing exercises. Resident gradually calmed, coughing subsided, and breathing became more controlled. Resident resting comfortably. No further concerns at this time. Will continue to monitor respiratory status closely and report any changes. -On 3/3/26 at 11:11 AM, Communication - with Resident Note Text: Writer went to resident's room to assist her with insurance claim documents. Resident stated she wasn't feeling well and does not want assistance right now. Writer offered assistance tomorrow, and the resident stated she may not be feeling better tomorrow. On 04/06/26 at 9:37 AM, Surveyor interviewed Licensed Practical Nurse (LPN) G and asked how R46 presented on 03/03/26. LPN G reported on 03/03/26, R46 was complaining of shortness of breath (SOB) and having hard time catching breath. LPN G assessed vitals which showed R46's oxygen saturation was in the 80s on room air, LPN G quickly applied O2 at 2L to increase resident's oxygen intake. LPN G was following a standing order which states, Apply oxygen at 2L [liters] NC [nasal cannula] and if ineffective, notify the provider on call. Surveyor asked LPN G if LPN G notified a physician on call with R46's oxygen changes and complaint of SOB. LPN G reported that LPN G did not notify provider as LPN G thought the standing orders were enough. Surveyor asked LPN G to review the October 2025 staff meeting notes where LPN G was educated on Change in Condition (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	which include: Any new symptoms, abnormal findings, or adverse reactions must be documented immediately, with physician and family notification and follow-up clearly documented. LPN G reported to Surveyor LPN G should have notified provider on call with changes. After 03/03/26, LPN G went on vacation, so LPN G did not know any other information pertaining to R46's care. Surveyor reviewed R46's Treatment Administration Record (TAR), which was missing the 03/03/26 respiratory assessment. Surveyor could not find a comprehensive assessment performed for R46 with the new onset of shortness of breath and complaints of not being able to breathe. Progress note review continued:-On 03/05/26 at 3:11 PM, Administration notes: Resident complaints of SOB and refusing to take CPAP off. O2 is 98% with 2L via CPAP.-On 03/05/26 at 6:30 PM, Resident has been getting aggressive with staff. She begins to yell when things are not done exactly her way. The nurse attempted to administer an as needed medication, and resident started screaming because the CPAP machine was asked to be taken off to avoid aspiration. The nurse left the room and attempted to administer the medication again and she refused to listen to any reason.-On 3/5/2026 at 11:23 PM, Weekly Progress Note: Note Text: Resident has been obsessed with having CPAP with O2 2L on continuously since 3/4/26 in the AM. Resident frequently yelling at staff for all and any needs. Resident demands that her door be left open at all times d/t [due to] possible choking hazards. Resident states this is a rule which is in place. Resident complained of a dry sore mouth this shift, possibly due to wearing CPAP 24/7. Mouthwash and toothettes offered. Will continue to monitor resident. On 04/06/26 at 11:45 AM, Surveyor interviewed LPN F and asked LPN F to review the 03/05/26 progress notes and explain how R46 presented to LPN F. LPN F reported R46 was complaining of SOB and having a hard time breathing. Surveyor asked LPN F if this was out of the ordinary for R46. LPN F reported typically yes but had been going on since 03/03/26. Surveyor asked LPN F if LPN F needed to contact provider to notify of R46's increase in difficulty breathing and using CPAP all day. LPN F stated, Since resident was having hard time breathing since 03/03/26, I thought we were just monitoring until further notice or further decline. On 04/06/26 at 12:50 PM, Surveyor interviewed Registered Nurse (RN) AA and asked RN AA to review progress note with Surveyor. Surveyor read off the progress note and asked RN AA if RN AA should have notified physician, who was on call, of R46's new onset use of CPAP machine all day instead of just at night and the anxiousness pertaining to R46 not being able to breathe without CPAP. RN AA reported R46 is always anxious about something daily. RN AA stated, Yes, the new onset use of the CPAP is not typically [R46's] baseline and only uses the CPAP at night but that RN AA felt R46's new anxiousness was a behavior thing as RN AA completed a respiratory assessment of R46 that night and O2 was fine. Surveyor asked RN AA what R46's physician orders were pertaining to O2 usage. RN AA reported R46 did not have a physician order for the O2, but RN AA knows R46's oxygen level should be above 91% on room air and if not, then facility can use standing orders to adjust oxygen as needed. RN AA felt R46's anxiousness did not appear to be in relation to R46's respiratory status. Progress note review continued:-On 3/6/26 at 10:59 AM, Behavior Note: Resident was asked if she would like to get up and attend church services. Resident declined, stating she could not remove her CPAP because she would not be able to breathe without it. Staff assessed resident while on room air; resident showed no signs or symptoms of shortness of breath. Respirations were even and unlabored, and lung sounds were clear bilaterally. Resident continued to insist she needed to keep the CPAP on and declined removing it. No respiratory distress noted during assessment. Resident remained calm and comfortable. No further concerns at this time.-On 03/07/26 at 12:58 PM, Resident refused to get out of bed today.-On 03/08/26 at 4:13 PM, Resident refused to get out of bed today. Surveyor could not find evidence of any comprehensive assessments being completed for R46 and her refusals of getting out of bed. On 03/24/26 at 2:20 PM, Surveyor interviewed Certified Nursing Assistant (CNA) Q and asked if R46 was receiving PT services before going to the hospital. CNA Q reported to Surveyor R46 received PT services but also has some home exercises R46 is supposed to complete on own in room. R46 can be non-compliant and refuse to get out of bed or do exercises PT asks of R46. R46 becomes fixated on (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	certain things and refuses if R46 does not want to do something. Progress note review continued:-On 03/09/26 at 6:31 AM, Respiratory assessment note: CPAP assessed. No SOB noted. Pulse 80, respirations 18, 96% on room air, lung sounds clear, CPAP cleaned and inspected. No acute respiratory concerns noted. Time spent 15 minutes.-On 3/9/26 at 11:56 AM, Alert Note-Resident has a cough with no secretions noted. Resident is currently using her CPAP machine during the day. She says she is having SOB without the CPAP being used. Otherwise, resident is at 97% on room air and 100% with the CPAP machine on. No fever noted this shift. Resident prefers to eat meals in her room. -On 3/9/26 at 11:12 PM, Behavior Note: Writer started shift at 6:00 PM. Resident has been yelling/screaming out from room all pm shift. Resident yelling for nurse, yelling for some aides by name, yelling for help, and CNAs in room frequently. Resident does not want her door closed; other residents and visitors verbalize that they are annoyed with this behavior due to being able to hear everything clearly. Writer attempted to rationalize with resident but was unsuccessful. Resident is not a good listener; resident just yells and is anxious and extremely excited. Staff and writers will continue to redirect. Staff continue to attempt to meet resident's needs to the best of their ability.-On 03/10/26 at 7:35 AM, Administration notes: Resident insists on wearing CPAP at all times.-On 03/10/26 at 1:10 PM, Resident has refused to get up for meals and only take liquids. Resident is refusing to take CPAP off this day. Resident refusing to get up from bed. Refusing solid foods and only taking liquids.-On 3/10/26 at 6:42 PM, Alert Note: 10 min trial on room air. Resident sats from 98 to 92%. Resident is very anxious and able to be calmed with 1:1 by staff. Resident immediately demanded to have C-pap replaced after trial.-On 03/11/26 at 11:44 AM, Resident refused to get up out of bed to have completed weight.-On 3/11/26 at 3:33 PM, General Note: NP visit with resident related to SOB. NP orders: schedule CTA as soon as possible for SOB related to DVT. R46's physician order 03/11/26:Please schedule CTA of chest as soon as able for shortness of breath, DVT, bed bound at this time, 1 view chest x-ray. The fax cover sheet to Radiology Scheduling states, Please call STAT to schedule. The order summary states, CTA of chest STAT to r/o DVT with experienced SOB. STAT for rule out DVT. A progress note on 03/11/26 at 4:15 PM states, Late entry: Called to schedule chest CTA ASAP. Radiology stated to send order and they would call to schedule. She said to write STAT on it so they could schedule for ASAP. Per nursing, it does not have to be today, so order was sent to radiology. On 04/06/26 at 9:17 AM, Surveyor interviewed Nurse Practitioner (NP) BB and asked when the first time NP BB was notified about R46's shortness of breath. NP BB reported to Surveyor NP BB was on vacation between 03/2/26-03/6/26. Facility was to notify the on-call provider covering for NP BB until NP BB was back from vacation. NP BB reported NP BB then came to facility Monday 03/09/26 or 03/10/26 but thinks it was on Monday 03/09/26. NP BB entered resident room and completed assessment. NP BB had concerns with possible PE so ordered computed tomography angiography [CTA] [non-invasive, quick imaging test (often 5-30 minutes) combining CT scans with iodine contrast dye to create detailed 3D images of blood vessels] as soon as possible. Surveyor asked NP BB to clarify what As soon as possible means versus STAT order. NP BB reported resident R46 was assessed as stable, didn't need ER, and the order could go through the clinic. While NP BB was assessing R46, oxygen was removed so we could communicate and O2 was off for a total of 10-15 mins where resident R46 was assessed to be ok at that time, but NP BB had concerns for potential PE, so NP BB ordered CTA to be completed as soon as possible. Surveyor asked NP BB if NP BB's expectation was the nursing staff should have reported the SOB, with new oxygen use, and continuous use of the CPAP machine throughout the days of R46's complaints prior to NP BB being able to assess resident when back from vacation. NP BB reported staff should have notified provider of this new onset of SOB right away on 03/03/26. Surveyor asked NP BB if NP BB thought staff should have considered this to be potential PE with resident's history of DVT and anti-coagulation therapy. NP BB stated, I guess. My thought was potential PE due to resident being on anticoagulant therapy and history of PE and DVTs. Progress note review continued:-On 3/12/26 at 2:05 PM, Appointment: Resident has an appt for chest CTA today at 3 pm.-On 03/12/26 at 2:41 PM, Resident (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	trouble with SOB on 03/02/26. On 03/03/26, R46 became SOB, and the nurse applied oxygen via nasal cannula. DON B reported DON B was unaware R46 started having breathing concerns on 03/02/26. DON B reported R46 is a difficult resident who has a lot of co-morbidities. DON B reported DON B did not know that the nurse had applied oxygen on 03/03/26 until now. Surveyor asked DON B if it was her expectation for nursing staff to notify the doctor once R46 became SOB and received oxygen supplementation. DON B reported the facility has standing orders which allow nursing staff to apply oxygen at 2L NC and if ineffective, notify the provider on call. Surveyor asked DON B if staff are to follow R46's individualized care plan stating if R46 develops SOB and/or cough notify the provider right away per R46's care plan for R46's diagnosis of altered cardiovascular status. DON B reported expectation is the nurse should have notified provider on call of the SOB concern, O2 change, and the constant use of the CPAP Machine. DON B reported that respiratory assessments were being done by the Respiratory Therapist for the use of CPAP but not for the new oxygen needed via nasal cannula. Surveyor requested provider notification on 03/03/26 with R46's condition change in needing oxygen supplementation while complaining of SOB. DON B reported to Surveyor that DON B would gather provider notification. On 03/25/26 at 1:10 PM, Surveyor spoke with DON B again. DON B reported to Surveyor the provider was not notified on 03/03/26 with the condition change. Surveyor asked DON B why R46 was not assessed more thoroughly or provider notified between 03/03/26-03/11/26. DON B reported expectation would have been nursing to report the continual usage of CPAP and oxygen 2 L NC with the complaint of SOB. Surveyor reported to DON B that Surveyor was reviewing R46's progress notes and reviewed R46 did not receive the chest x-ray as ordered by provider to complete STAT (as soon as possible.) DON B reported DON B did not realize it was delayed. Surveyor reviewed the progress note from 03/11/26 with DON B, and DON B confirmed that nursing should have never stated, Per nursing, it does not have to be today, so order was sent to radiology. DON B reported when provider ordered STAT, which meant provider needed it completed as soon as possible. On 04/06/26 at 11:58 AM, Surveyor interviewed DON B and asked DON B about why LPN G did not notify physicians on call. DON B reported to Surveyor LPN G did in fact try to notify on call provider but could not get through on the service line. DON B reported Nurse Manager C had sent an overall general email to the on-call provider service that the facility was unable to reach a provider on call for residents with significant change in condition. Surveyor requested email documentation. DON B reported that DON B will print the documentation right away. On 04/06/26 at 12:36 PM, Surveyor interviewed DON B again and asked DON B about the on-call provider notification process. DON B reported LPN G did in fact try to call provider on call on 03/03/26 but LPN G could not get hold of anyone, and LPN G did not document in R46's medical record LPN G attempted to contact provider. Surveyor asked DON B what the process is in case a provider on-call does not answer. DON B reported DON B is unsure. Clinical Coordinator M was also present and stated, personally I feel like staff should call the local emergency room (ER) for further direction. Surveyor asked DON B and Clinical Coordinator M if there is a more detailed process or policy in place to replace the on-call provider with someone else to notify such as the Medical Director. DON B reported the Medical Director is also with the [on-call service] system. Nurse Manager C reported to Surveyor that Clinical Coordinator M will revamp the policy on when and how to call the on-call with a backup option such as the local ER. DON B reported to Surveyor nursing staff was having issues with other provider notification concerns for the whole week of 03/02/26-03/06/26. DON B reported Nurse Manager C has an email to verify Nurse Manager C reached out to the [on-call service] system to try to fix the concern of not receiving answers from on-call providers. Surveyor asked what the facility did in the meantime to report changes in condition to a provider. DON B reported there were no other interventions put into place for any residents' change of conditions until NP BB came back from vacation. On 04/06/26 at 1:26 PM, Surveyor interviewed DON B again and asked DON B what standards of practice are used as a resource in providing care in the facility. DON B reported DON B is unsure exactly what Standards of Practice is used but will find out right away. Surveyor asked DON B (continued on next page)

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	525654	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Lakeside	1016 Lakeshore Dr Rice Lake, WI 54868

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	if there was any education to all the nursing staff on notification to provider with change of condition, process in place for actions to be taken if unable to contact provider, care plan updates as new issues arise, processes and interventions for change in [TRUN

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prepare and distribute food under sanitary conditions. This has the ability to affect all 38 of the facility's residents.Staff were observed to not complete hand hygiene during food preparation and service or maintain sanitary storage.Food was not labeled with identifying information. Open food is not labeled with open or use by dates and no manufacturer's label with use by date. Food was not stored in refrigerator with a cover. A scoop was found in food container, increasing food's risk for contamination.Safe food temperatures for food service were not ensured.Food was not cooled in a way to prevent contamination.Staff washing dishes contaminated their uniform with dirty water sprayed off dishes and then returned to the duty of food preparation and service with the same uniform, no barrier.This is evidenced by:Example 1 The facility policy, titled Hand Washing, dated 1/26/26, states: Staff will wash hands as frequently as needed throughout the day following proper hand washing procedures. Procedure:Clean hands and exposed portions of arms (or surrogate prosthetic devices) immediately begore engaging in food preparation including working with exposed food.During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing task.Before donning (putting on) on gloves to work.The facility policy, titled Food Preparation and Service, dated 2001, states: Food Service Distribution4. Food and nutrition services staff. wash their hands before serving food to residents. Employees also wash their hands after collecting soiled plates and food waste prior to handling food trays.The Wisconsin Food Code, dated 2024, states: .food workers must wash their hands thoroughly before putting on gloves and each time gloves are changed. Gloves are not a replacement for handwashing; they are a barrier, and hands must be clean to prevent contamination when gloves fail or are replaced.Gloves should be changed when switching tasks to prevent cross contamination.On 3/23/26 at 8:54 AM, Surveyor observed Dietary Aide (DA) N leave the kitchen. DA N came back into the kitchen and started putting juice trays back into the refrigerator. DA N did not wash hands when she entered the kitchen or before handling the juice.On 3/23/26 at 11:31AM, Surveyor observed DA N getting buckets of ice and placing them on the tray by steamer table. DA N then went to walk-in cooler and took already prepared juices and milks and placed them on same cart. DA N then took a thermometer to take temperatures of the beverages. No hand hygiene prior to taking temperatures.On 3/23/26 at 11:56 AM, Surveyor observed Dietary Manager (DM) I entered kitchen and walked around to observe all staff. DM I did not wash hands upon entering kitchen.On 3/23/26 at 11:58 AM, Surveyor observed DM I observe the steam tray still in oven and asked about it. [NAME] L stated what it was. DM I, with her contaminated hands, took potholders and took meat out of the oven and handed it to [NAME] L to put on the steam table. On 3/23/26 at 12:09PM, Surveyor observed DA K wash hands and set up in front of the steam table preparing to set up trays, while DA N and [NAME] O stood behind waiting for the task to carry trays out to dining room. DA N and [NAME] O did not wash hands prior to starting task. Surveyor was standing right next to the hand washing sink and could easily identify when it was used, even when concentrating on steam table and task in front of Surveyor. On 3/23/26 at 12:36 PM, Surveyor observed DA N return to the kitchen after lunch service to start cleaning. DA N did not wash hands entering the kitchen or before starting task. DA N took leftover beverages back to the cooler, put empty containers in the dish room, and covered leftover desserts with saran wrap with her contaminated hands.On 3/23/26 at 12:36 PM, Surveyor observed DM I also enter the kitchen and go straight to the rack with food storage containers. DM I did not wash her hands when she entered the kitchen, resulting in a contaminated storage container left out by food.On 3/23/26 at 1:21 PM, Surveyor observed DA N with gloves on cleaning and sanitizing tables in dining room. At 1:23 PM, DA N brought her detergent bucket back into the kitchen, did not take off her gloves or wash her hands. With same contaminated gloves she went (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to clean side of the dish room, picked up a tray of glasses, and brought them out of the clean dish room into the kitchen storage rack On 3/23/26 at 1:25 PM, Surveyor observed Registered Dietician (RD) J come into the kitchen and stop DA N from taking any more clean dishes and instructed DA N to take off her gloves and wash her hands. RD J stated RD J saw what DA N did and just went over to reeducate her. RD J stated she told DA N that hands were to be washed when you start a new task, take gloves off and anytime you touch something dirty. The gloves are a barrier not replacement for washing hands, take off gloves and wash your hands. Example 2 Facility did not provider a policy related to food storage.On 3/23/26 at 8:18 AM, Surveyor completed initial tour inspection with DM I. During tour the following was found:-4 Large bags of classic noodles, rotini noodles, corkscrew noodles, elbow noodles were open, twisted shut without a manufacturer's label, open date, or use by date. Surveyor provided DM I an opportunity to show Surveyor where the date and label were.-A scoop was found in the large flour bin.-An open gallon of milk in cooler without open date, expiration date unreadable. DM I dated the cap with today's date (3/23/26) while Surveyor was standing there, stating DA N opened it. -2 of 3 bottles of BBQ sauce were undated. One bottle was labeled 2/3/26. DM I looked at bottle for visible manufacturer's dates. DM I was unable to find a date. The unlabeled sauces were in the front. DM I wrote the date 2/3/26 on the other two bottles. Surveyor told DM I she was not expected to label the items immediately just because Surveyor found they were undated, especially if she wasn't sure of date.-3 large bottles of syrup were undated. DM I stated they just came in last Friday. This time DM I did not label the product in front of Surveyor. On 3/23/26 at 1:25 PM, Registered Dietician (RD) J came to surveyor with the [NAME] Brother invoices and stated the syrup came in on 2/3/26 and the BBQ sauce came in 2/27/26. On 3/23/26 at 2:56 PM, Surveyor observed a stainless-steel bowl with 7 peeled English cucumbers. Cucumbers were not covered.On 3/23/26 at 8:22 AM, Surveyor interviewed DM I, who stated all things are supposed to be labeled when received, when opened, and clearly marked. On 3/23/26 at 2:57 PM, Surveyor interviewed RD J who stated all food should be stored and handled to prevent food contamination. Surveyor asked what that meant. RD J stated at the right temperature, in a clean, labeled container with a cover.Example 3 The facility policy, titled Food Preparation and Service, dated 2001, states: Food Preparation, cooking, and Holding Time/Temperatures1. The danger zone for food temperatures is between 41 F and 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness.3. The longer food remain in the danger zone the greater the risk for growth of harmful pathogens. Therefore, [PHF] (potentially hazardous food) must be maintained below 41 F or above 135 F.Rapid Cooling1. Potentially hazardous foods are cooled rapidly. This is defined as cooling from 135 to 70 within 2 hours and then to a temperature of 41 F within the next 4 hour. The total cooling time between 135 F and 41 F is not to exceed 6 hours.The facility policy titled, Use of Leftovers, dated 1/16/26, states: Excess leftovers should be avoided. Leftovers will be properly handled and used or discarded as appropriate. Leftover foods will not be used for pureed diets.2. Leftovers will be covered, labeled and dated; then stored appropriately (refrigerated or frozen if necessary) immediately after the end of the meal service. 3. Leftovers must be cooled to 70 F within 2 hours and then to 41 F within another 4 hours.4. Leftovers that have not been properly stored will be discarded. (When in doubt, throw it out.)5. Food that is leftover will be handled as noted above and may be used as follows.a. Leftovers should be held for a maximum of 7 days at 41 degrees or less or discarded. Day 1 is the original preparation day. Day 7 is the use by date. (According to the 2022 Federal Food Code.)On 3/23/26 at 8:18 AM, Surveyor observed open browning lettuce in the cooler, dated 3/13/26. Per policy, leftover food dated 3/17/26 reaches day 7 on 3/23/26, and food dated prior to 3/17/26 should be discarded.On 3/23/26 at 12:36 PM, Surveyor observed DM I also enter the kitchen and go straight to the rack to pull a 2-quart tall food storage container with a green lid and place it by steam table. DM I did not wash her hands when she entered the kitchen, resulting in a contaminated storage container left out by food.On 3/23/26 at 12:53 PM, Surveyor observed [NAME] L take food off the steamer tray. [NAME] L stated I am going to throw most of it away; there is not (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	enough to keep. [NAME] L stated she will keep the gravy. Gravy was pulled and placed on the counter in same steamer pan. [NAME] L did not take temperature of gravy but left it sitting on table.On 3/23/26 at 12:58 PM, Surveyor observed [NAME] L place leftover gravy in the contaminated tall 2-quart food storage container, placed by steam table at 12:36 PM by DM I. Container was more than 1/2 full and cover was left off.On 3/23/26 at 2:48 PM, Surveyor interviewed [NAME] L who stated [NAME] L takes food off the steamer and lets it sit out for 1/2 hr.- 1 hr., to cool, checking them within the hour. [NAME] L stated if it is still warm, I leave them out. [NAME] L stated I don't know what temp they are supposed to be at for sure, just want them cooler. Surveyor asked [NAME] L if there was a log where they recorded temperatures of cooling foods. [NAME] L stated there is no log that [NAME] L is aware of. [NAME] L stated [NAME] L does not recheck once it is in the refrigerator.On 3/23/26 at 2:56 PM, Survey observed DM I check the temperature of the gravy container placed in the refrigerator. DM I was uncertain the time the gravy was put in the cooler. Surveyor observed it taken off the steam table and placed in food storage container at 12:58 PM, 1 hour and 58 minutes ago. DM I took cover off thermometer, wiped it with alcohol pad, and waved it in the air for a few minutes. When thermometer read 55 F it was placed in the gravy and read 120 F. DM I stirred the gravy with thermometer. The gravy temperature went down but came back up to 120 F. DM I stated DM I knows it is supposed to cool down to a certain temperature in a certain timeframe, but I will need to look.On 3/23/26 at 3:42 PM, Surveyor interviewed RD J and DM I regarding process on cooling down. RD J stated food is put in a container and put in the fridge. Surveyor asked if there was a time frame and goal temperature. DM I stated the temperature should be between 70-135 in 2hrs. Surveyor asked if they monitor the temperatures while it cools. DM I stated yeah we go back. RD J stated we don't have a log to track. It is something we will be fixing. On 3/24/26 at 10:42 AM, Surveyor observed with RD J, the chicken gravy from 3/23/26 still in the cooler. RD J did not make any comment, took container and threw it away.Example 4The facility policy, titled Food Preparation and Service, dated 2001, states:Food Service Distribution1. Proper hot and cold temperatures are maintained during food service. Foods that are held in the temperature danger zone are discarded after 4 hours. 2. The temperatures of food held in steam tables are monitored throughout the meal by food and nutrition staff.4. Food and nutrition services staff. wash their hands before serving food to residents. Employees also wash their hands after collecting soiled plates and food waste prior to handling food trays.On 3/23/26 at 11:30 AM, Surveyor entered the kitchen for follow up. [NAME] L was putting the steamer tray in place; no food placed on tray yet. Once together, [NAME] L started putting steam pans in place. DA N was setting up the condiment/beverage cart. Trays of covered coffee cups and juice cups were already on the tray. DA N was pouring milk. On 3/23/26 at 11:34 AM, Surveyor observed DA N take temperatures of the juices. On 3/23/26 at 11:42 AM, Surveyor observed [NAME] L start taking temperatures of food in steamer tray. [NAME] L had temperature log on table on right, and pile of alcohol pads. Surveyor observed no temperatures recorded for lunch yet. The following food items' temperatures were taken by [NAME] L. While Surveyor observed, [NAME] L vocalized the temperatures. The outcome was: Chicken strips in gravy (182 F), mashed potatoes (190 F), cauliflower (192 F), and ground meat (177 F). All were within range. Gravy temperature was 170 F. Log stated gravy should be >175 F; this was not reheated. Cut up chicken's temperature was 156 F. [NAME] L took steamer pan of meat and placed it back in oven. Surveyor observed two brown bowls with cover and no label in a pan, sitting in the steamer. [NAME] L did not take temperature of food in brown bowls or pan of liquid with hamburgers floating. [NAME] L stated the hamburgers are for a couple residents that don't like chicken.On 3/23/26 at 11:48 AM, Surveyor observed DA N writing temperatures down in the log. Coffee was 70 and juice was 57 F. Per the log coffee should be 170 F and juice should be <41 F. Surveyor interviewed DA N who stated I write down temperatures for juice, all the time. Surveyor asked what do you do if it is out of range. DA N stated I don't know the range.On 3/23/26 at 11:58 AM, Surveyor observed DM I ask what the meat in the oven was for. [NAME] L stated that it is my cut meat, it wasn't to temperature. Surveyor observed DM I take meat out of oven (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and ask [NAME] L if she had room for it and DM I handed it to [NAME] L. [NAME] L placed on steamer tray and did not take a temperature.On 3/23/26 at 12:00 PM, Surveyor observed [NAME] L serve the two bowls. [NAME] L stated this is pureed meat and vegetable. [NAME] L did not take temperature of pureed food at beginning or just before serving.On 3/23/26 at 12:29 PM, Surveyor observed the lunch food service was completed. Surveyor observed entire process. Gravy that was not within temperature log requirements was used on most of the resident's plates. Between 11:42 AM and 12:53 PM, Surveyor did not observe food temperatures were taken again, not during service, nor when taken off the steamer table. Surveyor interviewed DM I and asked how they ensure the temperatures hold. CM I stated the cooks write the temperature down and place it on the steamer table right away.On 3/23/26 at 12:39 PM, Surveyor interviewed DA K who stated juice and milk should be approximately 40 F and coffee should be 170 F. Surveyor asked DA K what you do when out of range. DA K stated I don't know that has never happened. DA K stated he would have to ask the manager.On 3/23/26 at 1:00 PM, Surveyor reviewed the food service temperature log. There were no temperatures documented for substitute meat (hamburger), ground meat, pureed meat, or pureed vegetable.On 3/26/26 at 1:01 PM, Surveyor interviewed [NAME] L about temperature taking and log. [NAME] L stated she takes the temperature just before serving only and it goes in the log. [NAME] L noted that substitute meat, ground meat, pureed meat and pureed vegetable were blank. [NAME] L stated, Oh I didn't do that. I was in a hurry. [NAME] L looked at ceiling for a minute and then wrote 170 for both substitute and ground meat. Note: above ground meat was 177 F and substitute meat (hamburgers) did not have a temperature taken by [NAME] L during this food service event.On 3/23/26 at 3:42 PM, Surveyor interviewed DM I and RD J about food temperatures. DM I stated they go back and check temperatures. RD J stated we do not have a log to track. RD J stated it is something we will be fixing. Surveyor told RD about observation with temperature log. RD J stated expectation is that everything is temped prior to service, stays on the steamer table until lunch is over, and temperatures are written down in the log when the food temperature is taken.Example 5On 3/23/26 at 12:36 PM, Surveyor observed DA K doing dishes. DA K separated and sprayed dirty dishes, getting water and debris on the front of DA K's scrubs. DA K did not wear an apron. Dirty water was spraying and contaminating his scrubs.On 3/23/26 at 1:16 PM, Surveyor interviewed DA K who stated they do not have or need to wear aprons while doing dishes. DA K stated he could feel the water spraying up when doing dishes but if he held it just right it was not a lot. DA K stated he was not done for the day after he did dishes. Surveyor asked what other tasks DA K has to do today. DA K stated DA K will get the snack cart ready, go on the floor, and serve snack to residents.On 3/23/26 at 2:20 PM, Surveyor observed DA K delivering snacks to residents on unit, wearing same contaminated scrubs, no cover up or apron. On 3/24/25 at 11:02 AM, Surveyor interviewed RD J who stated, aprons, I hadn't thought of that. I suppose if they are getting wet. I'll have to look into that.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 1 resident (R) (R6) of 5 residents reviewed had documentation the resident and/or legal representative had been informed in advance of the risks and benefits of prescribed psychotropic medications.R6 was prescribed Escitalopram Oxalate (a psychotropic medication). The facility did not obtain written consent from R6 or R6's legal representative.Findings include:R6 was admitted on [DATE] with diagnoses including in part, hypertensive chronic kidney disease, gangrene of left leg, atherosclerosis of arteries of extremities, multiple fracture ribs, type 2 diabetes mellitus, acute pulmonary edema, and major depressive disorder, and anxiety. Surveyor reviewed R6's physician orders, which state in part, -Escitalopram Oxalate Oral Tablet 5 MG (Escitalopram Oxalate), Give 5 mg by mouth one time a day for depression. Surveyor reviewed R6's medical record and did not find an informed consent filled out for R6's depression medication Lexapro. On 03/24/26 at 12:30 PM, Surveyor interviewed Director of Nursing (DON) B and asked if facility had informed consent for R6's Escitalopram Oxalate for depression that was started on 02/19/26. DON B reported that DON B would look for informed consent. On 03/24/26 at 1:10 PM, DON B came into conference room and provided Surveyor with R6's monthly pharmacy reviews but could not provide Surveyor with informed consent for R6's Escitalopram Oxalate.On 03/24/26 at 1:22 PM, Surveyor reviewed R6's medical record and observed an informed consent completed today on 03/24/26 for R6's Escitalopram Oxalate and scanned into R6's medical record. Surveyor reviewed R6's progress notes, which stated, On 03/24/26 at 12:50 PM, Note text: Obtained verbal consent from POA, for Escitalopram. Asked him to stop in to sign forms also. Left at front desk.On 03/25/26 at 9:09 AM, Surveyor interviewed Regional DON P since DON B was not available and asked Regional DON P the process for informed consents when starting psychotropic medications and why R6's informed consent was missed for Escitalopram Oxalate. Regional DON P reported to Surveyor that DON B has a good process in place. Regional DON P reported DON B will usually complete informed consent the day of starting and gives to medical records to scan into the computer. Regional DON P reported that somehow R6's was missing and that this is audited daily but somehow was missing.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's (R) R20) right to be free from verbal abuse by staff for 1 out of 2 residents reviewed.R20 reported Registered Nurse (RN) V grabbed R20's arm. RN V yelled at R20 and stood in front of R20's wheelchair stopping him, as he attempted to get away from RN V. Findings include:The facility's policy titled, Resident Safety Abuse Policy reviewed October 2023 states, Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting I harm, pain, or mental anguish. It includes verbal abuse. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents. Mistreatment means inappropriate treatment or exploitation of a resident.R20 was admitted to the facility on [DATE] with diagnoses that included orthopedic after care following surgical amputation of the lower extremity, acute osteomyelitis of the right tibia and fibula (forearm), mild cognitive impairment, and anxiety disorder.[NAME] Data Set (MDS) quarterly assessment completed on 3/17/26 indicated that R20 had no behaviors, required some assistance with activities of daily living, can independently use a wheelchair for mobility, and has a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated intact cognition, R20's care plan initiated 12/17/25 states: Resident presents with and/or family/resident reports trauma related symptoms as related to a history of traumatic event or repeated events- acts of violence with a goal that resident safety will be maintained and resident will continue to verbalize preferences in care plan goals and approaches. Interventions included in part. encourage to tell staff when an event makes him feel uncomfortable. allow resident time to understand and ask questions.R20's care plan initiated 2/25/26 states: . Resident demonstrates a pattern of misinterpreting staff communication.This may lead to distress, conflict with staff, or inaccurate reporting of care interactions with a goal that included, staff interactions with resident will remain consistent, calm, and clear, minimizing opportunities for misunderstanding. R20's care plan interventions include in part, .remain calm, neutral, and supportive if resident becomes accusatory or misinterprets comments.On 3/23/26 at approximately 9:30 AM, Surveyor observed R20 was in bed and his breakfast tray on bedside table was covered and appeared untouched.On 3/23/26 at 10:45 AM, Surveyor requested to interview R20. R20 stated R20 wanted to go and have a cigarette but agreed to meet later, stating R20 had a lot to say.On 3/23/26 at 11:44 PM, Surveyor interviewed R20. R20 reported he was treated badly by a nurse, Registered Nurse (RN V), yesterday (3/22/26). RN V told him he had to wear a mask, and he couldn't leave his room without a mask. R20 reported RN V put a sign up on his bathroom door, said he could not use the shared bathroom and brought a commode into his room, all because his girlfriend had a cough.R20 reported R20's girlfriend (GF) CC came into facility on 3/22/26 to drop R20 off after he had spent the day with her. GF CC was wearing a mask because she had symptoms of being sick. During the interview R20's lunch was brought to R20's room, and Surveyor offered to continue interview after his lunch. R20 stated I'm not really even hungry, I'm just so traumatized by what happened last night with that nurse [RN V].On 3/23/2026 at 1:40 PM, Surveyor continued interview with R20, who reported RN V yelled at him last night, told him he had to wear a mask, and that he would have to stay in his room and couldn't use shared bathroom if he refused to wear a mask. R20 stated when he was downstairs trying to go outside and get away from her, She stood in front of my chair yelling at me to wear a mask and wouldn't let me leave alone. When I tried to leave, she grabbed my bad arm. I just can't stop thinking about it and it makes me mad. She had no right to do what she did.On 3/23/2026 at 1:56 PM, another Surveyor reported that Nursing Home Administrator (NHA) A was made aware of R20's report of RN V holding R20's arm down so the facility has started an investigation. The Surveyor's report is as follows:On 03/23/26 at 12:10 PM, Surveyor entered NHA A's office and NHA A divulged information about a recent accusation of (continued on next page)

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	525654	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Lakeside	1016 Lakeshore Dr Rice Lake, WI 54868

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physical abuse concerning R20 and a nurse. Surveyor asked NHA A to explain the details of the incident. NHA A reported to Surveyor that NHA A received an incident report via email right away this morning on 03/23/26 from R20's significant other of a concern that a nurse had not let R20 out of his room and grabbed his wheelchair to prevent him from leaving room. NHA A reported that NHA A is going to start the investigation process and report this incident to the state officials right away. Surveyor asked NHA A why nurse would not let resident out of resident's room. NHA A reported that R20's significant other had come to visit wearing a mask. NHA A reported that the nurse advised R20 that he needed to wear a mask since he may have been exposed and the nurse brought commode in and educated R20 on staying in room. Surveyor asked NHA A if that is normal process to quarantine residents when they are exposed to a potential infected person. NHA A stated to Surveyor, I thought that was ok, as we really don't want Norovirus going through the whole facility since we just got over respiratory issues in the facility. I will have to reach out to infection control about the guidelines for quarantine with potentially exposed residents. NHA A reported that NHA A is starting the investigation process and completing interviews. Surveyor reported to NHA A that Surveyor would update the other Surveyor with this information and let Surveyor communicate with NHA A going forward on this matter.Record review indicated RN V's documentation as follows on 3/22/2026 at 5:32 PM, Behavior Note- Note Text: earlier today this nurse was notified that resident's girlfriend possibly had a virus. She had been here for short time and yesterday with a mask on. Resident had been out with her for a few hours. Girlfriend called later and she stated to this nurse that she went to the MD who said he wanted to test her. She did not have the results at this time and was waiting for the MD [Medical Doctor] to call her with the results. This nurse thanked her and went to talk with resident about masking to help prevent any other residents from coming down with the virus. Resident went out to smoke. This nurse went to find resident and found him wheeling down the hallway very fast with his 12 pack of pop on his lap. Nurse asked to speak to resident, and he yelled 'get away from me you fat b****, I don't want to talk with you' This nurse again attempted to talk to him saying 'I just want to talk to you about wearing a mask. He attempted to wheel into nurse and said 'I told you I don't want to talk to you b****, I'm leaving. Nurse stopped resident's wheelchair to prevent chair from running into her. Residents pop on his lap slipped and he grabbed it with his Lt hand. Nurse removed self from resident's path. Resident wheeled to front door yelling 'I'm leaving' Nurse called nurse manager to update her on what happened at that time. Then resident came back into facility to his room to eat his supper. At that time call received from resident's girlfriend who stated she just got a call from the MD, and she just has a bad spring cold. This nurse then went to resident's room to talk with him. Nurse stood in doorway and said his girlfriend just called and said she does not have the virus, just a very bad cold and left. Nurse attempted to talk to resident later. Went to his room and he said, 'I don't want to talk to you, but you can talk to my girlfriend' and handed me his phone. Nurse put phone on speaker so resident could hear us speak but resident left. I talked with his girlfriend who said she told resident she only has a cold, but he said you grabbed his bad arm when pop slid from his lap. Nurse explained what happened earlier where she attempted to talk with resident, but he attempted to run into writer with his w/c, so I stopped the w/c, and he grabbed his 12 pack of pop with his bad arm to keep it from falling off his lap. There was no physical interaction with resident other than touching the w/c. I thanked her for the update and found resident sitting in the TV room, so I gave him back his phone and told him she wanted to talk with him again. At 1800 this nurse gave report to both night nurses and asked if they could talk with resident who continued to be upset with the situation related to his girlfriend's illness.Further record review indicated a progress note on 3/23/2026 at 1:24 PM, states, COMMUNICATION - with Physician/Res/Family/HPOA/Guardian. Resident complained of pain in the left upper shoulder and requested an X-ray. Nurse Practitioner was notified and with verbal order for X-ray to left upper shoulder. Order placed with Biotech.On 3/24/2026 at 8:28 AM, Surveyor spoke with R20 who reported he spoke with the police yesterday. R20 reported he is very traumatized by the incident, and he stated he often gets his dates mixed up, so he hopes he didn't mix anything up (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with interviews. R20 stated he is concerned the facility will retaliate.On 3/24/2026 at 9:33 AM, Surveyor interviewed NHA A regarding incident that occurred on 3/22/26 at approximately 5:30 PM between R20 and RN V. NHA A reported that R20's GF CC had emailed the Director of Rehabilitation (Rehab) on 3/22/26 at 5:28 PM with report of RN V grabbing R20's arm. Rehab Director didn't get email until 3/23/26 at 9:06 AM and forwarded it to NHA A, who then received it and sent it to the Social Worker (SW) designee Z to interview R20. Surveyor was provided with a copy of SW Designee Z's documentation R20's statement of the event. No further documentation for an assessment was provided at that time. On 3/24/26 at 10 AM, Surveyor interviewed Director of Nursing (DON) B, who reported RN V suggested R20 wear a mask. DON B stated, We obviously can't make him. DON B also stated R20 was not isolated to his room. We can't make him stay in his room; he goes outside to smoke. DON B stated RN V did report she brought the commode in his room because R20 has a shared bathroom. DON B was not aware if a sign was put on R20's bathroom door. DON D stated RN V had reported the event on 3/22/26 to Nurse Manager (NM) C.On 3/24/2026 at 10:49 AM, Surveyor interviewed NM C, who reported she received a text from RN V that R20's GF CC had suspected she had Norovirus. NM C stated, I told her to have him wear mask, told her to put him on droplet isolation. NM C reported they put a commode in his room and had him wear a mask. A Clinical Coordinator who was in the office during the interview with NM C, interjected stating, Suggested he wear a mask. NM C then stated, I mean I suggested he use it.Surveyor asked NM C if RN V reported GF CC stating anything about RN V grabbing R20's bad arm. Nurse Manager C read through her text messages and read from her phone that RN V texted, Just an FYI [for your information], he [R20] is claiming I grabbed his arm. NM C replied to RN V that she (NM C) would investigate it in the morning. NM C told Surveyor that she gets to the facility early. When Surveyor asked for the investigation notes, NM C stated R20 was asleep, so she didn't get to talk to him and then found out SW Z had already spoken with R20, so NM C just did R20's skin assessment around 9 AM. Surveyor asked for NM C's documentation of assessment. Surveyor asked NM C for the time and a copy of the text. NM C stated she no longer had the texts saved on her phone. NM C reported she has no documentation of her conversation with RN V from 3/22/26. Surveyor reviewed record written by NM C dated 3/23/2026 at 1:37 General Note- Data: Skin assessment done with resident, not any bruising or skin discoloration noted to left arm.Further record review indicated R20 complained of pain after the incident occurred. Note dated 3/24/2026 at 22:29 [10:29 PM] reads in part, When asked about pain resident states his pain is 9/10, radiating from L [left] shoulder down to forearm area. Resident c/o [complains of] LUE [left upper extremity] pain daily, states he has had a past injury to L shoulder and has had trouble with it for years. Scheduled morphine and PRN [as needed] pain med administered during shift.On 3/24/2026 at 2:36 PM, Surveyor interviewed Certified Nurse Assistant (CNA) DD, who stated he was in the facility dining room when incident occurred on 3/22/26. CNA DD reported he did not notice R20 was acting any different nor did R20 mention the incident to him.On 3/24/2026 at 2:40 PM, Surveyor interviewed Licensed Practical Nurse (LPN) G, she did not work at the time of the incident on 3/22/26 but does work with RN V occasionally and has had no concerns with RN V's treatment of the facility residents. On 3/24/2026 at 2:45 PM, Surveyor interviewed CNA D, who reported she went in R20's room the morning of 3/23/26 and R20 said to her that he had a bad day on 3/22/26. CNA D stated R20 was not feeling good and looked drowsy groggy. R20 did not eat breakfast and said he wasn't feeling good. CNA D stated that is not his usual behavior. R20 is usually up and goes outside to have a cigarette before breakfast. CNA D stated that morning when she brought in his breakfast tray, R20 sat at edge of his bed with eyes closed and she was concerned about him sitting at edge as tired as he appeared so suggested he lay back down, and he went back to sleep.On 3/24/26 at 2:57 PM, Surveyor interviewed GF CC with R20 present, who stated she had brought R20 back to the facility around super time, and he had spent the day with her at her house. GF CC stated she wore a mask in the facility because she hadn't been feeling good earlier that day. She had some gastrointestinal symptoms and, I didn't want to spread my germs. Later that evening between 6 and 7 PM, R20 had (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	called her almost in tears and said RN V had pulled his bad arm. While on the phone with R20, RN V came into his room. R20 stated he didn't want to talk to her, and he ended up handing his phone to RN V stating she could talk to GF CC. GF CC stated she asked RN V if she grabbed R20's bad arm. GF CC reported RN V said she grabbed the back of his chair. GF CC stated RN V said R20 has to wear a mask, and she (GF CC) could not come back into facility until she got the results of her illness. GF CC stated RN V had no business yelling and screaming and demanding he wear a mask. GF CC reported she came back to the facility about 7- 7:30 PM on 3/22/26 to take R20 for a ride and to the store to help him calm down and feel better. He wanted to go home and was so upset about what happened.R20 stated the incident happened about 5-5:30 PM on 3/22/26 in the hallway on the 1st floor when he was going outside to have a cigarette. Prior to that RN V had come into his room demanding R20 wear a mask because of his girlfriend's suspected illness. When R20 refused and left, RN V chased him downstairs yelling at him to wear a mask. R20 stated RN V stood in front of my wheelchair yelling at me to wear the mask she had in her hand, when I tried to go around her, she grabbed my bad arm, and it hurt. I was finally able to get around her. R20 stated, Yes, I swore at her. I was mad at her for not letting me leave.The facility called law enforcement on 3/23/26; officers conducted interviews at the time of survey. That report was not yet available.Surveyor was provided with RN V's handwritten statement which states, March 22, 2026, at 15:44 [3:55P PM] I was told that a staff member heard resident and girlfriend talking and she said she had the virus. I texted my Nurse Manager on duty to ask her if she had heard about the above. At 1600 [4 PM] I called name of GF [GF CC] who stated she was sick yesterday, . I texted NM [NM C] and updated her and asked her what we should do at the facility. I also told NM resident did not have any symptoms [GF CC] at this time. She said to mask and glove at this time when working with resident, and have resident stay in his room. I went to his room to talk with him, but he was not in the room. I went to look for him and found him wheeling himself fast through the downstairs hallway with both hands and a 12 pack of pop on his lap. I asked to speak with him and he yelled back get away from me you fat b**** Nurse again in a calm and normal voice said, I just want to talk to you about wearing a mask until [GF CC] calls back with the results before nurse could finish the sentence he yelled and swung his arms saying why do I have to wear a mask he then shouted and wheeled toward nurse, I stopped wheelchair with my hand. He said, I told you I don't want to talk to you, you b****, I'm leaving He again started to move, and I also moved away from him. I saw his 12 pack of pop started to slide off his lap, but he caught it with his left hand and positioned it back on his lap and kept going toward the front door. I followed from a distance then stopped at front desk to talk to door staff. I then texted NM to tell her what happened. I then called her to talk. I went back to work charting, assisting on the floor, checking on other residents. I got another text telling me to put a commode in [R20's] room. I just got the commode in his room when [GF CC] called to tell me her test results were in and she doesn't have the virus. I went down to his [R20's] room to let him know. He said I don't want to talk to you, but you can talk to my girlfriend. so I put it on speaker so he could hear both of us talking but he just left the room. She started talking saying resident said to her I had grabbed his bad arm when the pop slid from his lap. I told [GF CC] what happened, and that there was no physical interaction from either of us other than me touching his wheelchair.Facility interview with CNA U during the facility investigation reads in part: [R20] was upset, said he [R20] was leaving. Nurse was telling him that masks were needed, [R20] was already high strung. Nurse [RN V] went after him after he went off on her, both yelling at each other, both in the wrong.Facility interview with Receptionist R during the facility investigation reads in part:[RN V] said he [R20] needed to be quarantined and masked, and his girlfriend can't come back and that I needed to let [R20] know.Facility interview with Receptionist S during the facility investigation reads in part: [RN V] said he is quarantined and he needed a mask.On 3/25/26, Surveyor was provided a document written by NM C that reads in part, March 22, 2026. At around 6PM, writer received another message from [RN V] that resident was accusing him of grabbing his sore arm. Writer instructed [RN V] to write a progress note and I will talk to him in the morning.On (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/25/2026 at 8:13 AM, Surveyor interviewed NHA A, who stated the expectation is the Nurse Manager should have called her (NHA) immediately after being told that the resident alleged that the RN grabbed his arm on 3/22/26. NHA A stated she was not made aware of the incident until Monday morning. Surveyor stated R20's, GF CC's, and the interviews obtained by the facility from staff witness noted that RN V was yelling at the resident. NHA A stated, yes, that's verbal abuse. The resident stated RN grabbed his arm and would not let him move past her by standing in front of his wheelchair. NHA A agreed this behavior by RN V toward R20 was considered abuse. Surveyor reported to NHA A of the interviews conducted and documentation reviewed, indicated R20 was upset by the incident, did not get out of bed or eat his breakfast the morning after the incident and staff stated this was not R20's normal routine, thus indicating RN V's behavior did cause R20 mental anguish and pain.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility did not ensure that an alleged violation involving abuse by a resident (R20) was reported immediately to the Nursing Home Administrator (NHA) and to the State Survey and Certification Agency. An incident which R20 reported Registered Nurse (RN) V grabbed R20's arm, yelled at R20, and stood in front of R20's wheelchair stopping him as he attempted to get away from RN V, was reported to on call Nurse Manager, who did not report it to the NHA and thus the facility did not report the abuse to the State Survey and Certification Agency.Findings include:The facility's policy titled, Resident Safety Abuse Policy reviewed October 2023 states, Reporting suspected violations: a. The supervisor on duty shall immediately safeguard the resident(s) and immediately report all alleged violations involving abuse, neglect, mistreatment, exploitation, including injuries of unknown source and misappropriation of residents property to the facility administrator. The Administrator will notify the DON and/or others as appropriate. c. The Administrator shall report immediately, but no later than 2 hours after forming the suspicion, if the events that caused the suspicion result in serious bodily injury. (see table 1). Table 1 indicates Alleged Violations- All alleged violations of abuse. R20 was admitted to the facility on [DATE] with diagnoses that included orthopedic after care following surgical amputation of the lower extremity, acute osteomyelitis of the right tibia and fibula (forearm), mild cognitive impairment, and anxiety disorder.Most recent [NAME] Data Set (MDS) assessment completed on 3/17/26 indicated that R20 had no behaviors, required some assistance with activities of daily living, can independently use a wheelchair for mobility, and has a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated intact cognition.On 3/23/26 at 11:44 PM, Surveyor interviewed R20. R20 reported he was treated badly by a nurse, Registered Nurse (RN V), yesterday (3/22/26). RN V told him he had to wear a mask, and he couldn't leave his room without a mask on. This interview was interrupted by R20's lunch.On 3/23/2026 at 1:40 PM, Surveyor continued interview with R20, who reported RN V yelled at him last night, told him he had to wear a mask, and that he would have to stay in his room and couldn't use shared bathroom if he refused to wear a mask. R20 stated when he was downstairs trying to go outside and get away from her she stood in front of my chair yelling at me to wear a mask and wouldn't let me leave alone. When I tried to leave, she grabbed my bad arm. I just can't stop thinking about it and it makes me mad. She had no right to do what she did.Record review indicated RN V's documentation as follows on 3/22/2026 at 5:32 PM, Behavior Note- Note Text: earlier today this nurse was notified that resident's girlfriend possibly had a virus. She had been here for short time and yesterday with a mask on. This nurse went to find resident and found him wheeling down the hallway very fast with his 12 pack of pop on his lap. Nurse asked to speak to resident and he yelled 'get away from me you fat b****, I don't want to talk with you' This nurse again attempted to talk to him saying 'I just want to talk to you about wearing a mask. He attempted to wheel into nurse and said 'I told you I don't want to talk to you b****, I'm leaving. Nurse stopped residents wheelchair to prevent chair from running into her. Residents pop on his lap slipped and he grabbed it with his Lt hand. Nurse removed self from residents path. Resident wheeled to front door yelling 'I'm leaving' Nurse called nurse manager to update her on what happened at that time. Nurse attempted to talk to resident later. Went to his room and he said 'I don't want to talk to you but you can talk to my girlfriend' and handed me his phone. Nurse put phone on speaker so resident could hear us speak but resident left. I talked with his girlfriend who said she told resident she only has a cold but he said you grabbed his bad arm when pop slid from his lap. Nurse explained what happened earlier where she attempted to talk with resident but he attempted to run into writer with his w/c so I stopped the w/c and he grabbed his 12 pack of pop with his bad arm to keep it from falling off his lap. There was no physical interaction with resident other than touching the w/c. I thanked her for the update and found resident sitting in the TV (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room so I gave him back his phone and told him she wanted to talk with him again. At 1800 this nurse gave report to both night nurses and asked if they could talk with resident who continued to be upset with the situation related to his girlfriend's illness.On 03/23/26 at 12:10 PM, Surveyor entered NHA A's office and NHA A divulged information about a recent accusation of physical abuse concerning R20 and a nurse. Surveyor asked NHA A to explain the details of the incident. NHA A reported to Surveyor that NHA A received an incident report via email right away this morning on 03/23/26 from R20's significant other of a concern that a nurse had not let R20 out of his room and grabbed his wheelchair to prevent him from leaving room. NHA A reported that NHA A is going to start the investigation process and report this incident to the state officials right away. Surveyor asked NHA A why nurse would not let resident out of resident's room. NHA A reported that R20's significant other had come to visit wearing a mask. NHA A reported that the nurse advised R20 that he needed to wear a mask since he may have been exposed and the nurse brought commode in and educated R20 on staying in room. Surveyor asked NHA A if that is normal process to quarantine residents when they are exposed to a potential infected person. NHA A stated to Surveyor, I thought that was ok, as we really don't want Norovirus going through the whole facility since we just got over respiratory issues in the facility. I will have to reach out to infection control about the guidelines for quarantine with potentially exposed residents. NHA A reported that NHA A is starting the investigation process and completing interviews.On 3/24/2026 at 10:49 AM, Surveyor interviewed Nurse Manager (NM) C, who reported she received a text from RN V that R20's GF CC had suspected she had Norovirus. Surveyor asked NM C if RN V reported GF CC stating anything about RN V grabbing R20's bad arm. Nurse Manager C read through her text messages and read from her phone that RN V texted, Just an FYI [for your information], he [R20] is claiming I grabbed his arm. NM C replied to RN V that she (NM C) would investigate it in the morning. NM C told Surveyor that she gets to the facility early. When Surveyor asked for the investigation notes, NM C stated R20 was asleep so she didn't get to talk to him and then found out Social Worker (SW) Z had already spoken with R20 so NM C just did R20's skin assessment around 9 AM. Surveyor asked for NM C's documentation of assessment. Surveyor asked NM C for the time and a copy of the text. NM C stated she no longer had the texts saved on her phone. NM C reported she has no documentation of her conversation with RN V from 3/22/26.On 3/25/26, Surveyor was provided a document written by NM C that reads in part, March 22, 2026. At around 6PM, writer received another message from [RN V] that resident was accusing him of grabbing his sore arm. Writer instructed [RN V] to write a progress note and I will talk to him in the morning.On 3/25/2026 at 8:13 AM, Surveyor interviewed NHA A, who stated the expectation is that the Nurse Manager should have called her (NHA) immediately after being told that the resident made the allegation that the RN grabbed his arm on 3/22/26. NHA A stated would have reported this allegation of abuse to the state agency. NHA A was not made aware of the incident until Monday morning.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the prevention of further potential abuse from occurring while an investigation was in progress for 1 out of 2 residents (R) investigated for abuse (R20).Facility did not protect R20 when allowing Registered Nurse (RN) V to continue to work with R20 when accused of verbal and physical abuse.Findings include:The facility's policy titled, Resident Safety Abuse Policy reviewed October 2023 states, Procedure for investigation: . d. The Supervisor will ensure that the resident(s) is/are protected from further potential abuse, neglect, exploitation or mistreatment while the investigation is in progress. R20 was admitted to the facility on [DATE] with diagnoses that included orthopedic after care following surgical amputation of the lower extremity, acute osteomyelitis of the right tibia and fibula (forearm), mild cognitive impairment, and anxiety disorder.Most recent [NAME] Data Set (MDS) assessment completed on 3/17/26 indicated that R20 had no behaviors, required some assistance with activities of daily living, can independently use a wheelchair for mobility, and has a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated intact cognition.On 3/23/26 at 11:44 PM, Surveyor interviewed R20. R20 reported he was treated badly by a nurse, Registered Nurse (RN V), yesterday (3/22/26). RN V told him he had to wear a mask, and he couldn't leave his room without a mask on.On 3/23/2026 at 1:40 PM, Surveyor continued interview with R20, who reported RN V yelled at him last night, told him he had to wear a mask, and that he would have to stay in his room and couldn't use shared bathroom if he refused to wear a mask. R20 stated when he was downstairs trying to go outside and get away from her she stood in front of my chair yelling at me to wear a mask and wouldn't let me leave alone. When I tried to leave, she grabbed my bad arm. I just can't stop thinking about it and it makes me mad. She had no right to do what she did.Record review indicated RN V's documentation as follows on 3/22/2026 at 5:32 PM, Behavior Note- Note states in part: . Nurse attempted to talk to resident later. Went to his room and he said 'I don't want to talk to you but you can talk to my girlfriend' and handed me his phone. Nurse put phone on speaker so resident could hear us speak but resident left. I talked with his girlfriend who said she told resident she only has a cold but he said you grabbed his bad arm when pop slid from his lap.On 3/24/2026 at 10:49 AM, Surveyor interviewed Nurse Manager (NM) C, who reported she received a text from RN V that R20's GF CC had suspected she had Norovirus. Surveyor asked NM C if RN V reported GF CC stating anything about RN V grabbing R20's bad arm. Nurse Manager C then read through her text messages and from her phone read that RN V texted, Just an FYI [for your information], he [R20] is claiming I grabbed his arm. NM C replied to RN V that she (NM C) would investigate it in the morning. NM C told Surveyor that she gets to the facility early.When Surveyor requested a copy of this communication, NM C stated she no longer had the texts saved on her phone. NM C reported she has no documentation of her conversation with RN V from 3/22/26.On 3/25/26, Surveyor was provided a document written by NM C that reads in part, March 22, 2026. At around 6PM, writer received another message from [RN V] that resident was accusing him of grabbing his sore arm. Writer instructed [RN V] to write a progress note and I will talk to him in the morning.RN V continued to work as R20's nurse after allegation of abuse was made. Record review indicated RN V's documentation on 3/22/26 reads in part, At 1800 [6PM] this nurse gave report to both night nurses and asked if they could talk with resident who continued to be upset with the situation related to his girlfriend's illness.On 3/25/2026 at 8:13 AM, Surveyor interviewed NHA A, who stated the expectation is that the Nurse Manager should have called her (NHA) immediately after being told that the resident made the allegation that the RN grabbed his arm on 3/22/26 so that a complete investigation could have been done ensuring R20's safety and not have RN V continue to care for R20. Surveyor reported to NHA A of the interviews conducted and documentation reviewed, indicated R20 was upset by the incident, did not get out of bed or eat his breakfast the morning after the incident and staff stated this was not R20's normal routine, thus indicating RN V's behavior did (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cause R20 mental anguish and pain. On 3/25/2026 at 9:48 AM, Surveyor interviewed NHA A, who stated her expectation would be that the harm be removed. Surveyor clarified that she meant the RN V should have immediately been removed from working with residents.On 03/25/2026 at 10:02 AM, Surveyor interviewed NHA A, who reported RN does not have any reports of abuse or mistreatment in her personnel file. NHA A provided dates of training provided to RN V on abuse prevention, recognizing, and reporting.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 3 residents/resident representative (R) (R6, R46, and R48) of 5 residents reviewed for hospitalization received the proper notice of transfer, reason for transfer, and bed hold notice.-Facility did not have a specific reason on the transfer notice for R6, R46, and R48.-Facility did not provide R6 and R46 a bed hold notice.-Facility did not notify the ombudsman of R6 and R46's transfers to the hospital.Per the Long-Term Care State Operations Manual (SOM), dated 7-23-25, regulation 483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. 483.15(c)(5) Content of Notice. The facility's notice must include all the following at the time notice is provided: -The specific reason for the transfer or discharge. Surveyor reviewed facility policy titled, Transfer and Discharge policy, dated 11/23 last reviewed, which states, 5, When residents are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, not discharges, because the resident's return is generally expected. 7. Before the facility transfers or discharges a resident, the facility will notify the residents and the resident's representative of the transfer and reasons for the move in writing and in a language the resident understands. A copy of the notice will be sent to representative of the office of the state long-term care ombudsman by social services. 9. The notice of transfer or discharge will include all the following: a. specific reason for the transfer or discharge. 11. The facility shall retain a copy of the notice of transfer and discharge and bed-hold acknowledgement in the medical record. Example 1 R6 was admitted on [DATE] with diagnoses including in part, hypertensive chronic kidney disease, gangrene of left leg, atherosclerosis of arteries of extremities, multiple fracture ribs, type 2 diabetes mellitus, acute pulmonary edema, and major depressive disorder, and anxiety. R6's record review indicated that R6 was sent out to the emergency room on [DATE] and 02/15/26. On 03/24/26 at 8:33 AM, Surveyor reviewed notice of transfers for R6's hospitalization on 02/06/26 and 02/15/26, which showed no specific reason for transfer to a higher level of care. On 03/24/26 at 3:05 PM, Surveyor interviewed Director of Nursing (DON) B and asked if DON B could provide Surveyor with documentation in R6's medical record for bed hold, transfer notice, and notification to Ombudsman for R6 being transferred to hospital on [DATE] and 02/15/26. On 03/25/26 at 6:58 AM, Surveyor observed a pile of papers on table in conference room addressed to (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this Surveyor. Surveyor reviewed documents that state in part, On 02/15/26 in progress note, [R6's] POA verbally gave consent for bed hold. Surveyor did not find a physical bed hold form filled out for R6's hospitalization on 02/15/26. Surveyor also did not find a bed hold form filled out for R6's hospitalization on 02/06/26. Surveyor did not find a notice of transfer for R6's transfer to hospital on [DATE]. Surveyor reviewed notice of transfer documents that stated in part, On 02/15/26, [R6] notice of transfer form: An immediate transfer or discharge is required by the residents' urgent medical needs. Surveyor did not find a specific reason for R6 being transferred to hospital on [DATE]. Surveyor did not find documentation that Ombudsman was notified of R6's hospitalizations on 02/06/26 and 02/15/26. On 03/25/26 at 7:08 AM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked about papers left in conference room. Surveyor asked NHA A if ombudsman was notified of R6's hospitalizations in February. NHA A reported that since Interim Social Services Designee Y was covering for Social Services Designee Z who had been on leave at the time, DON B and NHA A tried looking for the ombudsman notification and found that Interim Social Services Designee Y did not notify ombudsman and that Social Services Designee Z will complete this today in notifying ombudsman of hospitalizations for the month of February and March. Example 2 R46 was admitted on [DATE] with diagnoses including in part, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia, obstructive sleep apnea, morbidly obese due to excess calories, cardiomegaly, atherosclerotic heart disease with atherosclerosis of arteries of extremities with intermittent claudication of bilateral legs, essential hypertension, stage 3 kidney disease, type 2 diabetes mellitus, and fracture of the lower end of right femur. R46 was re-admitted to the facility on [DATE] after extensive care in hospital with new diagnoses including in part, acute respiratory failure, unspecified with hypoxia or hypercapnia, embolism and thrombosis of arteries of lower extremities, and acute embolism and thrombosis of unspecified deep veins of right lower extremity. On 03/24/26 at 3:05 PM, Surveyor interviewed DON B and asked if DON B could provide Surveyor with documentation in R46's medical record for bed hold, transfer notice, and notification to Ombudsman for R46 being transferred to hospital on [DATE] and 03/12/26. On 03/25/26 at 6:58 AM, Surveyor observed a pile of papers on table in conference room addressed to this Surveyor. Surveyor reviewed documents that state in part, On 03/12/26 Notice of transfer form: An immediate transfer or discharge is required by the resident's urgent medical needs. Surveyor did not find a specific reason R46 was being transferred to hospital on [DATE]. Surveyor did not find a notice of transfer for R46's transfer to hospital on [DATE]. Surveyor did not find documentation that Ombudsman was notified of R46's hospitalizations. Surveyor did not find a physical bed hold form filled out for R46's hospitalization on 02/16/26 or 03/12/26. On 03/25/26 at 7:08 AM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked about (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	papers left in conference room. Surveyor asked NHA A if ombudsman was notified of R46's hospitalizations in February and March. NHA A reported that since Interim Social Services Designee Y was covering for Social Services Designee Z who had been on medical leave at the time, DON B and NHA A tried looking for the ombudsman notification and found that Interim Social Services Designee Y did not notify ombudsman and that Social Services Designee Z will complete this today in notifying ombudsman of hospitalizations for the month of February and March. Example 3 R48 was admitted to the facility on [DATE], with diagnoses including in part, chronic respiratory failure, chronic obstructive pulmonary disease, morbid obesity, type 2 diabetes, muscle weakness, essential hypertension, chronic systolic congestive heart failure and chronic ischemic heart disease. R48's Minimum Data Set (MDS) assessment, dated 1/22/26, identified R48 required substantial maximal assistance for toileting and toilet transfer, personal cares and activities of daily living. R48, with a little set up help, could eat and complete his own oral hygiene. R48 was able to independently roll in bed, but dependent for all other position changes with assist of staff and an EZ Stander. R48's Brief Interview for Mental Status (BIMS), dated 1/22/26, was 15/15. A 15 indicates R48 was cognitively intact. R48 understands others but has a cognitive communication deficit. R48's record review indicated that R48 was sent to the emergency room on 2/28/26 in respiratory distress. On 03/24/26 at 8:02 AM, Surveyor reviewed notice of transfers for R48's hospitalization on 2/28/26 which showed no specific reason for transfer to a higher level of care.

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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 provide care consistent with professional standards of practice to promote the healing of existing pressure injuries (including prevention of infection to the extent possible) and prevent development of additional pressure injuries for 1 resident (R26) of 5 residents reviewed for pressure injuries in a sample of 12 residentsThe facility did not provide repositioning at a minimum of every 2 hours for R26, or document refusals by R26 to be repositioned at a minimum of every 2 hours, which potentially led to development and exacerbation of a pressure injury to R26's coccyx/sacral (lower back/tailbone) area. Findings include:The facility policy, titled Policy and Procedure for The Prevention and Treatment of Skin Breakdown, not dated, states in part: It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure injuries; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care.for a resident to exercise his or her right to appropriately make informed decisions about care and treatment or to refuse treatment, the facility and the resident will discuss the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment. The facility .will offer relevant alternatives.this will be documented in the resident's medical record.a Refusal of Skin Care Interventions Risk and Benefit Form can be utilized for refusal of care. The facility policy, titled Repositioning, not dated, states in part: Positioning the resident on an existing pressure ulcer should be avoided since it puts additional pressure on tissue that is already compromised and may impede healing.a turning/repositioning program includes a continuous consistent program for changing the resident's position and realigning the body. A program is defined as a specific approach that is organized, planned, documented, monitored and evaluated. R26 was admitted to the facility on [DATE] with diagnoses which include metabolic encephalopathy, nondisplaced fracture of right ulna with routine healing, muscle weakness, cognitive communication deficit and protein-calorie malnutrition. R26 has a Brief Interview for Mental Status (BIMS) score of 12/15, moderately impaired cognition. R26 makes own health care decisions. R26's care plan, dated 01/21/2026, with a target date of 04/28/2026, states in part: The resident has an ADL (activities of daily living) self-care performance deficit related to gait difficulty, generalized weakness. Interventions include.Bed Mobility: extensive assist of one.R26's care plan, dated 01/21/2026, with a target date of 04/28/2026, states in part: Skin: The resident has potential for impairment to skin integrity related to gait difficulty, history of falls, radius and ulna fracture, refusal of repositioning/offloading out of bed. Interventions include alternating air mattress, daily skin inspection and report abnormalities to nurse, repositioning every 2 hours and PRN (as needed), wound care as ordered.R26's care plan, dated 03/20/2026, with a target date of 04/28/2026, states: The resident has stage 3 pressure ulcer to coccyx. Interventions include.follow facility policies/protocols for the prevention/treatment of skin breakdown.the resident needs to turn/reposition at least every 2 hours, more often as needed.On 01/21/2026, R26 had a BRADEN Scale (tool used for predicting pressure sore risk) score of 16, which indicated R26 was mildly at risk of developing a pressure injury. On 03/05/2026, R26's BRADEN score was 14, which indicated moderate risk of developing a pressure injury. Note: R26 was already identified as having a stage III pressure ulcer on coccyx on hospital Discharge summary dated [DATE]. Nursing documentation dated 01/26/2026 states, Resident [R26] noted to have an open area to the coccyx measuring 3cm x 1cm, located between the buttocks directly over the tailbone.resident placed on offloading schedule every 2 hours. Coccyx wound was unstageable (purple or maroon localized area of discoloration with intact skin). R26's care plan included intervention for repositioning every 2 hours. Nursing documentation dated 01/27/2026 states, Resident [R26] continue refusing to get out of bed and offloading her buttocks and has a poor appetite. Nursing documentation dated 02/01/2026 states, Resident [R26] declining getting out of (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed for breakfast. Nursing note included R26 was educated on risk/benefit of mobility versus prolonged bedrest. R26's care plan did not include interventions for alternative options to promote offloading for R26. Weekly wound care assessments by wound care providers indicate R26 had wound progression on coccyx with measurements of 1.8cm (length) x 2.1cm (width) x 0.2cm (depth) on 02/13/2026, to 2.5cm (length) x 4.0cm (width) x 1.0cm (depth) on 03/20/2026. Physician orders dated 02/04/2026 states, Wound care to coccyx: apply calcium alginate plain to wound bed. On 02/27/2026, wound care provider was unable to debride R26's coccyx wound at facility. R26 was transferred to local emergency department (ED) for evaluation by a general surgeon for wound debridement. While in the ED, it was discovered R26 had a fever of 38 degrees Celsius (100.4 degrees Fahrenheit) and was subsequently admitted to the hospital to rule out sepsis of wound and receive intravenous antibiotic treatment. On 03/04/2026, R26 had further wound debridement by general surgeon. Wound cultures done were negative for infection. MRI (magnetic resonance imaging) done had findings compatible with ulcer and sinus tract extending into the underlying subcutaneous fat just right of midline. No indication of osteomyelitis noted per MRI. R26 was discharged back to facility on 03/04/2026 with new orders for wound care. No further antibiotics were recommended by the discharging physician. R26's discharge diagnosis included Stage 3 (full thickness tissue loss which may include tunneling and undermining) sacral ulcer with uncomplicated wound infection. R26's care plan dated 03/20/2026 includes interventions for wound care and repositioning every 2 hours, and as needed. There are no interventions for alternative options if R26 refuses to be repositioned, or to document refusals of repositioning. On 03/20/2026, physician ordered indwelling urinary catheter to be placed due to incontinence of urine impeding wound healing. To note: R26 is incontinent of both urine and bowel. On 03/23/2026 at 9:15 AM, Surveyor observed R26 sitting in wheelchair in room. Wheelchair had a pressure reducing mattress in place. R26 did not answer Surveyor's questions other than yes, in my back when asked if having discomfort due to her coccyx wound. On 03/23/2026 at 1:10 PM, R26 was in bed in supine (on back) position, head of bed in low fowlers (slight elevation). No offloading of coccyx area observed. Air circulating mattress on bed. On 03/24/2026 at 7:04 AM, Surveyor observed R26 lying supine in bed, low fowlers. No offloading of coccyx wound observed. Surveyor unable to find documentation of staff repositioning R26 in medical record. No documentation of R26 refusing repositioning noted in medical record since nursing notation on 02/04/2026. No paper record of CNA repositioning times in R26's room. On 03/24/2026 at 7:35 AM, Surveyor interviewed certified nursing assistant (CNA) D and CNA E and asked if R26 was able to reposition self in bed and both stated R26 could not. CNA D and CNA E were asked how often R26 is repositioned when in bed and both stated approximately every 2 hours, but R26 refused to be repositioned at times. Surveyor asked CNA D and CNA E how it is recorded and kept track of when R26 needs to be repositioned next. Both stated there is no record, it is offered to R26, no time frame indicated. CNA E stated R26 prefers to lie on her back while in bed. Surveyor asked CNA D and CNA E what is done when R26 refuses to change positioning, and they stated they respect R26's decision to remain in one position. CNA D and CNA E are not aware of alternatives to offload pressure on coccyx to offer R26. On 03/24/2026 at 7:04 AM, Surveyor interviewed licensed practical nurse (LPN) F, who was performing wound cares on R26 that day, and asked what interventions were in place for R26's wound. LPN F stated, Offloading, pain meds and wound care. LPN F stated R26 acquired wound while residing at facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.Licensed Practical Nurse (LPN) F, LPN G and Registered Nurse (RN) H did not perform hand hygiene prior to administering medication. This affected 5 out of 5 residents (R) (R6, R34, R20, R19, R2).LPN F did not wipe off blood pressure cuff and machine prior to RN H taking and using with another resident (R33). This was evidenced by:On 3/24/26, Nursing Home Administrator (NHA) A stated that Surveyor had all the policies related to hand hygiene. Policy received is specifically related to food preparation. NHA did provide Surveyor with a copy of the orientation plan that shows Director of Nursing (DON) B covers Hand Washing: how, when, why, during her portion of orientation.The Center for Disease Control (CDC) guidelines titled, Clinical Safety: Hand Hygiene for Health Care Workers, dated 2/27/24, states: Healthcare personnel must perform hand hygiene to prevent infection transmission:Before touching a patient,Before clean/aseptic procedures (e.g. obtaining a blood pressure, blood sugar), .Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene before donning (putting on) gloves,Before and after removing gloves,Before and after leaving a resident's room. If visibly dirty, healthcare staff should wash their hands.Example 1On 3/23/26 at 9:32 AM, Surveyor observed LPN F administer medications to R6. LPN F performed no hand hygiene prior to preparing medication. While preparing R6's medication, LPN F realized there was no normal saline spray in the cart. LPN F stated maybe it is in his room and continued medication prep. At 9:47 AM, LPN F minimized computer and locked cart. No hand hygiene at cart or prior to entering R6's room. LPN F administered R6's medication with contaminated hands. LPN F looked for normal saline and asked R6 if he had normal saline. It was not in his room. LPN F completed hand hygiene on way out of R6's room. LPN F went to medication room on [NAME] unit and then over to East unit to find normal saline spray. At 10:01 AM, LPN F came back with normal saline spray and took it to R6's room. LPN F did not complete hand hygiene upon entering room. LPN F, with contaminated hands, handed R6 the new bottle of normal saline spray.On 3/23/26 at 10:04 AM, Surveyor observed RN H prepare medications for R34. RN H completed hand hygiene before preparing R34's medication. RN H started preparing medication and identified missing medication. RN H put medication back in cart and went to medication room on East side. At 10:26 AM, RN H came back with the medication to med cart. RN H did not perform hand hygiene. With contaminated hands, RN H continued with the medication preparation. At 10:26 AM, RN H took medication to R34; no hand hygiene performed when leaving the cart or upon entering the room. With contaminated hands, RN H administered medication to R34.On 3/24/26 at 7:25 AM, Surveyor observed LPN G prepare medication for R19. No hand hygiene observed prior to prepping medication, upon leaving cart, or upon entering room. LPN G administered medication with contaminated hands. On 3/24/26 at 7:42 AM, R20 came out of his room that was right next to medication cart. Surveyor observed that LPN G asked R20 if LPN G could get R20's blood sugar before R20 went downstairs. R20 agreed. LPN G stopped preparing medications for R30 and pulled R20's glucometer kit from bottom drawer, set it up, and put on gloves. No hand hygiene before putting on gloves. With contaminated hands, LPN G obtained R20's blood sugar. On 3/24/26 at 9:28 AM, Surveyor observed LPN G prepare medication for R2. LPN G completed hand hygiene before she started. LPN G prepared medication and used the crusher to crush medication. LPN G did not perform hand hygiene at the med cart or before entering room. Surveyor observed that LPN G put gloves on contaminated hands, checked placement of g-tube, and administered medication. On 3/23/26 at 10:33 AM, LPN F stated hand hygiene is before and after everything. Surveyor asked if he had more specifics related to medication administration. LPN F stated before prepping medications, anytime taking off gloves, before you enter a room and after you leave a room. LPN F stated LPN F completed hand hygiene prior to preparing medication. Surveyor asked what about before entering the room. LPN (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F stated, no I didn't. Yes, I should have.On 3/23/26 at 10:33 AM, RN H stated hand hygiene is before and after everything. Surveyor asked if RN H had more specifics related to medication administration. RN H stated before prepping medications, anytime taking off gloves, before you enter a room and after you leave a room. RN H stated RN H completed hand hygiene prior to preparing medication. Surveyor asked what about before entering the room. RN H stated, no I didn't. Yes, I should have.On 3/23/26 at 9:32 AM, LPN G stated hand hygiene is always before and after working with patients. After a pause, LPN G stated preparing medication, putting on gloves, taking off gloves, going in a room, leaving a room, always.Example 2Surveyor requested a policy related to wiping down blood pressure equipment. NHA A stated they do not have a specific policy. On 3/23/26 during the 9:47 AM med pass event, Surveyor observed LPN F obtain the blood pressure and pulse of R6 via the blood pressure machine. LPN F took blood pressure cuff out of R6's room and parked it by wall just past nurses' station. LPN F did not wipe off blood pressure machine or cuff. Surveyor consistently monitored blood pressure cuff until its next use. BP cuff was not wiped down.On 3/23/26 at 9:56 AM, Surveyor observed RN H take the contaminated blood pressure cuff to use with R33. Surveyor confirmed blood pressure cuff was used. On 3/23/26 at 10:34 AM, Surveyor interviewed LPN F who stated blood pressure cuffs should be wiped down between use. Surveyor asked if that happened after LPN F used it with R6. LPN F stated no I didn't. Surveyor asked if LPN F should have wiped it down. LPN F stated yes. On 3/23/26 at 10:34 AM, RN H overheard questioning of RN F, and RN H stated she thought it was already wiped down when RN H took it to use with R33. On 3/24/26 at 2:31 PM, Surveyor interviewed Director of Nursing (DON) B who stated DON B expects staff to perform hand hygiene when passing medication, before and after preparing, upon entering and leaving a room, and before they put on gloves and after they take them off. DON B also stated that a blood pressure cuff should be wiped down between residents and glucometers are used on only one patient, they are not shared.