STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525657	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Care Center	251 Forest Lane Montello, WI 53949

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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 43361 Based on staff interview and record review, the facility did not ensure the resident environment was free of abuse for 2 residents (R) (R1 and R2) of 9 sampled residents. R2 had a diagnosis of dementia and an activated Power of Attorney for Healthcare (POAHC). R2 had a history of sexually intimate encounters and sexual comments toward other residents and displayed verbally and physically aggressive behavior. On 1/10/25, 1/29/25, and 2/8/25, R2 made sexual comments, was verbally and physically aggressive toward other residents, and exhibited wandering behavior. The facility did not implement interventions to ensure the safety of R2 and other residents. On 3/18/25, a resident walked past R1's room and observed R2 touching R1's breasts underneath R1's shirt. R1 was cognitively impaired and had an activated POAHC. The facility's failure to prevent a cognitively impaired resident from being sexually abused by a resident with a history of inappropriate sexual behavior led to a finding of immediate jeopardy that began on 3/18/25. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 4/2/25 at 4:30 PM. The immediate jeopardy was removed on 4/9/25, however, the deficient practice continues at a scope/severity level D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Findings include: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Resident-to-Resident Altercation policy, revised September 2022, indicates: All altercations, including those that may represent resident-to-resident abuse, are investigated and reported to the Nursing Supervisor, the Director of Nursing Services and the Administrator .2. Behaviors that may provoke a reaction by residents or others include: a. Verbally aggressive behavior such as screaming, cursing, bossing around/demanding, insulting race or ethnic group, intimidating: b. Physically aggressive behavior such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects; c. Sexually aggressive behavior such as making sexual comments, inappropriate touching/grabbing; d. Taking, touching, or rummaging through other's property; and e. Wandering into others' rooms/space .3. Occurrences of such incidences are promptly reported to the Nurse Supervisor, Director of Nursing Services, and Administrator .4. If two residents are involved in an altercation, staff: .d. Review the events with the Nursing Supervisor and Director of Nursing Services and evaluate the effectiveness of interventions meant to address distressed behavior for one or both residents; .f. Make any necessary changes in care plan approaches for any or all of the involved individuals; .i. Complete a report of incident/accident form and document the incident, findings, and any corrective measures taken in the resident's medical record. On 4/2/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had a diagnosis of dementia with psychosis. R2's Minimum Data Set (MDS) assessment, dated 3/5/25, had a Brief Interview for Mental (BIMS) score of 8 out of 15 which indicated R2 had moderate cognitive impairment. (A score of 7 out of 15 indicates severe cognitive impairment.) R2's 12/14/24 and 3/5/25 MDS assessments indicated R2 had verbal behavior directed toward others (threatening others, screaming at others, cursing at others) on 1 to 3 days during the observation period. R2's MDS assessment, dated 3/5/25, indicated R2 had wandering behavior on 1 to 3 days. R2 had an activated POAHC. A behavioral symptoms care plan (initiated 5/9/24) indicated R2 had socially inappropriate/disruptive behavioral symptoms as evidenced by sexually inappropriate behavior toward staff and other residents. The care plan contained interventions to observe and report socially inappropriate/disruptive behavior when around others (initiated 5/9/24), identify and report possible triggers for suggestive or sexual language or behavior including flirting and sexual jokes (initiated 5/9/24), assess R2 as needed using the sexuality and intimacy worksheet (initiated 5/9/24), redirect and remove when displaying negative forms of intimacy or sexual language (initiated 5/9/24), and provide supervision and/or escort to/from meals (initiated 7/9/24). A behavioral symptoms care plan (initiated 6/17/24 and revised 3/26/25) indicated R2 made statements regarding going home/leaving due to dementia and referenced placement of a WanderGuard. The care plan contained an intervention to remove R2 from other residents' rooms and unsafe situations (initiated 6/17/24). Surveyor reviewed previous facility-reported incidents (FRIs) submitted to the State Agency (SA) involving R2 and noted the following: ~ A FRI indicated R2 was involved in a resident-to-resident sexual interaction when R7 wandered into R2's room on 11/26/22. Staff discovered R2 rubbing R7's groin area. R7 was fully clothed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's medical record contained a sexual consent form, dated 7/9/24, that indicated R2 had no sexual intimacy or behaviors during the look back period or review with the Interdisciplinary Team (IDT). R2 had a WanderGuard due to a diagnosis of dementia. One-to-one supervision when outside of R2's room was discontinued. Fifteen minute checks were also discontinued. Staff were to provide supervision and/or escort R2 to and from meals. R2's POAHC was in agreement and R2's care plan was updated. A progress note in R2's medical record, written by Licensed Practical Nurse (LPN)-E and dated 1/10/25 at 6:25 PM, indicated R2 made inappropriate sexual comments and combative and angry comments toward other residents. LPN-E spoke with R2 which helped for a while, however, R2 later yelled in the dining room and tried to get other residents to leave the facility with R2. R2 was noted to have increased behaviors in the afternoon and evening. There were no care plan revisions for R2. A progress note, dated 1/29/25 at 3:05 AM, indicated R2 was verbally aggressive toward other residents. Staff kept an eye on R2 until R2 went to bed. Surveyor requested an incident report or more detail on what occurred, however, the facility was unable to provide the information. On 4/2/25 at 12:17 PM, Surveyor interviewed LPN-E who indicated R2 had a quick temper and little patience at times. LPN-E had not seen R2 strike anyone and indicated R2 was mostly verbally inappropriate. When asked about documentation on 1/10/25 regarding R2's sexual, combative, and angry comments toward other residents, LPN-E could not recall what R2 stated or who the comments were directed toward. LPN-E indicated R2's comments were blunt and often not directed at a specific person. LPN-E indicated incidents with R2 frequently occurred in the lobby which gets congested. LPN-E indicated female residents watch TV in the lobby which triggers R2 to make comments when R2 passes by. LPN-E indicated LPN-E's documentation should have been more specific regarding R2's comments and if they were directed at a specific resident. LPN-E indicated LPN-E reported all physical incidents and separated residents during physical and verbal incidents. LPN-E indicated incidents are documented in residents' progress notes and may be written on the 24-hour report board. LPN-E could not recall if LPN-E reported the incidents on 1/10/25 and 1/29/25 to administration. A progress note, dated 2/8/25 at 9:27 PM, indicated R2 wore (R8's) hat which angered (R8) who confronted R2. An argument was stopped by staff and the residents were separated. Staff were instructed to be sure R2 and R8 were kept apart. There were no care plan revisions for R2 following the incident. On 4/2/25 at 12:17 PM, Surveyor interviewed LPN-E who indicated R2 must have gone into R8's room and taken R8's hat. On 4/2/25 at 3:02 PM, Surveyor interviewed R8 who indicated R2 entered R8's room and took R8's hat. (R8's most recent MDS assessment, date 1/7/25, indicated R8 was not cognitively impaired.) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~ A FRI indicated R2 was in a wheelchair near the nurses' station on 2/21/25 when R6 who appeared emotional/tearful propelled around the nursing station in a wheelchair. R2 leaned forward to comfort R6 and put a hand on R6's thigh. R6 pushed R2's hand away which upset R2 who slapped R6's hand. Staff intervened and separated the residents. R6 was taken to R6's room and provided comfort. R2 remained in the common area near the nurses' station. Staff assessed R2 and R6 and noted no injuries. R2 and R6's physician and representatives were notified. LPN-E notified administration. The facility's investigation indicated R2 tried to console R6. A care plan initiated for R2 on 2/27/25 indicated R2 had a history of offering comfort to other residents via touch. The care plan contained interventions to encourage R2 to provide comfort through verbal communication and explain to R2 in a calm and respectful manner that R2's care and comfort is appreciated, however, not everyone likes to be touched. On 4/2/25 at 2:30 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-F who observed the interaction between R2 and R6 as CNA-F was coming up the hall and separated the residents. CNA-F indicated R6 was not tearful or upset prior to the incident but was an anxious person, had an anxious look on R6's face at times, and did not like to be touched. CNA-F indicated R6 was upset after the incident. On 4/2/25, Surveyor requested investigations and/or incident reports including care plan revisions for the progress notes that reference R2's behavior toward other residents. The facility was unable to provide the information. On 4/4/25, the facility provided care plans for R2 that included active and discontinued behavioral interventions. The care plans did not contain revisions following the incidents on 1/10/25, 1/29/25, or 2/8/25. On 4/2/25, Surveyor reviewed a FRI submitted to the SA. The FRI indicated on 3/18/25 at approximately 3:00 PM, R3 walked past R1's room and saw R2 feeling R1's breasts underneath R1's shirt. R3 told R2 to stop and notified staff who immediately responded and removed R2 from R1's room. Staff informed the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and the NHA. R1 was assessed and R2 was placed on 1:1 supervision. Law enforcement was notified and an investigation was initiated. R1 and R2's representatives were notified and R2 was moved to a room on the opposite side of the facility. R2's care plan was revised. Interviews with residents and staff were completed. Staff followed-up with R1, R2, and R3 for psychosocial well-being. The investigation did not indicate staff education was completed following the incident. On 4/2/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease and dementia. R1's MDS assessment, dated 3/19/25, indicated R1 had severe cognitive impairment. R1 had an activated POAHC. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/2/25 at 1:00 PM, Surveyor interviewed DON-B who indicated R2's behaviors were common knowledge. DON-B indicated there were interventions to redirect and remove R2 from the situation. DON-B indicated DON-B reviews progress notes and revises care plans if needed. DON-B was not aware of the 2/8/25 progress note that indicated a verbal altercation occurred when R2 took R8's hat. DON-B was aware of the 1/10/25 progress note that indicated R2 made sexually inappropriate comments and was physically and verbally aggressive toward other residents. DON-B was unable to provide further information regarding specific comments that were made and who the comments were directed toward or what type of aggressive behavior occurred and who it was directed toward. DON-B confirmed staff education was not completed post-event on 3/18/25 and indicated DON-B planned to provide staff education at a staff meeting next week. DON-B indicated staff were aware that R2 was on 1:1 supervision at all times when in R2's wheelchair. On 4/2/25 at 2:00 PM, Surveyor interviewed NHA-A who indicated NHA-A was not employed by the facility when the incident occurred on 1/10/25. NHA-A indicated NHA-A wanted to be informed of like-incidents in order to investigate and determine if care plan revisions were needed. NHA-A confirmed when incidents occur or when staff notice an increase in behaviors, NHA-A and DON-B should be notified so appropriate action can be taken. The failure to protect a resident from sexual abuse by a resident with a history of sexually inappropriate behavior created a reasonable likelihood for serious harm for that resident and other residents and led to a finding of immediate jeopardy. The facility removed the jeopardy on 4/9/25 when it completed the following: 1. Placed R2 on 1:1 supervision when awake. 2. Reviewed medical records and interviewed staff to identify other residents who may exhibit high-risk behavior. 3. Developed care plans for residents identified with the potential for high-risk behavior. 4. Reviewed the Abuse policy and playbook. 5. Completed staff education on resident rights, abuse, reporting responsibilities, and willful/intentional acts. 6. Initiated audits to ensure compliance. Surveyor observed R2 multiple times during the survey with 1:1 staff. R2 was noted to be in R2's room most of the day except for lunch. During lunch, R2 was seated at a table with like-gender residents. R2's 1:1 staff was observed seated beside R2.

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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 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** 43361 Based on staff interview and record review, the facility did not ensure allegations of abuse were reported to the State Agency (SA) timely for 2 residents (R2 and R8) of 8 sampled residents. R2's medical record indicated R2 was sexually inappropriate and/or verbally and physically aggressive toward other residents on 1/10/25 and 1/29/25. In addition, R2 and R8 were involved in a verbal altercation on 2/8/25. The facility did not report the allegations of abuse to the SA. Findings include: The facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, revised September 2022, indicates: All reports of resident abuse .are reported to local, state and federal agencies as required by current regulations and thoroughly investigated by facility management. Findings of all investigations are documented and reported . The facility's Resident-to-Resident Altercations policy, revised September 2022, indicates: All altercations, including those that may represent resident-to-resident abuse, are investigated and reported to the Nursing Supervisor, the Director of Nursing Services and the Administrator .2. Behaviors that may provoke a reaction by residents or others include: a. Verbally aggressive behavior such as screaming, cursing, bossing around/demanding, insulting race or ethnic group, intimidating; b. Physically aggressive behavior such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects; c. Sexually aggressive behavior such as making sexual comments, inappropriate touching/grabbing; d. Taking, touching, or rummaging through others' property; and e. Wandering into others' room/space. 3. Occurrences of such incidences are promptly reported to the Nurse Supervisor, Director of Nursing Services, and the Administrator. The Administrator will report the incident in accordance with the criteria established under Abuse, Neglect, Exploitation, or Misappropriation-Reporting and Investigating. On 4/2/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had a diagnosis of dementia with psychosis. R2's Minimum Data Set (MDS) assessment, dated 3/5/25, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R2 had moderate cognitive impairment. (A score of 7 out of 15 indicates severe cognitive impairment.) R2 had an activated Power of Attorney for Healthcare (POAHC). On 4/2/25, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had a diagnosis of history of stroke. R8's MDS assessment, dated 1/7/25, had a BIMS score of 15 out of 15 which indicated R8 was not cognitively impaired. A progress note, dated 1/10/25 at 6:25 PM, indicated R2 had behaviors and made inappropriate sexual comments and combative/angry comments to other residents. The writer had a talk with R2 which helped for a while until R2 yelled in the dining room and tried to get others to leave the facility with R2. R2's behaviors seemed to increase in the afternoon and evening. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 1/29/25 at 3:05 AM, indicated R2 displayed aggressive behavior toward other residents with aggressive talk. Staff kept an eye on R2 until R2 went to bed. A progress note, dated 2/8/25 at 9:27 PM, indicated R2 wore (R8's) hat which angered (R8) who confronted R2. An argument was quickly stopped by staff and the residents were separated. Staff were instructed to be sure R2 and R8 were kept apart. On 4/2/25 at 12:17 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who documented the above progress notes. LPN-E indicated R2 had a quick temper and little patience at times. LPN-E did not observe R2 strike anyone and indicated R2 was verbally inappropriate. When asked about documentation on 1/10/25 regarding R2's inappropriate sexual comments and combative and angry comments toward other residents, LPN-E could not recall what R2 said or who the comments were directed toward. LPN-E indicated R2's comments were blunt and often not directed at a specific person. LPN-E indicated incidents with R2 mostly occurred in the lobby. LPN-E indicated female residents watch TV in the lobby which can trigger R2 to make comments when R2 passes by. LPN-E indicated LPN-E's documentation should have been more specific regarding what comments were made and if they were directed at specific residents. LPN-E indicated LPN-E always reports physical incidents and separates residents during physical and verbal altercations. LPN-E indicated incidents are documented in residents' progress notes and might be on the 24-hour report board. LPN-E could not recall if LPN-E reported any incidents that occurred on 1/10/25, 1/29/25, or 2/8/25. On 4/2/25 at 1:00 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated physical altercations should be reported to the SA, however, verbal altercations depend on the situation. DON-B indicated DON-B reviews progress notes daily, discusses incidents at clinical meetings, and updates residents' care plans if needed. DON-B acknowledged R2's 1/10/25 progress note but was unable to provide a report or investigation. DON-B was not aware of R2's 2/8/25 progress note. DON-B indicated the facility was looking for documentation, an investigation, and/or follow-up for the 1/10/25 and 2/8/25 progress notes. On 4/2/25 at 2:00 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A was not employed by the facility on 1/10/25 and started at the facility on 1/20/25. NHA-A indicated NHA-A wanted to know more about the information documented in the progress notes to determine whether or not the incidents were reportable. NHA-A indicated the facility follows their Resident-to-Resident Altercation policy, Abuse and Reporting policy, and the flow sheet. NHA-A confirmed when incidents occur or staff notice an increase in a resident's behavior, staff should notify NHA-A and DON-B in person or by phone to ensure action is taken and the incident is reported appropriately.

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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** 43361 Based on staff interview and record review, the facility did not ensure allegations of abuse were thoroughly investigated for 2 residents (R) (R2 and R8) of 8 sampled residents. Progress notes, dated 1/10/25 and 1/29/25, indicated R2's medical record indicated R2 was sexually inappropriate and/or verbally and physically aggressive toward other residents on 1/10/25 and 1/29/25. In addition, R2 and R8 were involved in a verbal altercation on 2/8/25. The facility did not thoroughly investigate the allegations of abuse. Findings include The facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, revised September 2022, indicates: All reports of resident abuse .are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported 6. Upon receiving an allegations of abuse .the Administrator is responsible for determining what actions (if any) are needed for the protection of residents. Investigating allegations: 1. All allegations are thoroughly investigated. The Administrator initiates investigations .7. The individual conducting the investigation at a minimum: a. Reviews the documentation and evidence; .d. Interviews the person reporting the incident; e. Interviews any witnesses to the incident. f. Interviews the resident (as medically appropriate) or the resident's representative; h. Interviews staff members (on all shifts) who had contact with the resident during the period of the alleged incident .k. Reviews all events leading up to the alleged incident; and i. Documents the investigation completely and thoroughly. The facility's Resident-to-Resident Altercations policy, revised September 2022, indicates: .All altercations, including those that may represent resident-to-resident abuse, are investigated and reported to the Nursing Supervisor, the Director of Nursing Services and the Administrator .2. Behaviors that may provoke a reaction by residents or others include: a. Verbally aggressive behavior such as screaming, cursing, bossing around/demanding, insulting race or ethnic group, intimidating; b. Physically aggressive behavior such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects; c. Sexually aggressive behavior such as making sexual comments, inappropriate touching/grabbing; d. Taking, touching, or rummaging through others' property; and e. Wandering into others' room/space. 3. Occurrences of such incidences are promptly reported to the Nurse Supervisor, Director of Nursing Services, and the Administrator . On 4/2/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had a diagnosis of dementia with psychosis. R2's Minimum Data Set (MDS) assessment, dated 3/5/25, had a Brief Interview for Mental (BIMS) score of 8 out of 15 which indicated R2 had moderate cognitive impairment. (A score of 7 out of 15 indicates severe cognitive impairment.) R2 had an activated Power of Attorney for Healthcare (POAHC). On 4/2/25, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had a diagnosis of history of stroke. R8's MDS assessment, dated 1/7/25, had a BIMS score of 15 out of 15 which indicated R8 was not cognitively impaired. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 1/10/25 at 6:25 PM, indicated R2 made inappropriate sexual and combative and angry comments to other residents. The writer had a talk with R2 which helped for a while until R2 yelled in the dining room and tried to get others to leave facility with R2. R2's behaviors seemed to increase in the afternoon and evening. A progress note, dated 1/29/25 at 3:05 AM, indicated R2 displayed aggressive behavior toward other residents with aggressive talk. Staff kept an eye on R2 until R2 went to bed. A progress note, dated 2/8/25 at 9:27 PM, indicated R2 wore (R8's) hat which angered (R8) who confronted R2. An argument was quickly stopped by staff and the residents were separated. Staff were instructed to keep R2 and R8 apart. On 4/2/25, Surveyor requested investigations for the above progress notes. The facility was unable to provide the information. On 4/2/25 at 1:00 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R2's behavior was common knowledge and there were care plan interventions in place. DON-B indicated DON-B reviews progress notes, follows-up, and revises residents' care plan(s) if needed. DON-B was not aware of the 2/8/25 progress note that indicated R2 took (R8's) hat. DON-B was aware of the 1/10/25 progress note that indicated R2 made sexually inappropriate comments and was physically and verbally aggressive toward other residents. DON-B stated the team would have discussed the documentation at a clinical meeting. DON-B could not provide further information about specific comments that were made or who the comments were directed toward or what type of aggressive behavior was displayed and who the behavior was directed toward. DON-B did not provide documentation to indicate the incidents were reviewed and appropriate action was taken. DON-B indicated staff education had not yet been completed, however, DON-B would provide staff education on sexual abuse, general abuse, and resident-to-resident altercations next week. DON-B indicated R2 was on 1:1 supervision at all times when in R2's wheelchair. On 4/2/25 at 2:00 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A was not employed by the facility on 1/10/25 and started employment on 1/20/25. NHA-A confirmed NHA-A wanted more details regarding the above mentioned progress notes in order to further investigate and determine if care plan revisions were necessary. NHA-A confirmed when incidents occur or staff notice an increase in a resident's behavior, staff should notify NHA-A and DON-B so appropriate action can be taken, including an investigation and care plan revisions.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility did not ensure care plans were revised for 3 residents (R) (R4, R5 and R6) of 8 sampled residents. R4, R5 and R6 were assessed as high risk for falls. The facility did not ensure fall interventions were reviewed, revised, or added to R4, R5, and R6's falls care plans in a timely manner. Findings include: The facility's Falls and Fall Risk, Managing policy, revised March 2018, indicates: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling .5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant . 1. On 4/2/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including chronic pain syndrome and unspecified dementia without behavioral disturbances. R4's Minimum Data Set (MDS) assessment, dated 10/26/24, stated R4's Brief Interview for Mental Status (BIMS) score was 3 out of 15 which indicated R4 had severe cognitive impairment. R4 had a Power of Attorney for Healthcare (POAHC) who was responsible for R4's healthcare decisions. R4 was emergently transferred to a hospital on 1/18/25 and did not return to the facility. A care plan indicated R4 was at risk for falls related to weakness and balance deficits. The care plan contained interventions (all with edited dates of 5/9/24) to assess and treat for postural/orthostatic hypotension, evaluate need for bed/chair alarms, implement exercise program that targets strength, gait and balance, increase staff supervision with intensity based on R4's need, order comprehensive medication review by pharmacist, assess for polypharmacy and medications that increase fall risk, and provide individualized toileting interventions based on needs/patterns. In addition, the care plan indicated R4 required the assistance of two staff for transfers with a sit-to-stand lift (edited date 5/9/24) and the assistance of two staff specifically for toileting with a sit-to-stand lift (created date 1/14/25). A Morse Fall Scale assessment, dated 1/16/25, indicated R4 was at high risk for falls. A fall report, dated 11/6/24, indicated R4 fell at 7:04 PM during a sit-to-stand transfer when R4 lifted R4's arms up and slid out of the sling. Staff slowed the fall and lowered R4 to the floor. The report indicated staff should use a full mechanical lift for transfers as a new intervention. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525657	A. Building B. Wing	04/09/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A fall report, dated 1/18/25, indicated R4 fell at 3:35 AM. Multiple sections of the report were not completed. The report indicated a Certified Nursing Assistant (CNA) discovered R4 sitting on the floor next to the bed without socks or footwear. R4 indicated R4 was trying to get up to go but would not specify where. Staff noted slight redness on R4's right outer ankle and a slight red area on R4's right lower back. R4 was unable to rate the pain. When staff entered the room, R4 was leaning against an unpadded area of the bed which was in contact with R4's right lower back. R4's right foot was flexed, extended, and rotated without issue or visual pain. There were no other injuries, including signs and symptoms of a head injury. R4's vital signs and neuro checks were within normal limits. R4 was assisted back to bed via full mechanical lift. Staff administered Tylenol for generalized pain and applied ice to R4's right ankle. R4's medical record did not indicate if any new interventions were instituted to prevent future falls. A fall report, dated 1/18/25, indicated at approximately 9:00 AM, a CNA called a nurse to R4's room and stated R4 was on the floor and had fallen out of bed. Staff assisted R4 with morning cares and the bed pan approximately 5 minutes before the fall. R4 did not have any results and was assisted back to a sleeping position in the center of the bed facing the window. When the nurse entered the room, R4's head was toward the door and R4's left forehead was resting against the leg of the bedside table. A large amount of blood was on the floor. R4's right hip/leg was across R4's body to the left and under the breast/abdomen and R4's left shoulder/elbow was under R4's body. Blood was observed on the back of R4's head but no posterior head wound was noted. There was a laceration on R4's left forehead just above the brow line. Staff stabilized R4's head and neck to prevent movement and stabilized R4's right leg/hip when R4 was repositioned. R4 had hematomas (blood that collects and fills a space under the skin) on the left arm and right upper thigh but no change in range of motion (ROM) or grip to the upper extremities. R4's right lower extremity was flaccid and without muscle strength. Staff maintained control of R4's right lower extremity until Emergency Medical Services (EMS) arrived. Hospital records, dated 1/18/25 to 1/20/25, indicated R4 was diagnosed with a closed right femur (upper leg long bone) fracture, hypothermia, and hyponatremia. R4's scalp laceration was sutured. R4 was also treated for a urinary tract infection (UTI). R4 underwent palliative surgery for the right femur fracture on 1/29/25. Surveyor reviewed an undated Ad Hoc (done for a specific purpose or situation rather than being planned in advance) Quality Assurance Performance Improvement (QAPI) form that indicated R4's fall out of bed may have been related to staffs' use of a bed pan instead of transferring R4 to the toilet for urinary urgency. On 4/2/25 at 2:11 PM, Surveyor interviewed Director of Nursing (DON)-B who was unsure what interventions were implemented after R4's fall at 3:35 AM on 1/18/25. DON-B thought a fall mat was placed by R4's bed and staff completed increased rounding checks. DON-B indicated changes should be documented on the resident's care plan when they are implemented. On 4/2/25, Surveyor reviewed an undated document from DON-B that indicated R4's care plan was not updated after the early morning fall on 1/18/25, however, staff put a fall mat at R4's bedside and lowered the bed. The document indicated the interventions were not documented on R4's care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 2:46 PM, Surveyor interviewed CNA-C via phone who verified CNA-C was working when R4 fell on [DATE] at 3:35 AM. CNA-C indicated CNA-C was rounding on the opposite end of the building when an agency CNA alerted CNA-C that R4 fell out of bed. CNA-C stayed with R4 while the agency CNA informed the nurse who assessed R4. Staff transferred R4 off the floor and into bed via full mechanical lift and took turns staying with R4 during the remainder of the shift which ended at 6:30 AM. CNA-C indicated there were brief periods when R4 was alone because staff had to provide care for other residents. CNA-C was unsure if new interventions were implemented following the fall. CNA-C indicated R4's bed was in a low position prior to the fall but there was not a mat on the floor next to R4's bed before or after the fall. On 4/2/25 at 2:52 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D via phone who was working when R4 fell on [DATE] at 3:35 AM. LPN-D indicated staff discovered R4 on the floor during rounds. LPN-D completed an assessment and informed R4's POAHC that R4 had no injuries. LPN-D indicated LPN-D found it odd that R4 was sitting on the floor next to the bed because R4 required a full mechanical lift for transfers. LPN-D indicated R4's bed was in a low position and staff completed frequent checks on R4 after the fall. LPN-D could not recall if a mat was on the floor next to R4's bed. 50467 2. On 4/2/25, Surveyor reviewed R5's medical record. R5 was admitted to facility on 6/14/25 and had diagnoses including neurocognitive disorder with Lewy bodies, arthritis left knee, edema, anxiety disorder, pressure-induced deep tissue damage to sacral region, urinary tract infection, and history of left femur fracture. R5's MDS assessment, dated 2/13/25, had a BIMS score of 3 out of 15 which indicated R5 had severe cognitive impairment. R5 had a Guardian who was responsible for R5's healthcare decisions. Fall assessments, dated 11/12/24 and 3/5/25, indicated R5 was at high risk for falls. A falls care plan (with a start date of 6/14/24) contained interventions for bed in low position and locked, mat on the floor next to bed when R5 is in bed, gripper socks on when shoes are off, offer and assist with getting up for the day and completing activities of daily living (ADLs) by 6:00 AM due to prior lifestyle, assess and treat for postural/orthostatic hypotension, ensure call light is within reach, and provide verbal reminders. R5 had falls on 10/25/24, 2/8/25, 2/21/25, and 3/11/25. On 4/2/25 at 2:52 PM, Surveyor reviewed R5's care plan and fall interventions. A fall report indicated R5 was discovered lying on the floor of R5's room on 10/25/24. R5 hit R5's head behind the ear and stated R5's buttock hurt. There were no interventions added to R5's care plan following the fall. Following R5's fall on 2/8/25, an intervention was added for gripper socks. According to R5's care plan, the intervention was already in place as of 6/18/24. Following R5's fall on 2/21/25, interventions were added for a low bed and floor mat. According to R5's care plan, the interventions were not initiated until 3/4/25. Following R5's fall on 3/11/25, an intervention was added for a floor mat. According to R5's care plan, a floor mat was already added on 3/4/25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 4/2/25, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including dementia, pathological fracture to left ulna and left radius, fall from non-moving wheelchair, unspecified injury of the head, encounter for removal of sutures, presence of left artificial hip joint, history of falling, and specified injuries of left hip. R6's MDS assessment, dated 2/12/25, had a BIMS score of 6 out of 15 which indicated R6 had severe cognitive impairment. R6 had a POAHC who was responsible for R6's healthcare decisions. A fall risk assessment, dated 3/5/25, indicated R6 was at high risk for falls. R6's falls care plan (with a start date of 5/13/24) contained interventions for staff to toilet R6 after supper, a fall mat on the floor next to R6's bed at night, encourage regular bedtime routine, assist R6 to the bathroom after lunch, gripper socks on at all times when shoes are not worn, including bed, wheelchair at bedside with brakes engaged, assessment and treatment for postural/orthostatic hypotension, and bed in lowest position R6 had falls on 12/10/24, 1/4/25, 1/10/25, and 2/14/25. Surveyor reviewed R6's fall documentation for the above noted falls. Documentation for R6's 12/10/24 fall indicated an intervention was added to toilet R6 after supper. According to R5's care plan, the intervention was not added until 3/4/25. Documentation following R6's fall on 1/4/25 did not indicate any new interventions were implemented. Documentation for R6's fall on 1/10/25 indicated a floor mat would be implemented. According the R6's care plan, a floor mat was not implemented until 1/14/25. Documentation for R5's fall on 2/14/25 indicated an intervention was added for gripper socks. According to R6's care plan, gripper socks were already implemented on 8/1/24. On 4/2/25 at approximately 3:15 PM, Surveyor interviewed DON-B about R5 and R6's falls. DON-B confirmed changes should be documented on the care plan at the time the change is made or the intervention is implemented. DON-B indicated staff should follow the facility's falls policy.