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	12/04/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and record review, the facility did not ensure food was stored, prepared, and served in a sanitary manner. This practice had the potential to affect all 29 residents residing in the facility.Staff did not consistently monitor and document food holding and cooking temperatures.Staff did not adhere to temperature requirements when testing parts per million (PPM) of the sanitizing solution.The temperatures of kitchen and unit coolers and freezers were not consistently monitored or documented.The dish machine temperatures and chlorine test strips were not consistently monitored or documented.Findings include:During an initial tour of the kitchen on 12/1/25 at 10:03 AM, Dietary Manager (DM)-D stated the facility follows the Wisconsin Food Code as their standard of practice.Holding/Cooking Temperatures:The Wisconsin Food Code documents at 3-401.11 Raw Animal Foods: .Raw animal foods such as eggs, fish, meat, poultry, and foods containing these raw animal foods, shall be cooked to heat all parts of the food to a temperature and for a time that complies with one of the following methods based on the food that is being cooked. The Wisconsin Food Code documents at 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding: (A) .Time/temperature control for safety food shall be maintained: (1) 135 degrees Fahrenheit (F) or above, except that roasts cooked to a temperature and for a time specified in paragraph 3-401.11 (B) or reheated as specified in paragraph 3-403.11 (E) may be held at a temperature of 130 degrees F or above; or (2) At 41 degrees F or less.The Wisconsin Food Code documents at 2-103.11 Person in Charge: The person in charge shall ensure that: .(G) employees are properly cooking time/temperature control for safety food, being particularly careful in cooking those foods known to cause severe foodborne illness and death, such as eggs and comminuted meats, through daily oversight of the employees' routine monitoring of the cooking temperatures using appropriate temperature measuring devices properly scaled and calibrated .From 12/2/25 to 12/3/25, Surveyor reviewed the facility's food holding and cooking temperature logs for October and November 2025 and identified the following deficiencies in maintaining required documentation for all perishable foods across all three daily meals:~ For the month of October, 12 of 93 meals did not contain cooking and holding temperature entries.~ For the month of November, 13 of 90 meals did not contain cooking and holding temperature entries.~ For the month of November, 30 of 90 meals did not contain holding temperatures. ~ For the month of November, 14 of 90 meals did not contain cooking temperatures.On 12/3/25 at 10:36 AM, Surveyor interviewed DM-D who confirmed the missing temperature entries and verified cooking and holding logs should be consistently completed. DM-D stated facility-wide kitchen improvements have been in progress since DM-D started in October. DM-D acknowledged that staff have not been recording holding temperatures for cold items and noted beverages remain out of the cooler during meal service which can extend up to two hours.Sanitizing Solution:The Wisconsin Food Code documents at 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization-Temperature, pH, Concentration, and Hardness: A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under 4-703.11(C) shall meet the criteria specified under 7-204.11 Sanitizers, Criteria, shall be used in accordance with the Environmental Protection Agency (EPA)-registered label use instructions.The Wisconsin Food Code (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	documents at 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration: Concentration of the sanitizing solution shall be accurately determined by using a test kit or other deviceThe Wisconsin Food Code documents at 2-103.11 Person in Charge: The person in charge shall ensure that.(L) employees are properly sanitizing cleaned multiuse equipment and utensils before they are reused, through routine monitoring of solution temperature and exposure time for hot water sanitizing, and chemical concentration, pH, temperature, and exposure time for chemical sanitizing. During an initial kitchen tour that began at 10:03 AM on 12/1/25, Surveyor and DM-D observed sanitizing buckets and a quaternary (quat) sanitizer testing log at the three-compartment sink. The log required twice daily (AM/PM) concentration readings of 200 PPM but did not include a designated column to record the temperature of the sanitizing solution. DM-D stated the facility uses Hydrion QT-40 sanitizer test strips. The manufacturer's instructions on the dispenser indicate for accurate results, the solution must be between 65 F and 75 F and the strip must be submerged for 10 seconds. DM-D confirmed the facility does not verify or document the temperature of the solution prior to testing.On 12/2/25 at 12:28 PM, Surveyor observed [NAME] (CK)-E fill the 3-compartment sink with water and a sanitizing chemical. CK-E then submerged a sanitizing test strip in the sink for approximately 10 seconds which resulted in a reading between 150 and 200 PPM. CK-E did not verify the temperature of the sanitizing solution before testing. CK-E confirmed that checking the temperature of the sanitizing solution is not part of the facility's standard procedure.Surveyor's reviewed the facility's sanitizer test strip logs and noted 26 missing entries over a two month period: 15 omissions in October and 11 omissions in November.On 12/3/25 at 10:36 AM, Surveyor interviewed DM-D who acknowledged the missing entries and confirmed kitchen logs should be consistently completed. DM-D stated DM-D has been working to implement various departmental changes since starting in October.Cooler and Freezer Temperatures:The 2022 Wisconsin Food Code documents at 3-202.11 Temperature: .Perishable food items must be stored at appropriate temperatures to prevent spoilage and reduce the risk of foodborne illnesses. Refrigerators should be set below 41 F (5 Celsius (C)) and freezers at or below 0 F (-18 C).The Wisconsin Food Code documents at 2-103.11 Person in Charge: The person in charge shall ensure that .(F) employees are verifying that foods delivered to the food establishment during non-operating hours are from approved sources and are placed into appropriate storage locations such that they are maintained at the required temperatures, protected from contamination, unadulterated, and accurately presented.From 12/2/25 to 12/3/25, Surveyor reviewed temperature logs for the main kitchen cooler and freezer and a snack refrigerator on the unit. The facility required three daily temperature checks for the main kitchen units. Surveyor identified 14 missing entries in October and 4 in November. The facility required twice daily temperature checks for the snack refrigerator. Surveyor identified 17 missing entries in October and 20 in November.On 12/3/25 at 10:36 AM, Surveyor interviewed DM-D who acknowledged the missing entries for the kitchen and snack refrigerator logs and confirmed temperature checks should be consistently documented. DM-D stated DM-D was working to implement departmental improvements to address the documentation gaps.Dishwashing Temperatures/Chemical Logs:The Wisconsin Food Code documents at 4-501.110 Mechanical Warewashing Equipment, Wash Solution Temperature: .(B) The temperature of the wash solution in spray-type warewashers that use chemicals to sanitize may not be less than 120 degrees F. The Wisconsin Food Code documents at 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration: Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device.The Wisconsin Food Code documents at 2-103.11 Person in Charge: The person in charge shall ensure that .(L) employees are properly sanitizing cleaned multi-use equipment and utensils before they are reused through routine monitoring of solution temperature and exposure time for hot water sanitizing and chemical concentration, pH, temperature, and exposure time for chemical sanitizing. During an initial tour of the kitchen on 12/1/25 at 10:03 AM, DM-D stated the facility operates a low-temperature chemical dish machine. Surveyor observed the machine's data plate which specified a minimum wash and rinse (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperature of 120 F and a chlorine rinse concentration of 50 PPM. DM-D stated the facility used Hydrion chlorine test strips and required staff to verify water temperatures three times daily (prior to the start of dishwashing) and to test chlorine levels twice daily. From 12/2/25 to 12/3/25, Surveyor reviewed the facility's chlorine test strip log which indicated staff should submerge the test strip for one second with a PPM reading of 50. Surveyor noted in October, 6 of 62 entries were incomplete and 21 entries measured 100 PPM or higher. In November, 11 of 60 entries were incomplete and 30 entries measured or exceeded 100 PPM.Surveyor also reviewed the facility's dishwasher temperature log and noted 11 of 93 incomplete entries in October, and 30 of 90 incomplete entries in November. On 12/3/25 at 10:36 AM, Surveyor interviewed DM-D who acknowledged the missing dishwasher temperature and chlorine test strip log entries. DM-D stated DM-D has been implementing kitchen improvements since October and confirmed all log entries should be consistently completed.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 1 resident (R) (R10) of 4 sampled residents received a written transfer and bed-hold notice, including their right to return to the facility. In addition, the facility did not notify the Office of the State Long-Term Care (LTC) Ombudsman of resident transfers and discharges. This practice had the potential to affect more than 4 of the 29 residents residing in the facility.R10 was transferred to the hospital on 9/22/25, 10/10/25, and 11/18/25. The facility did not provide a written transfer notice to R10 for the hospital transfers. In addition, the facility did not provide bed-hold information for R10's 9/22/25 and 10/10/25 hospitalizations.The facility did not ensure the Office of the State LTC Ombudsman was notified of all transfers and discharges for 4 consecutive months. Findings include:The facility's Bed-Hold and Return policy, dated October 2022, indicates: All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payor source, are provided written notice about these policies at least twice: a. Well in advance of any transfer (e.g., in admission packet); and b. At the time of the transfer (or, if the transfer is an emergency, within 24 hours).The facility's Transfer, Emergency Acute Care policy, dated March 2025, indicates: Residents transferred to an acute care setting for emergency treatment are provided with a notice of transfer and permitted to return to the facility .2. When a resident is temporarily transferred to an acute care facility, a notice of transfer is provided to the resident and resident representative as soon as practicable before the transfer. 3. Copies of notices for emergency transfers are also sent to the representative of the Office of the State Long-Term Care Ombudsman.1. From 12/1/25 to 12/4/25, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including local infection due to central venous catheter. R10's Minimum Data Set (MDS) assessment, dated 11/26/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R10 had intact cognition. R10 was responsible for R10's healthcare decisions.R10's medical record indicated R10 was transferred to the hospital on 9/22/25, 10/10/25, and 11/18/25. R10's medical record did not include documentation that R10 was provided a written transfer notice on 9/22/25, 10/10/25, or 11/18/25 or bed-hold information for R10's 9/22/25 and 10/10/25 hospitalizations.On 12/3/25 at 2:11 PM, Surveyor interviewed Regional Nurse Consultant (RNC)-C who stated a verbal bed-hold was obtained for R10's 11/18/25 hospitalization but nothing was provided in writing. RNC-C also verified that R10 was not provided written transfer notices for any of R10's hospital transfers. RNC-C stated Social Worker (SW)-I was responsible for issuing transfer/discharge and bed-hold notices.On 12/4/25 at 12:21 PM, Surveyor interviewed SW-I who confirmed R10 was not provided with written transfer or bed-hold notices. SW-I confirmed a verbal bed-hold authorization was documented for R10's 11/18/25 hospitalization. SW-I stated SW-I was aware transfer and bed-hold notices should have been issued.2. On 12/3/25 at 2:11 PM, Surveyor interviewed RNC-C and requested documentation of transfer/discharge notifications to the State LTC Ombudsman. RNC-C stated SW-I was responsible for Ombudsman notification; however, RNC-C did not believe it had been done since SW-I was hired.On 12/4/25 at 12:21 PM, Surveyor interviewed SW-I who stated SW-I began working at the facility on 7/28/25. SW-I was not aware of SW-I's responsibility to notify the State LTC Ombudsman of transfers and discharges and had not done so since SW-I started at the facility.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, staff interview, and record review, the facility did not ensure essential equipment was maintained in safe operating condition. This practice had the potential to affect more than 4 of the 29 residents and staff residing or working in the facility.The kitchen oven door was not in working condition.Findings include:The Vulcan VG260 is a heavy-duty, 60-inch wide gas restaurant range featuring two standard ovens, each 26 inches wide with thermostats adjustable from 150 Fahrenheit (F) to 500 F, one rack, and two rack positions.During a follow-up visit to the kitchen on 12/2/25 at 12:42 PM, Surveyor observed a black bungee cord tied around the oven door handle and secured around the leg of a side table next to the oven.On 12/2/25 at 12:42 PM, Surveyor interviewed [NAME] (CK)-E who stated the cord is used to keep the oven door shut. CK-E stated the oven door will not stay closed and will slam open if the bungee cord is not secured. CK-E stated the oven door had been broken for 3 years. CK-E stated CK-E was injured when the door fell open and had a burn on CK-E's lower leg as a result.On 12/2/25 at 12:42 PM, Surveyor asked CK-E to remove the bungee cord from the oven door. When CK-E removed the cord, the oven door fell open without resistance. Surveyor noted the kitchen is next to the resident dining room with an adjoining open door.On 12/2/25 at 12:46 PM, Surveyor interviewed Dietary Manager (DM)-D who verified the oven door was broken and did not remain closed unless secured with a bungee cord. DM-D stated the door had been broken for several years. DM-D indicated Nursing Home Administrator (NHA)-A submitted a purchase request to the corporate office for a new oven; however, the corporate office put a hold on all large purchase items. DM-D confirmed CK-E was injured when the oven door fell open and burned CK-E's leg. DM-D stated the door to the kitchen is left open during dining hours and when staff are in the kitchen. DM-D witnessed residents enter the kitchen through the door. DM-D stated residents can get within a few feet of the kitchen door before staff are able to assist them. DM-D stated when the kitchen is not in operation, the door to the dining room is locked.On 12/2/25 at 4:09 PM, Surveyor completed a follow-up observation in the kitchen. Surveyor noted the oven was in use and the bungee cord was removed from door. During the observation, DM-D attempted to remove a panel from the oven and the oven door fell open. DM-D caught the door before being hit.On 12/2/25 at 1:01 PM, Surveyor interviewed NHA-A who was aware the oven door was broken and held shut by a bungee cord. NHA-A stated the door had been broken since NHA-A started in October. NHA-A stated the goal was to get a new oven. NHA-A sent a purchase request to the corporate office for approval but was not aware of its status. NHA-A acknowledged the broken oven door was a potential safety risk.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure a call light was within reach for 2 residents (R) (R8 and R12) of 15 sampled residents.R8 and R12 were observed without access to a call light or a means to notify staff if assistance was needed.Findings include:The facility's Answering the Call Light policy, revised September 2022, indicates: The purpose of this procedure is to ensure timely responses to residents' requests and needs .Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility, and from the floor. 1.From 12/1/25 to 12/4/25, Surveyor reviewed R8's medical record. R8 was most recently admitted to the facility on [DATE] and had diagnoses including dementia, affective mood disorder, anxiety, stroke, convulsions, psychosis, and insomnia. R8's Minimum Data Set (MDS) assessment, dated 9/26/25, indicated R8 was rarely/never understood. R8 had a Guardian for healthcare decisions.On 12/1/25 at 10:51 AM, Surveyor observed R8 in a wheelchair by a window in R8's room. R8's call light was on the bed and not within reach. On 12/3/25 at 10:15 AM, Surveyor observed R8 in a wheelchair by a window in R8's room. R8's call light was on the floor at the foot of the bed and not within reach.(See interviews under example 2.)2. From 12/1/25 to 12/4/25, Surveyor reviewed R12's medical record. R12 was most recently admitted to the facility on [DATE] and had diagnoses including dementia, epilepsy, respiratory failure, cognitive communication deficit, anxiety, depression, and stroke. R12's MDS assessment, dated 10/7/25, had a Brief Interview for Mental Status (BIMS) score of 99 which indicated R12 could not complete the assessment. R12 had a Guardian for healthcare decisions. On 12/1/25 at 12:17 PM, Surveyor observed R12 in a Broda chair next to R12's bed. R12's call light was on the bed and not within reach.On 12/3/25 at 10:15 AM, Surveyor observed R12 in a Broda chair in R12's room. R12's call light was on the bed attached to a pillow behind the Broda chair and not within reach. On 12/3/25 at 10:17 AM, Surveyor activated R12's call light and verified the call light was working.On 12/3/25 at 10:29 AM, Surveyor observed Certified Nursing Assistant (CNA)-Q enter R12's room and assist R12 to Bingo. CNA-Q verified the call light should have been within R12's reach.On 12/3/25 at 10:45 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-M who verified a resident's call light should always be within reach.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on staff interview and record review, the facility did not ensure 2 residents (R) (R27 and R38) of 3 sampled residents signed and received copies of a Notice of Medicare Non-Coverage (NOMNC) form which is used to inform residents of their final day of Medicare Part A insurance coverage, potential liability for payment (daily cost of care and services at the facility), and standard claim appeal rights and instructions.The facility did not provide a NOMNC form to R27 or R38 at least two calendar days before their Medicare Part A services ended.Findings include:The facility's undated Advance Beneficiary Notices policy indicates: It is the policy of the facility to provide timely notices regarding Medicare eligibility and coverage .4. The current Centers for Medicare & Medicaid Services (CMS)-approved versions of the forms shall be used at the time of issuance to the beneficiary. Contents of the form shall comply with related instructions and regulations regarding the use of the form .c. A Notice of Medicare Non-Coverage (NOMNC), form CMS-10123, shall be issued to the resident/representative when Medicare covered service(s) are ending, no matter if the resident is leaving the facility or remaining in the facility .7. To ensure the resident or their representative has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided at least two days before the end of a Medicare-covered Part A stay .8. The Business Office Manager, or designee is responsible for issuing notices .10. Delivery Requirements: a. The notice shall be written legibly in a language and/or format that the resident/representative understands .b. The notice shall be hand-delivered if possible to obtain the beneficiary or representative signature .c. The notice shall be prepared with an original and at least two copies. The facility shall retain the original and give a copy to the resident/representative.CMS form CMS-10123 indicates a NOMNC form must be delivered at least two calendar days before Medicare-covered services end or the second to last day of service if care is not being provided daily. Note: The two-day advance requirement is not a 48 hour requirement .The provider must ensure the beneficiary or representative signs and dates the NOMNC form to demonstrate the beneficiary or representative received the notice and understands the termination decision can be disputed.1. From 12/1/25 to 12/4/25, Surveyor reviewed R27's medical record. R27's Medicare Part A stay began on 11/19/25. R27's last covered day of Part A services was 11/28/25. The facility did not provide R27 or R27's representative with a NOMNC form or provide evidence that R27 or R27's representative were aware of appeal rights. R27 discharged home from the facility on 11/28/25.On 12/2/25 at 4:08 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified a NOMNC form was not issued to R27. NHA-A indicated it is Social Worker (SW)-I's responsibility to issue the NOMNC form. NHA-A acknowledged that R27 should have received a NOMNC form.On 12/2/25 at 4:17 PM, Surveyor interviewed SW-I who verified SW-I did not issue a NOMNC form to R27 or notify R27 of appeal rights.2. From 12/1/25 to 12/4/25, Surveyor reviewed R38's medical record. R38's Medicare Part A stay began on 8/20/25. R38's last covered day of Part A services was 9/3/25. The facility did not provide R38 or R38's representative with a NOMNC form or provide evidence that R38 or R38's representative were aware of appeal rights. R38 discharged home from the facility on 9/3/25.On 12/2/25 at 4:08 PM, Surveyor interviewed NHA-A who verified a NOMNC form was not issued to R38. NHA-A indicated it is SW-I's responsibility to issue the NOMNC form. NHA-A acknowledged that R38 should have received a NOMNC form.On 12/2/25 at 4:17 PM, Surveyor interviewed SW-I who verified SW-I did not issue a NOMNC form to R38 or notify R38 of appeal rights.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure the effectiveness of psychotropic medication was assessed for 1 resident (R) (R25) of 5 sampled residents.R25 was prescribed trazodone (an antidepressant medication) for insomnia. The facility did not complete a sleep assessment for R25 to assess the effectiveness of the medication. In addition, R25 did not have a care plan for insomnia.Findings include:The facility's Sleep Disorders-Clinical Protocol, revised April 2018, indicates: .2. Nursing staff (especially night shift staff) will describe any sleep disturbance in detail; for example, patterns over time, associated behavior, daytime sleepiness, and factors that appear to improve or worsen the situation .Cause Identification: 1. The staff will consider various causes of sleep disturbance such as noise level, room temperature, lighting levels, bed comfort, roommate distractions, and staff intrusion .Treatment/Management: .2. The physician will order appropriate interventions to address sleep disturbances. A. If sleep medications are indicated, they should be prescribed judiciously, in the lowest possible doses for the shortest possible time. Intermittent or short-term use is preferable to continuous nightly use .Monitoring: 1. The physician and staff will monitor the resident's progress toward improving sleep and adjust interventions accordingly. The facility's Psychotropic Medication Use policy, revised February 2025, indicates: 1. Psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. 2. Medication in the following categories are considered psychotropic medications: antipsychotic, antidepressant, antianxiety, hypnotic/sedative medication .3. Psychotropic medication management is an interdisciplinary process .that includes: a. determining adequate indications for use .c. adequate monitoring for efficacy and adverse consequences .Assessment and Evaluation of the Resident: 1. When determining whether to initiate, modify, or discontinue medication therapy, the Interdisciplinary Team conducts and documents an evaluation of the resident.From 12/1/25 to 12/4/25, Surveyor reviewed R25's medical record. R25 was most recently admitted to the facility on [DATE] and had diagnoses including neurocognitive disorder with Lewy bodies, insomnia, anxiety, psychosis, and conduct disorder. R25 received Hospice care and had a Guardian for healthcare decisions.R25 had the following medication orders: ~ Trazodone 100 milligrams (mg) oral tablet at bedtime for insomnia (dated 8/8/25)Medical provider documentation from 8/24/25 at 2:45 PM indicated R25 had experienced increased insomnia and anxiety.R25's medical record did not contain a sleep assessment or a care plan for insomnia. On 12/3/25 at 12:45 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-M who verified R25 received trazodone but did not have a sleep assessment to monitor the effectiveness of the medication.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview and record review, the facility did not implement their abuse policy and procedure for 1 (Certified Nursing Assistant (CNA)-R) of 8 staff reviewed for caregiver background checks. CNA-R was hired through a staffing agency and worked shifts at the facility starting on 7/9/25. The facility did not ensure the staffing agency completed an out-of-state background check for CNA-R who resided outside of Wisconsin within 3 years of hire. Findings include: The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, indicates: .4. Conduct employee background checks and not knowingly employ or otherwise engage any individual who has: a. been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; b. had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of their property; or c. a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property. On 12/4/25, Surveyor reviewed a sample of caregiver background checks for 8 facility and contracted staff, including CNA-R. Surveyor noted CNA-R's Background Information Disclosure form, dated 4/24/23, contained a home address in Louisiana which indicated CNA-R lived outside of Wisconsin within 3 years of hire. On 12/4/25 at 12:00 PM, Surveyor asked Nursing Home Administrator (NHA)-A for CNA-R's out-of-state background check. NHA-A stated CNA-R's out-of-state background check was not available through the staffing agency's website when NHA-A obtained background check information that Surveyor had requested earlier. NHA-A stated NHA-A would contact the staffing agency to obtain the out-of-state background check. On 12/4/25 at 1:45 PM, NHA-A informed Surveyor that when NHA-A contacted the staffing agency and requested CNA-R's out-of-state background check, the staffing agency stated they would look for it and get back to NHA-A. On 12/4/25 at 2:17 PM, NHA-A informed Surveyor that NHA-A had not received CNA-R's out-of-state background check. NHA-A stated when a caregiver is hired through the staffing agency, the agency obtains all background check information. Once hired by the staffing agency, the caregiver may pick up shifts at the facility. NHA-A stated background checks should be available through the staffing agency's website, but are not always verified due to agency staff that pick up shifts at their convenience. NHA-A stated when staff are hired by the agency, the facility trusts the agency to complete a thorough background check prior to hire.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure Preadmission Screening and Resident Review (PASRR) requirements were met for 2 residents (R) (R2 and R25) of 4 sampled residents.R2 was admitted to the facility with a diagnosis of epilepsy. The facility did not include the diagnosis on R2's PASRR Level I Screen and did not submit a referral for a PASRR Level II Screen.R25 was admitted to the facility without a diagnosis of mental illness and was not on psychotropic medication. R25 was later prescribed medication for psychosis, anxiety, depression, insomnia, and conduct disorder. The facility did not complete a new PASRR Level I Screen or submit a referral for a PASRR Level II Screen.Findings include: The facility's Behavioral Assessment, Intervention and Monitoring Policy, revised February 2025, indicates: .2. Behavioral symptoms are identified using facility-approved behavioral screening tools and the comprehensive assessment. 3. The facility complies with regulatory requirements related to the use of psychotropic medications .Comprehensive Resident Assessment: 1. As part of the initial assessment, the nursing staff and attending physician identify individuals with a history of impaired cognition, altered behavior, substance use disorder, or mental disorder. A. All residents receive a Level I PASRR Screen prior to admission. B. If the Level I Screen indicates the individual may meet the criteria for a mental disorder, intellectual disability, or related condition, he or she will be referred to the state PASRR representative for the Level II (evaluation and determination) screening process. C. The Level II evaluation report is used when conducting the resident assessment and developing the care plan .4. Circumstances that warrant a behavioral assessment of a resident include .b. new or worsening change in status or condition. 1. From 12/1/25 to 12/4/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including generalized epilepsy and epileptic syndromes. R2's Minimum Data Set (MDS) assessment, dated 11/11/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R2 had intact cognition. A hospital Discharge summary, dated [DATE], indicated R2 had a witnessed generalized tonic-clonic seizure that lasted approximately 1.5 minutes. R2 was treated with 2 milligrams (mg) of Ativan. R2 was noted to have a remote history of seizures that went back 20 years. R2's diagnoses list included a diagnosis of generalized epilepsy and epileptic syndromes, dated 11/7/25. R2's PASRR Level I Screen, dated 11/7/25, indicated R2 did not have a diagnosis of epilepsy. On 12/4/25 at 10:46 AM, Surveyor interviewed Regional Nurse Consultant (RNC)-C who stated the employee who completes the PASRR Level I Screen does so based off the hospital records. RNC-C stated R2's hospital information did not include a diagnosis of epilepsy which must have been added after R2 was admitted to the facility. RNC-C confirmed R2's PASRR Level I Screen was not updated when the diagnosis was added. RNC-C stated R2's PASRR Level I Screen was now up-to-date and had been submitted for a PASRR Level II Screen. 2. From 12/1/25 to 12/4/25, Surveyor reviewed R25's medical record. R25 was most recently admitted to the facility on [DATE] and had diagnoses including neurocognitive disorder with Lewy bodies, insomnia, anxiety, psychosis, and conduct disorder. R25 received Hospice care and had a (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Guardian for healthcare decisions. R25 had physician orders for: ~ Lorazepam (an anxiolytic medication) 0.5 mg every 2 hours as needed (order date 12/11/25; end date 12/5/25) ~ Lorazepam 0.5 mg twice daily (order date 7/1/25) ~ Mirtazapine (an antidepressant medication) 7.5 mg at bedtime on Monday, Tuesday, Wednesday, Thursday, and Friday (order date 11/12/25) ~ Trazodone (an antidepressant medication) 100 mg at bedtime (order date 8/8/25) R25 was previously prescribed olanzapine (an antipsychotic medication) and quetiapine (an antipsychotic medication) with several dosage changes and eventual discontinuation. On 12/2/25 at 10:05 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who was not aware that a PASRR Level I and Level II had to be submitted for review. NHA-A verified that a PASRR Level I Screen was not redone for R25 and a Level II was also not completed. NHA-A indicated the facility would redo R25's PASRR Level I Screen for submission and initiate audits to make sure PASRRs are correctly completed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure nail care was provided for 2 residents (R) (R7 and R8) of 15 sampled residents.R7 and R8's fingernails were long, jagged, and contained dirt or chipped polish. R7 and R8 were not consistently provided nail care with activities of daily living (ADLs).Findings include:The facility's Care of Fingernails/Toenails policy, revised February 2018, indicates: The purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections .1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed .4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. 1.From 12/1/25 to 12/4/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, brain bleed, fractures of the right femur and second thoracic vertebra with routine healing, and cognitive communication deficit. R7's Minimum Data Set (MDS) assessment, dated 11/3/25, had a Brief Interview for Mental Status (BIMS) score of 99 which indicated R7 could not complete the assessment. R7 had an activated Power of Attorney for Healthcare (POAHC).A care plan, dated 6/6/25, indicated R7's ability to complete ADLs had deteriorated related to dementia. The care plan contained an intervention for staff to assist, using cueing or reminders, with completion of ADLs.On 12/1/25 at 10:30 AM, Surveyor observed R7 in a wheelchair. R7's fingernails were of varying lengths and some were jagged and long. The right middle fingernail and left thumb, index, and middle fingernails were greater than 1/4 inch long. The left fourth and fifth fingers contained dirt underneath the nails. In addition, R7's fingernails contained chipped nail polish. On 12/2/25 at 9:00 AM, Surveyor and Director of Nursing (DON)-B observed R7 in a wheelchair in the doorway of R7's room. When Surveyor asked DON-B to check R7's fingernails, DON-B indicated to R7 that is was time for a manicure which activity staff could provide that afternoon. DON-B also asked R7 to wash R7's hands.On 12/3/25 at 10:06 AM, Surveyor noted R7's fingernails were still long and jagged and had chipped polish. Surveyor interviewed R7 who acknowledged R7's fingernails were long and should be filed.2. From 12/1/25 to 12/4/25, Surveyor reviewed R8's medical record. R8 was most recently admitted to the facility on [DATE] and had diagnoses including dementia, affective mood disorder, anxiety, stroke, convulsions, psychosis, and insomnia. R8's MDS assessment, dated 9/26/25, indicated R8 was rarely/never understood. R8 had a Guardian.A care plan, dated 1/14/25, indicated R8's ability to complete ADLs had deteriorated due to weakness and cognitive deficits. The care plan contained an intervention for staff to assist with ADLs. On 12/1/25 at 10:45 AM, Surveyor noted the nails on R8's left thumb and fourth and fifth fingers were jagged. The left middle finger contained dirt underneath the nail.On 12/2/25 at 9:05 AM, Surveyor and DON-B observed R8's nails. DON-B did not acknowledge that R8's fingernails were jagged or contained dirt but indicated R8's hands should be washed.On 12/3/25 at 9:51 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-M who verified residents' fingernails should be short, clean, and not jagged. ADON-M stated the facility promotes daily nail care if required, otherwise Certified Nursing Assistants (CNAs) trim and clean fingernails on shower days.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure restorative care was provided for 1 resident (R) (R12) of 3 sampled residents. R12 had limited range of motion (ROM) and had a functional restorative program. Staff did not consistently provide restorative care for R12.Findings include:The facility's Restorative Nursing Services policy, revised July 2017, indicates: Residents will receive restorative nursing care as needed to help promote optimal safety and independence. 1. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services. 2. Residents may be started on a restorative nursing program upon admission, during the course of stay, or when discharged from rehabilitative care. 3. Restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care .5. Restorative goals may include, but are not limited to, supporting and assisting the resident in: a. adjusting or adapting to changing abilities; b. developing, maintaining, or strengthening his/her physiological and psychological resources; c. maintaining her/her dignity, independence, and self-esteem.From 12/1/25 to 12/4/25, Surveyor reviewed R12's medical record. R12 was most recently admitted to the facility on [DATE] and had diagnoses including stroke, foot drop, epilepsy, vascular dementia with agitation, cognitive communication deficit, anxiety, depression, malignant neoplasm of connective and soft tissue of left lower limb, and muscle wasting and atrophy of the left thigh and right lower leg. R12's Minimum Data Set (MDS) assessment, dated 10/7/25, had a Brief Interview for Mental Status (BIMS) score of 99 which indicated R12 could not complete the assessment. R12 had a Guardian.A care plan, dated 5/13/24, indicated R12 had reduced physical mobility related to a stroke. The care plan contained interventions (dated 5/13/24) for physical therapy (PT) and occupational therapy (OT) for strengthening as needed and the following functional restorative program: ~ Use documents in closet for guidance of how stretches need to be performed; stretches to be performed preferably while activities of daily living (ADLs) are being completed to complete hygiene; provide gentle approach to stretches and ask R12 to have stretches done as R12 will be more tolerable to stretching. Ask for feedback during stretches to minimize too much discomfort. Facial expressions will let you know if the stretch is too much as well; perform stretches 1-2 times per day minimum to maintain range of motion; assist of 2 will maximize stretches and complete cares. Can be performed in the afternoon when laid down; Follow PT/OT recommendations and functional restorative program as available.On 12/1/25 at 12:16 PM, Surveyor observed R12 who was unable to move any extremities independently. Surveyor was not able to interview R12.On 12/2/25 at 2:05 PM, Surveyor interviewed agency Certified Nursing Assistant (CNA)-U who stated when R12 is assisted to bed, CNAs stretch R12's legs but do not do exercises. On 12/2/25 at 2:11 PM, Surveyor checked R12's closet which did not contain functional restorative exercises. On 12/4/25 at 11:10 AM, Surveyor interviewed Physical Therapy Assistant (PTA)-T who verified R12 had a functional restorative program. PTA-T stated the initial plan was 12 hours per week allotted for a restorative aide for all long-term residents. PTA-T indicated the availability was limited since the restorative aide had other duties and was also the shower aide. PTA-T verified R12 is supposed to receive passive range of motion (PROM) for the upper and lower extremities. PTA-T was uncertain of the amount and frequency of restorative aide visits and stated the estimated time for PROM was 20 minutes and the initial set up was 3 times per week. PTA-T indicated PTA-T did not instruct the CNAs to do PROM and indicated nursing might have incorporated their own restorative program into the care plan.On 12/4/25 at 11:59 AM, Surveyor interviewed CNA-V who stated CNA-V did not do PROM for R12 that day since night shift staff had gotten R12 up already. CNA-V was unaware if NOC shift staff or other staff did PROM.Surveyor reviewed R12's medical record but could not determine if restorative care was being completed. Surveyor asked Nursing Home Administrator (NHA)-A to (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide restorative care documentation.On 12/4/25 at 12:47 PM and 2:47 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the facility did not have a CNA scheduled as a restorative aide and used a staffing agency for staffing needs. NHA-A was uncertain if PROM was being done and indicated it would be done by floor CNAs. NHA-A verified R12's care plan contained a functional restorative program. NHA-A confirmed there was not sufficient charting for PROM and indicated the documentation in R12's medical record was scarce and lacking. NHA-A verified PROM for R12 should have been done daily.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not provide pharmacy services to ensure the accurate administration of medication for 2 residents (R) (R17 and R4) of 8 sampled residents.Staff did not administer a buprenorphine 10 microgram (mcg) per hour transdermal patch or a guaifenesin 600 mg extended release (ER) tablet to R17 in accordance with physician orders.Medications were left at the bedside for R4 to self-administer. R4's last self-administration of medication assessment indicated R4 could not safely and accurately self-administer medication. Findings include: The facility's Reordering, Changing, and Discontinuing Medication Orders policy, revised 7/1/24, indicates: .2. Reorder/Refill Orders: 2.1 Facilities are encouraged to reorder medications electronically or by fax whenever possible . The facility's Resident Self-Administration of Medications policy, revised 11/26/25, indicates: A resident may only self-administer medication after the facility's Interdisciplinary Team (IDT) has determined which medications may be self-administered safely .When determining if self-administration is clinically appropriate for a resident, the IDT should at a minimum consider the following: a) The medications appropriate and safe for self-administration; b) The resident's physical capacity to swallow without difficulty, open medication bottles, and administer injections; c) The resident's cognitive status, including their ability to correctly name their medication and know what conditions they are taken for; d) The resident's capability to follow directions and tell time to know when medications need to be taken; e) The resident's comprehension of instructions for the medications they are taking, including dose, timing, and signs of side effects, and when to report to facility staff; f) The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs; g) The resident's ability to ensure that medication is stored safely and securely .The results of the IDT assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record. 1. From 12/1/24 to 12/4/25, Surveyor reviewed R17's medical record. R17 was admitted to the facility in November 2025 with diagnoses including closed fracture of tibia, diabetes mellitus with diabetic polyneuropathy (nerve pain), and pain unspecified. R17's Minimum Data Set (MDS) assessment, dated 12/2/25, had a Brief Interview for Mental Status (BIMS) score of 1 out of 15 which indicated R17 had severely impaired cognition. R17's medical record included the following orders: ~ Buprenorphine-Schedule III patch weekly; 10 micrograms per hour; transdermal; Special instructions: Remove old patch prior to placing new patch; Once daily on (Wednesday) Morning 6:00-10:00 (AM) (start date 11/15/25) ~ Guaifenesin over-the-counter (OTC) tablet extended release (ER) 12 hour; 600 milligrams (mg); twice daily; Morning 6:00-10:00 (AM), Evening (3:00-5:00 PM) (start date 11/13/25) On 12/3/25 at 8:33 AM, Surveyor observed Registered Nurse (RN)-J prepare medication for R17. RN-J could not find a guaifenesin 600 mg ER tablet in the medication cart but found a bulk bottle of 400 mg guaifenesin tablets. RN-J stated RN-J would look for the guaifenesin 600 mg ER tablets and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continued with medication pass. RN-J also could not find R17's buprenorphine patch in the cart. RN-J stated RN-J would continue to look for the patch when R17 went to bed and would have staff assist in repositioning R17 so RN-J could determine if R17 had a patch on. RN-J stated R17 was scheduled to receive a new patch that day and RN-J would remove the old patch prior to administering a new one. On 12/3/25 at 8:44 AM, Surveyor interviewed RN-J regarding R17's guaifenesin and buprenorphine patch. RN-J stated RN-J would update Surveyor after R17 looked into the medications. On 12/3/25 at 9:35 AM, RN-J approached Surveyor and stated R17's buprenorphine patch was being delivered that night. RN-J stated RN-J would leave R17's current patch on until the new patch arrived. RN-J also stated RN-J was unable to find guaifenesin 600 mg ER tablets. On 12/4/25 at 10:36 AM, Surveyor interviewed Medication Technician (MT)-L who was working on R17's unit and showed Surveyor an OTC unit dose package of guaifenesin 600 mg ER tablets in the medication cart. The medication had been in the top drawer as far as MT-L was aware. MT-L verified MT-L administered R17's guaifenesin 600 mg ER tablet that morning. When Surveyor asked if R17's buprenorphine patch was received last night, MT-L checked the narcotic medication box and observed the patch. The medication sheet indicated one buprenorphine patch was received by the night shift nurse and was not administered. MT-L viewed R17's Medication Administration Record (MAR) which contained a note from RN-J that indicated the medication was not administered on 12/3/25. The order did not show up to administer at the time of review. On 12/4/25 at 10:55 AM, Surveyor interviewed RN-J and Licensed Practical Nurse (LPN)-K regarding R17's buprenorphine patch. RN-J stated RN-J informed the two oncoming PM shift nurses that R17's buprenorphine patch was being delivered and needed to be administered. RN-J stated since the nurse who received and signed for the buprenorphine patch was a night shift nurse, the PM shift nurse may not have relayed that the patch should be administered upon arrival. When Surveyor asked RN-J and LPN-K about the guaifenesin 600 mg ER tablets that were observed in the medication cart, LPN-K stated the guaifenesin tablets were always in the cart. RN-J stated the tablets either just came in or RN-J did not see them. RN-J verified that RN-J did not administer guaifenesin to R17 on 12/3/25. On 12/4/25 at 11:01 AM, RN-J entered Assistant Director of Nursing (ADON)-M's office to ask how to change R17's buprenorphine patch since it was a day late. Physician Assistant (PA)-P was present during the discussion. It was decided to discontinue R17's original patch order and renter an order to begin on 12/4/25 and then weekly. Surveyor interviewed PA-P who stated R17 did not have adverse effects or discomfort due to the delay of the buprenorphine patch and had other medications to control pain. PA-P indicated since the patch was a seven day therapy, an extra day was still therapeutic. PA-P stated the pharmacy only provides one patch at a time and the facility should be more diligent in ensuring the patch is ordered. On 12/4/25 at 12:12 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Regional Nurse Consultant (RNC)-C regarding the medication reordering process. NHA-A indicated medications are filled monthly and nurses add new medications sent by the pharmacy to the appropriate medication cart. If a medication runs out during the month, the nurse should select the resupply button in the resident's medical record. RNC-C stated the nurse can order the medication by faxing a refill to the pharmacy. 2. On 12/3/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and had diagnoses including colectomy with creation of a colostomy, stage 4 sacral decubitus ulcer, stage 4 heel ulcer, quadriplegia due to C5-C7 spine complete injury, diabetes, chronic obstructive pulmonary disease (COPD), and depression. R4's MDS assessment, dated 10/24/25, had a BIMS score of 13 out of 15 which indicated R4 had intact cognition. R4 made R4's own healthcare decisions. A Self-Administration of Medication Approval form, dated 8/19/24, indicated R4 did not want to self-administer medication. The assessment indicated R4 had modified independence with daily decision-making, could not open medication containers, pour pills out of a bottle, or punch out of a card/package, could not properly dispense eye drops, inhalers, or nasal sprays, and could could not swallow medication without altering the dispensed form (crushed). The form indicated it was not appropriate for R4 to self-administer medication. On 12/2/25 at 12:19 PM, Surveyor observed MT-X dispense medications for R4 (which were not crushed) into a cup and hand the cup to R4. R4 self-administered a metoclopramide 5 mg tablet but left two 80 mg simethicone tablets in the cup. R4 put the on the bedside table. As MT-X exited the room, Surveyor asked if R4 self-administered medication. R4 stated staff brought medication to R4's room in a cup and R4 took the medication after lunch. R4's medical record contained an order for simethicone 80 mg chewable oral tablet, 2 tablets four times daily (order date 5/12/25). R4's medical record did not contain an order to self-administer medication or a care plan for self-administration of medication. On 12/2/25 at 12:23 PM, Surveyor interviewed MT- X who stated R4 could self-administer medication at the bedside. MT-X was not sure if R4 had a self-administration of medication order. MT- X stated MT- X was trained to leave the medications at the bedside for R4 to take at will. MT- X indicated MT-X checked on R4 later to make sure the medications were taken which Surveyor did not observe. On 12/3/25 at 9:56 AM, Surveyor interviewed ADON-M who verified medication should not be left at the bedside and indicated a new self-administration of medication assessment should have been completed for R4.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure monitoring for adverse reactions to a high-risk medication was in place for 1 resident (R) (R19) of 4 sampled residents.R19 was prescribed cefdinir (an antibiotic) for prophylactic measures. R19 was not monitored for adverse reactions to the medication.Findings include:The facility's High Risk Medications policy, dated 2025, indicates: The facility recognizes that some medications are associated with greater risks of adverse consequences than other medications. These high-risk medications can include .antibiotics .6. The resident's plan of care shall alert staff to monitor for adverse consequences of any high-risk medications given.https://medlineplus.gov indicates cefdinir may cause side effects including vomiting, nausea, stomach pain, diarrhea, headache, vaginal itching, reddish-colored stools, rash, hives, swelling of the face, throat, tongue, lips or eyes, difficulty breathing or swallowing, watery or bloody stools, stomach cramps, or fever during treatment or for up to two or more months after stopping treatment, a return of fever, sore throat, chills, or other signs of infection.From 12/1/25 to 12/4/25, Surveyor reviewed R19's medical record. R19 was admitted to the facility on [DATE] and had diagnoses including history of urinary tract infection (UTI), retention of urine, infection and inflammatory reaction due to indwelling urethral catheter, and sepsis. R19's Minimum Data Set (MDS) assessment, dated 11/7/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R19 had intact cognition.R19's physician orders included an order for cefdinir 300 milligrams (mg) once daily (start date 5/28/25). The order did not include an end date. The order indicated the medication was for prophylactic measures due to a history of UTIs.R19's medical record did not indicate R19 was being monitored for adverse reactions to the prophylactic antibiotic.On 12/3/25 at 2:13 PM, Surveyor interviewed Regional Nurse Consultant (RNC)-C who confirmed adverse reaction monitoring was not implemented for R19's antibiotic. RNC-C stated monitoring for adverse reactions should have been implemented when R19 started the antibiotic.

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	525657	A. Building B. Wing	12/04/2025

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 2 residents (R) (R8 and R13) of 2 sampled residents were assessed for safety and had care plans to guide assistance by Paid Feeding Assistants (PFAs).The facility did not assess if R8 and R13 were appropriate to be assisted by PFAs prior to using PFAs to assist R8 and R13 with dining. In addition, R8 and R13 did not have care plans that indicated they could be fed by PFAs.Findings include:The facility's undated Dining Assistant policy indicates: Dining Assistants will follow the requirements of federal regulations and the Wisconsin Feeding Assistant Program .I. The following individuals are able to provide feeding assistance: .C. Dining Assistants - 1) Who have successfully completed an approved training program, written quiz, and skills demonstration; 2) Who only physically assist feeding residents who have no complicated swallowing/feeding concerns, as determined by a Registered Nurse basic assessment who may consult with Interdisciplinary Team (IDT) members; .4) Works under the direct supervision and receives direction from a Licensed Nurse; D. Procedure for assessment of complicated eating/drinking problems may include but is not limited to: 1. Modified diet; 2. Difficulty swallowing current diet; 3. Signs/symptoms of choking or aspiration with eating/drinking prior to admission or since last admission; 4. Aspiration pneumonia history; 5. Diagnosis of dysphagia with indicated swallowing problems; 6. Speech therapy guidelines - is patient/resident consistently adhering to them? .The RN, in assessing the above indicators of potential complicated eating/drinking problems, will determine if a PFA may assist with meals based on resident history and/or with consultation with Speech Therapist and other members of the IDT .E. The nurse will complete an assessment upon admission to determine whether the resident has a complicated feeding condition. The results will be included on the care plan. Additional assessments will be completed quarterly and when a resident exhibits a change in condition resulting in difficulty chewing/swallowing.1. From 12/1/25 to 12/4/25, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including dementia with behavioral disturbance, history of cerebral infarction, protein-calorie malnutrition, and unspecified psychosis. A Speech Language Pathologist (SLP) Evaluation, signed by R8's physician on 5/15/25, included a diagnosis of oropharyngeal dysphagia. R8's Minimum Data Set (MDS) assessment, dated 10/3/25, indicated R8 had severely impaired cognition. R8 had a Guardian who was responsible for healthcare decisions.A SLP evaluation, dated 5/6/25, indicated R8 required assistance with feeding and had to be fed by staff at times. The evaluation indicated R8 was at risk for aspiration due to dependency on staff for feeding for adequate nutritional dehydration.A SLP Discharge summary, dated [DATE] and completed by SLP-F, indicated a functional maintenance program was established to include decreased distractions, upright positioning, slow rate, small bites, alternation of liquids and solids, visualize swallow before presenting next bite, encourage self-feeding and drinking, offer verbal cues and tactile cues to continue with meal, try all food and drink items, and reapproach and provide food alternatives as able to improve nutrition and hydration.Surveyor reviewed the facility's DHS F-62595-Long Term Care Facility Feeding Assistant Roster. The roster included Human Resources (HR)-G and Medical Records (MR)-H.On 12/2/25 at 2:31 PM, Surveyor interviewed HR-G who confirmed HR-G was trained as a PFA and had assisted residents with meals, including R8. HR-G indicated the last time HR-G assisted a resident was a few months ago. On 12/3/25 at 11:52 PM, Surveyor completed a follow-up interview with HR-G who clarified that HR-G did not physically assist R8 and with eating but did assist with cueing. HR-G was unaware of a list or written instructions on how to assist residents and stated nursing staff provide instructions in the moment if HR-G is asked to assist a resident.On 12/2/25 at 2:39 PM, Surveyor interviewed MR-H who confirmed MR-H was trained as a PFA and had assisted residents with meals. MR-H indicated MR-H assisted R8 with a meal a few weeks prior.R8's medical record and care plan did not indicate an IDT (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment or evaluation was completed regarding R8's appropriateness for the PFA program.2. From 12/1/25 to 12/4/25, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had diagnoses including severe dementia with anxiety, pneumonia, acute cough, and oropharyngeal dysphagia. R13's MDS assessment, dated 11/25/25, had a Brief Interview for Mental Status (BIMS) score of 00 out of 15 which indicated R13 had severely impaired cognition. R13 had an activated Power of Attorney for Healthcare (POAHC) who was responsible for R13's healthcare decisions.R13's most recent SLP evaluation, dated 5/28/22, indicated R13 had difficulty swallowing, choked on medications, coughed on liquids, and had poor liquid intake. The evaluation indicated R13 was at risk for choking, aspiration, and inadequate intake of liquids and solids to meet hydration and nutrition needs.A SLP Discharge summary, dated [DATE] and completed by SLP-F, included discharge recommendations of upright positioning, slow rate, small bites, assist with feeding if sleepy, alternate liquids and solids to facilitate oral clearance, regular texture solids, thin liquids, and medications crushed or whole in puree with extra time for swallowing and extra liquids to facilitate oral clearance.On 12/2/25 at 2:31 PM, Surveyor interviewed HR-G who confirmed HR-G was trained as a PFA and had assisted residents with meals, including R13. HR-G indicated the last time HR-G assisted a resident was a few months ago. On 12/3/25 at 11:52 PM, Surveyor completed a follow-up interview with HR-G who clarified that HR-G did not physically assist R13 with eating but did assist with cueing. HR-G reported specifically assisting R13 in HR-G's office during one-to-one supervision. HR-G was unaware of a list or written instructions on how to assist residents and stated nursing staff provide instructions in the moment if HR-G is asked to assist a resident.R13's medical record and care plan did not indicate an IDT assessment or evaluation was completed regarding R13's appropriateness for the PFA program.On 12/3/25 at 12:46 PM, Surveyor interviewed SLP-F who confirmed SLP-F evaluated and completed treatment programs with R8 and R13. SLP-F stated SLP-F assessed R8 in the summer of 2025 but had not assessed R13 since 2022. SLP-F indicated it was not appropriate for PFAs to physically assist residents with dysphagia. SLP-F stated PFAs may assist with additional supervision in the dining room but should not provide swallowing cues specific to SLP recommendations. SLP-F indicated PFAs should not complete one-to-one cueing for a resident with dysphasia.On 12/2/25 at 2:23 PM, Surveyor interviewed Regional Nurse Consultant (RNC)-C and Nursing Home Administrator (NHA)-A. RNC-C stated the facility does not have a true PFA program because the facility does not hire outside staff to be PFAs. RNC-C stated the facility trained some of their non-clinical staff to be PFAs and confirmed the facility is approved to provide the state training. RNC-C and NHA-A stated the facility does not have any residents currently on the program and has rarely used the program in the past because the IDT could not approve residents who required assistance with eating because of complications. On 12/4/25 at 2:48 PM, Surveyor completed a follow-up interview with NHA-A who confirmed the facility does not have a list of residents who have been assessed as appropriate for the PFA program. NHA-A confirmed PFAs should not physically assist or provide cueing for residents with dysphagia. NHA-A stated the facility will provide education to necessary staff to ensure PFAs do not provide verbal or physical assistance to residents diagnosed with dysphagia.

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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, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 1 resident (R) (R3) of 11 sampled residents.R3 had a Foley catheter but was not on enhanced barrier precautions (EBP). Staff provided high-contact care for R3 without wearing a gown. In addition, staff did not complete appropriate hand hygiene during the provision of care.Findings include: The facility's Enhanced Barrier Precautions policy, revised December 2024, indicates: Enhanced barrier precautions (EBP) are used to prevent the spread of multidrug-resistant organisms (MDROs) to residents .1. EBP refers to infection prevention and control interventions designed to reduce the transmission of MDROs during high-contact resident care activities. 2. EBP applies when: a. A resident is infected or colonized with a Centers for Disease Prevention and Control (CDC)-targeted MDRO, but does not have a wound or indwelling medical device, and does not have secretions or excretions that cannot be covered or contained; b. A resident is not known to be infected or colonized with an MDRO, has a wound or indwelling medical device, and does not have secretions or excretions that are unable to be covered or contained; and c. Contact precautions do not otherwise apply .5. Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheostomies .8. Examples of high-contact resident care activities requiring the use of a gown and gloves for EBP include: a. dressing; b. bathing/showering; c. providing hygiene or grooming; d. changing briefs or assisting with toileting; e. transferring; f. providing bed mobility; g. changing linens; h. prolonged, high-contact with items in the resident's room, with resident's equipment, or with resident's clothing or skin (e.g., in the shower room, therapy gym, or during restorative care); i. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and j. wound care (any skin opening requiring a dressing.) The facility's Handwashing/Hand Hygiene policy, revised October 2023 indicates: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections .1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Alcohol-based hand rub (ABHR) dispensers are placed in areas of high visibility and consistent with workflow throughout the facility .Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); c after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching a resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal; .5. The use of gloves does not replace hand washing/hand hygiene. On 12/2/25 at 1:22 pm, Surveyor reviewed R3's medical record. R3 was admitted to the facility in April 2025 with diagnoses including unspecified displaced fracture of first cervical vertebra, discitis cervical region, methicillin-susceptible Staphylococcus aureus (MSSA) (an infection caused by a type of bacteria commonly found on the skin), type 2 diabetes, and unspecified pain. R3 had a urinary catheter. R3's Minimum Data Set (MDS) assessment, dated 11/12/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R3 had intact cognition. On 12/2/25 at 1:57 PM, Surveyor entered R3's room with permission. Upon entering the room, Surveyor observed two staff who were not wearing gowns and had just transferred R3 from wheelchair to bed. One staff then exited the room with a lift. Agency Certified Nursing Assistant (CNA)-S donned gloves, emptied R3's catheter bag, cleansed the drainage port with an alcohol wipe, and disposed of R3's urine. During the provision of care, CNA-S did not wear a gown. CNA-S completed hand hygiene after removing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA-S and Surveyor exited the room after CNA-S could not find a brief. At 2:07 PM, Surveyor observed CNA-S stop outside R3's door prior to re-entering the room. CNA-S indicated there was a personal protective equipment (PPE) cart near the door but not a sign indicating if CNA-S should wear PPE. CNA-S donned a gown and gloves prior to re-entering R3's room and completed catheter and peri-care. CNA-S then removed gloves. Without completing hand hygiene, CNA-S donned clean gloves and put a clean brief on R3. After the observation and upon exiting R3's room, Surveyor interviewed CNA-S who verified CNA-S did not wash or sanitize hands after removing soiled gloves and prior to donning clean gloves. When asked when gowns and gloves should be worn, CNA-S stated if the resident has a Foley catheter, tuberculosis (TB), or influenza. When asked if staff should wear a gown and gloves while emptying a catheter bag or transferring a resident on EBP, CNA-S indicated it is okay not to if the resident doesn't have a wound. When asked about infection control education provided by the facility, CNA-S stated CNA-S was an agency staff and had not received infection control education from the facility. CNA-S stated a phone app used by CNA-S's agency indicated to review a binder at the facility prior to working. CNA-S did not see the binder and thought it was locked in the nurses' station. CNA-S had previously worked at the facility but had not received infection control education or reviewed a binder. On 12/2/25 at 2:29 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Regional Nurse Consultant (RNC)-C regarding EBP, hand hygiene, and agency staff infection control training. Surveyor shared observations of CNA-S emptying R3's catheter bag without wearing a gown, not completing hand hygiene between removing soiled gloves and donning clean gloves, and not wearing a gown while transferring R3. Surveyor also indicated there was not an EBP sign on or near R3's door. DON-B stated EBP should have been implemented due to R3's Foley catheter and indicated the sign must have fallen off the door. DON-B stated DON-B did not think transferring a resident in their room was close contact that required the implementation of EBP. (Of note, observations of other EBP signs on residents' doors indicated staff should wear a gown and gloves during transfers.) DON-B stated outgoing CNAs complete walking rounds with oncoming CNAs at shift change and relay information about the binder that agency staff need to review. NHA-A verified EBP is not included in the education on the agency's website for agency staff to complete prior to working at the facility. When NHA-A asked DON-B if the facility had an agency orientation binder, DON-B stated not that DON-B was aware of.