STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525665	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frederic Nursing and Rehab Community	205 United Way Frederic, WI 54837

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview and record review, the facility did not ensure sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This has the potential to affect all 54 residents residing at the facility.The facility's Payroll Based Journal (PBJ) triggered for excessively low weekend staffing for Quarter 3 2025 and Quarter 1 2026.Resident Council interviews voiced concerns with short staffing on weekends and longer call light wait times.Staff interviews voiced insufficient staffing levels to meet resident needs.Findings include:Example 1On Sunday, 05/17/26, Surveyors entered facility shortly after 9 AM. Census posting noted 54 residents, 2 licensed nurses, and 5 Certified Nursing Assistants (CNA). Surveyors observed posted staff to be present.Surveyor reviewed the facility's census for Quarter 3 2025 (April 1-June 30) and Quarter 1 2026 (October 1 - December 31). Facility's average daily census is greater than 51. Working schedules noted a licensed nurse on each shift to be consistent every day of the week. CNAs schedule shows as follows:Monday - Friday had 6 CNAs on days, 5 CNAs on evenings, and 3 CNAs on overnights. Saturday and Sunday had 5 CNAs on days, 5 CNAs on evenings, and 3 CNAs on overnights.Surveyor noted every schedule posted had multiple shifts which did not have a staff member scheduled and was highlighted.Surveyor reviewed the facility's actual working schedule and noted the following dates to have working CNAs less than anticipated to be scheduled:-Quarter 3 202504/12/25: 4 CNAs on days; 4 CNAs on evenings.04/13/25: 4 CNAs on evenings; 2 CNAs on overnights.04/18/25: 4 CNAs on days; 2 CNAs on overnights.04/19/25: 4 CNAs on evenings.04/20/25: 4 CNAs on evenings.04/26/25: 4 CNAs on evenings; 2 CNAs on overnights.04/27/26: 4 CNAs on days; 2 CNAs on overnights.05/03/25: 4 CNAs on evenings.05/04/25: 4.5 CNAs on days; 2 CNAs on overnights.05/10/25: 4 CNAs on days.05/11/25: 4 CNAs on days; 4 CNAs on evenings.05/17/25: 4 CNAs on days.05/18/25: 4.5 CNAs on days.05/24/25: 4 CNAs on days; 4 CNAs on evenings; 2 CNAs on overnights.05/25/25: 4 CNAs on days; 2 CNAs on overnights.05/31/25: 4 CNAs on evenings.06/08/25: 2 CNAs on overnights.06/14/25: 4 CNAs on days.06/15/25: 2 CNAs on overnights.06/21/25: 4 CNAs on evenings.06/22/25: 4 CNAs on evenings.06/28/25: 3 CNAs on days.-Quarter 1 202610/04/25: 4 CNAs on evenings.10/05/25: 4 CNAs on evenings.10/11/25: 4 CNAs on days; 4 CNAs on evenings; 2 CNAs on overnights.10/12/25: 4 CNAs on evenings.10/18/25: 4 CNAs on days.10/19/25: 4 CNAs on days.10/25/25: 3 CNAs on evenings; 2 CNAs on overnights.10/26/25: 4 CNAs on days; 3.5 CNAs on evenings; 2.5 CNAs on overnights.11/15/25: 4 CNAs on days; 4 CNAs on evenings; 2.5 CNAs on overnights.11/16/25: 4 CNAs on days.Surveyor reviewed staffing schedules for 01/01/26 - 05/17/26 and noted continued CNA openings on multiple shifts which were not filled.On 05/19/26 at 9:03 AM, Surveyor interviewed Scheduler D who stated staffing levels are determined by the census and the Director of Nursing (DON). Surveyor asked Scheduler D if the facility had enough full-time and part-time staff to fill all the required shifts needed to meet resident needs. Scheduler D stated no and every schedule usually has shift openings which will hopefully be filled by as-needed (PRN) staff or regular staff picking up shifts. Surveyor asked Scheduler D why the weekend CNAs are scheduled less than weekday. Scheduler D stated she tries not to do that, but with staff working every other weekend it can be (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	difficult to fill. Surveyor asked if there was a chart or guide used to determine staffing levels. Scheduler D said no.On 05/19/26 at 10:16 AM, Surveyor interviewed DON B regarding scheduling. DON B stated staffing needs are determined by patient per day (PPD) ratios and based on census. Surveyor asked DON B for a copy of the PPD used to determine staffing. DON B stated she did not have it. Surveyor asked DON B why less CNAs are needed on weekends if census does not change. DON B stated weekdays usually include a 6th CNA to assist residents with baths, and this isn't typically done on weekends, but otherwise it should be no different. Surveyor asked DON B why schedules have highlighted areas with no staff scheduled for numerous shifts. DON B stated these were shifts which were open and it gets posted for staff to volunteer to fill. Surveyor asked DON B what steps are taken to fill these shifts if staff do not volunteer. DON B stated they just do their best to get it filled.On 05/19/26 at 10:50 AM, Surveyor interviewed Nursing Home Administrator (NHA) A regarding scheduling. NHA A stated the facility uses a grid showing PPD that guides staffing levels. Surveyor asked for a copy of the grid. NHA A stated she couldn't find it but will look. No grid or guide was provided to Surveyor showing CNA staffing levels needed.Example 2On 05/18/26 at 2:20 PM, Surveyor completed Resident Council interview with 9 residents (R13, R17, R24, R28, R36, R38, R3, R47, and R49). Surveyor asked residents how long, on average, they wait for assistance. All residents stated the typical wait time is 10-15 minutes during the week. On weekends, wait times can be upwards of 20-30 minutes. Surveyor asked how long this has been happening. Residents voiced this to be a constant. Surveyor asked if this concern has been reported to the facility. Residents stated that the facility already knows about short staffing, so there is no point in saying anything.Example 3On 05/18/26 at 7:25 AM, Surveyor interviewed Licensed Practical Nurse (LPN) K if she felt there were enough staff to meet resident needs. LPN K stated some days it is, others not so much. Surveyor asked LPN K to explain her answer. LPN K stated it just sometimes feels like there are not enough people staffed or there are lots of call-ins and you are running around frantically.On 05/19/26 at 10:16 AM, Surveyor interviewed Maintenance Supervisor (MS) L. MS L stated, I am so glad that we got to talk. I want to explain that we are down 2 housekeepers, and a housekeeper had called off last Friday which then was a trickle effect where rooms were missed. I can promise you Evergreen hallway does not normally look like that. Usually if we are short-staffed, we know we can't get to the deep cleaning, but resident rooms should have been cleaned daily but we just didn't have the staffing capacity.On 05/19/26 at 11:01 AM, Surveyor interviewed CNA H regarding staffing. CNA H stated schedules are always posted with open shifts for staff to pick up. CNA H stated inability to recall one schedule with all shifts completely filled. CNA H stated by the end of most shifts, CNA H feels as though CNA H was unable to meet all resident needs in a timely manner, and baths are often pushed to the next day because there wasn't enough time to get to everyone. Surveyor asked if this concern has been brought to the DON's attention. CNA H stated yes, the facility keeps putting out ads on the radio and in the paper, but there just doesn't seem to be any improvement.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility did not ensure the facility wide assessment developed by the facility included all relevant details to ensure the facility provided care and services to residents to meet their individual needs within the facility's identified resources. This has the potential to affect all 54 residents.The Facility Assessment did not indicate how resident needs are assessed to determine sufficient staffing levels.Findings include:Facility Assessment Tool, with a reviewed date of 03/09/26, states: .Average daily census: 50-53.Assistance with Activities of Daily Living include an assist of 1-2 for up to 85% of residents and dependent assist up to 15% of residents.Direct care staff needs of 5-6 CNAs on day shift; 4-5 CNAs on evening shift; 2-3 CNAs on overnight shift.The department directors along with the medical records/staffing clerk for nursing develop a block schedule.On 05/19/26 at 10:16 AM, Surveyor interviewed Director of Nursing (DON) B regarding assessing staffing needs. DON B stated staffing is determined using a patient per day (PPD) system. Surveyor asked for clarification and DON B stated it means staffing is determined by census and the overall budget. DON B stated facility tries to staff more based on resident acuity but this is not always possible.On 05/19/26 at 10:50 AM, Surveyor interviewed Nursing Home Administrator (NHA) A regarding facility assessment of staffing needs. NHA A stated a PPD system is used. Surveyor asked how this method is evaluated to determine the residents' needs are met. NHA A did not provide additional documentation demonstrating current methods for evaluating staffing levels were sufficient to meet resident care needs.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility did not ensure that each resident has a safe, clean, comfortable, and homelike environment, including, but not limited to, receiving treatment and support for daily living for 5 (R38, R25, R41, R47, R48) of 6 resident rooms observed and in the hallway on Evergreen unit. Findings include: Surveyor reviewed facility policy titled, Cleaning and Disinfecting Resident Rooms, dated last revised 01/25, states: .Purpose: To provide guidelines for cleaning and disinfection resident's room. Procedure: 1. Housekeeping surfaces (e.g. floors, tabletops) will be cleaned on a regular basis when spills occur, and when these surfaces are visibly soiled. 2. Environmental surface will be disinfected (cleaned) on a regular basis (e.g. daily, three times a week) when surfaces are visibly soiled. 4. Wall, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled. Surveyor reviewed facility Housekeeping task form titled, Housekeeping Areas of Responsibility, which states: .Housekeeper 2 performs cleaning for all of Evergreen Wing, Evergreen public restrooms, dining room, lounge, front entryway, 1 deep clean, and therapy room spa. On 05/17/2026 at 10:04 AM, Surveyor walked down Evergreen hallway and immediately observed stains, sunflower seeds, and trash on floor of the hallway and in residents' rooms. Surveyor observed used dirty napkins scattered all over R38's floor. Surveyor observed food crumbs on R38's floor around bedside table and underneath R38's bed. On 05/17/26 at 10:06 AM, Surveyor observed trash and cracker wrappers under R25's bed. Surveyor observed brown stains on floor upon entry into R25's room. On 05/17/2026 at 10:19 AM, Surveyor observed R41's floor to have stained brown spots from entryway to R41's bed. Surveyor observed trash crinkled and lying under R41's bed. Surveyor observed red stains on the outside of R41's door on wall upon entry. On 05/17/2026 at 10:25 AM, Surveyor observed R47's contact precaution room to have an odor and a severe build-up film of dirt and sticky substance on floors. Surveyor observed a strong odor coming from R47's room. Surveyors observed cookie crumbles and broken crackers on R47's floor. On 05/17/2026 at 10:30 AM, Surveyor observed grime and dirt built up along the walls and hand railings down Evergreen hallway. On 05/18/2026 at 7:41 AM, Surveyor observed R47's contact precaution room to have a severe build-up film of dirt and sticky substance on floors. Surveyor observed a strong odor coming from R47's room, same as yesterday's observation on 05/17/26. On 05/18/26 at 8:10 AM, Surveyor observed R48's room to have a trash can full of garbage, which was falling out onto the floor and trash noted under R48's bed. Surveyor observed a yellow brown liquid stain on floor located near R48's bed. On 05/18/26 at 9:31 AM, Surveyor observed debris, dirt, and sunflower seeds in the Evergreen hallway. Surveyor observed the Evergreen hallway still had dirt and food on the floors. On 05/19/26 at 8:19 AM, Surveyor interviewed Housekeeping Assistant (HA) M and asked if HA M and Surveyor could assess R47's room for cleanliness together and also the Evergreen hallway. HA M reported to Surveyor that the housekeeping department has been short-staffed, and HA M spent Saturday 05/16/26 and Sunday 05/17/26 fixing wheelchair brakes and other items which were broken to help maintenance department. Surveyor asked if HA M is also cross trained in maintenance department. HA M reported to Surveyor they just help out in the maintenance department, if need be, but HA M did not get to clean the rooms on Evergreen hallway this last weekend. Surveyor showed HA M R47's floor in R47's room and the lack of cleanliness. HA M reported to Surveyor R47's room was deep cleaned prior to R47 being admitted to the facility because there was a previous resident who was in there and the room had an odor after the resident left. Surveyor asked HA M if R47's room was cleaned within the last 3 days. HA M reported R47's room had not been cleaned since last week. Surveyor asked HA M if any rooms on Evergreen hallway were cleaned in the last 3 days. HA M reported HA M did not get to clean any of Evergreen hallway rooms since last week. Surveyor asked HA M when Evergreen hallway rooms are supposed to be cleaned. HA M reported all resident rooms are to be cleaned daily by the full-time housekeepers. HA M reported at this time, full-time (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	housekeepers are HA M and HA N. HA M reported working over the weekend, and HA N has come in today, 05/19/26, to catch up on Evergreen hallway rooms. Surveyor asked HA M when Evergreen hallway should be cleaned. HA M reported Evergreen hallway should be vacuumed and deep cleaning of walls and rails are done weekly but since short-staffed the deep cleaning has been put on hold. On 05/19/26 at 10:16 AM, Surveyor interviewed Maintenance Supervisor (MS) L and asked what the expectation for HA M is to clean Evergreen hallway rooms. MS L stated, I am so glad that we got to talk. I want to explain we are down 2 housekeepers, and a housekeeper had called off last Friday which was a trickle effect where rooms were missed. I can promise you that Evergreen does not normally look like that. Usually if we are short-staffed, we know we can't get to the deep cleaning but that resident rooms should have been cleaned daily but we just didn't have the staffing capacity. MS L reported to Surveyor all housekeepers are to clean resident rooms daily, and if short-staffed deep cleaning can be held off until staffed appropriately.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility did not make a prompt effort to resolve resident grievances for 4 of 4 residents (R13, R24, R54, and R59).In March 2026, R13 and R24 filed a grievance to report missing clothing. The facility did not complete an investigation, resolve or follow-up on grievance.In April 2026, R54 and R59 filed a grievance to report missing clothing. The facility did not complete an investigation, resolve or follow-up on grievance.Findings include: Facility policy titled, Grievances/Concerns, with a reviewed date of 01/2025, states: Purpose: Providing prompt actions to resolve grievances/concerns and to keep the resident apprised of progress towards resolution.On 05/18/26 at 2:20 PM, Surveyor completed Resident Council interview with residents. R13 and R24 were present and reported that a grievance had been filed with the facility involving missing clothing and R13 and R24 did not receive any follow-up on it. Surveyor asked residents if missing items can't be found, does the facility offer reimbursement or another resolution. R13 and R24 stated no.Surveyor reviewed the facility's grievance/concern log and noted:On 03/17/26, R13 filed a missing item report for pajama pants with R13's initials on them. Under follow-up summary it states, Still looking.On 03/31/26, R24 filed a missing item report for pajama bottoms, 2 pairs of grippy socks, and 1 pair of textured socks. Under follow-up summary it states, Still looking.On 04/01/26, R54 filed a missing item report for a green and yellow quilt with R54's initials on it. No documentation under follow-up summary.On 04/08/26, R59 filed a missing item report for a pair of jeans and khaki pants. Under follow-up summary it states, Writer looked in R59's closet; not to be found. No additional documentation.On 05/19/26 at 11:06 AM, Surveyor interviewed Nursing Home Administrator (NHA) A regarding grievances. NHA A stated an investigation is completed on all grievances and includes a follow-up with the individual who filed it. Surveyor asked if missing items cannot be found, is reimbursement/replacement offered. NHA A stated yes. Surveyor asked if this would be documented. NHA A stated yes. On 05/19/26 at 11:15 AM, Surveyor interviewed Social Services (SS) C regarding grievances. SS C stated all grievances are investigated, resolved, and follow-up with the complainant to notify of the findings. Surveyor asked SS C about R13, R24, R54, and R59's missing item grievances. SS C stated she did not know why those grievances were not followed up on, but they should have been completed by now.

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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 record review and interview, the facility failed to ensure proper discharge documentation was completed for 4 of 15 residents (R) (R56, R54 R8, R9) reviewed for discharge and transfer from the facility.R56, R54 and R9 were missing documentation of notification of the Office of the State Long-Term Care Ombudsman.R8 was missing Bedhold and Transfer notice and the Ombudsman was not notified of the transfer. Findings: The facility policy titled, RESIDENT TRANSFERS AND DISCHARGE Notification reviewed 01/2025 stated in part:The facility will provide written notice in a language the resident or the resident's representative can understand. The notice must also be provided to an immediate family member or legal representative.The facility will utilize and complete all appropriate State forms that include the reason for the discharge, the date of the proposed discharge, the location to which the person will be discharged and their right to appeal the discharge by requesting hearing.The facility will provide the local Ombudsman a copy of the notice, informing the resident that the discharge process has been initiated. Example 1 R56 was admitted on [DATE] and discharged on 03/14/26 with a Brief Interview of Mental Status (BIMS) score of 10/15 which indicated R56 was moderately cognitively impaired. R56 had a Minimum Data Set (MDS) dated [DATE], Discharge return not anticipated. On 05/19/26 at 8:03 AM, Surveyor was unable to find Ombudsman notification in the Electronic Health Record (EHR) and asked Nursing Home Administrator (NHA) A for this. On 05/19/26 at 9:16 AM, Surveyor spoke with Business Office Manager (BOM) E. BOM E informed this Surveyor there was no Ombudsman notification for this discharge. Example 2 R54 was admitted to the facility on [DATE] with a BIMS of 15/15 which indicated R54 was cognitively intact. R54 had two MDS's in the EHR titled, Discharge – Return Anticipate. On 05/19/26 at 8:03 AM, Surveyor was unable to find an Ombudsman notification in the EHR and asked NHA A for this. On 05/19/26 at 9:16 AM, Surveyor spoke with BOM E. BOM E indicated she started here in October of 2025 and there were gaps in the training she had received, and the Ombudsman was not notified of any of the hospital transfers or discharges form the facility. Example 3 R9 was admitted to the facility on [DATE] and has diagnoses including acquired absence of right foot (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(amputation), chronic osteomyelitis, chronic kidney disease, type 2 diabetes, high blood pressure, and diverticulitis. Record review identified R9 was transferred to the hospital on [DATE] due to vomiting with scant amount of darker red blood, cold sweats and uncontrollable shaking. The Ombudsman was not notified. Record review identified R9 was transferred to the hospital on [DATE] due to vomiting, tachycardia (elevated heart rate), decreased 02 (oxygen) saturation readings, and a distended abdomen. The Ombudsman was not notified. Record review identified R9 was transferred to the hospital on 4/1/26 due to aspiration of vomit and had a non-ST segment elevation myocardial infarction (heart attack) while in the Emergency Department. The Ombudsman was not notified. On 5/19/26 at 9:53 AM, Surveyor interviewed Business Office Manager (BOM) E who stated BOM E transitioned to the position last October and with gap in training BOM E did not realize BOM E needed to let the Ombudsman know of hospitalizations. Example 4 R8 was admitted to the facility on [DATE]. Surveyor reviewed R8's Electronic Health Record (EHR) and noted R8 was transferred to the hospital on [DATE] and returned to the facility on [DATE]. Surveyor requested the bed hold and transfer notice from R8's transfer to the hospital. On 05/19/26 at 12:10 PM, Surveyor asked Business Office Manager (BOM) E for documentation of R8's transfer and bed hold notice from hospitalization on 01/14/26. On 05/19/2026 at 1:07 PM, BOM E walked into conference room and reported to Surveyor there was not a bed hold or transfer form for R8's hospitalization from 01/14/26. BOM E reported that at the time the nurse on duty is usually good at filling a progress note out and putting it into computer. BOM E reported to Surveyor that at this time we are unable to locate the form and BOM E was wondering if it was even completed or not due to R8 being significantly sick.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview and record review, the facility did not promote and facilitate resident self-determination through support of resident choice for 1 of 18 sampled residents (R12). R12 reported his dissatisfaction with the facility not allowing R12 to have his self-purchased coffee maker in R12's room. Findings include: On 05/17/2026 at 10:31 AM, Surveyor interviewed R12 who indicated R12 could not have a coffee maker in his room. R12 reported to Surveyor, R12 had bought his own coffee maker and facility told R12 that R12 could not have R12's coffee maker in the facility. Facility had R12 take coffee maker and place back in the original box and placed in R12's cupboard on top of shelf. R12 stated to Surveyor, I just want my own coffee as the facility coffee sucks. On 05/17/26 at 10:33 AM, Surveyor observed R12 had a coffee maker in an opened box on top shelf in R12's closet in room. On 05/18/26 at 1:13 PM, Surveyor interviewed Certified Nursing Assistant (CNA) H and asked if R12 ever had a coffee maker in his room or requested a coffee maker. CNA H reported to Surveyor that R12 had a coffee maker about 3 or so months ago. R12 was utilizing the coffee maker in R12's room for about a week and a half before Nursing Home Administrator (NHA) A found out and took R12's coffee maker away. Surveyor asked CNA H how NHA A took R12's coffee maker away. CNA H reported to Surveyor that NHA A just told R12 he could not have the coffee maker in his room, and the coffee maker was packed up and placed on R12's shelf in closet. Surveyor asked CNA H if any other arrangements were set up so R12 can have coffee R12 would like. CNA H reported R12 is just given the facility coffee at this time, and no other arrangements have been established but knows R12 wants his own coffee if possible. On 05/19/26 at 7:38 AM, Surveyor interviewed NHA A and asked if NHA A is aware R12 wants his own coffee maker in R12's room. NHA A reported to Surveyor last year survey facility was cited for a coffee maker in the building. Surveyor asked NHA A to clarify exactly what was wrong with the concern of the coffee maker and the citation from previous survey. NHA A reported the past citation had something to do with a power extension cord. Surveyor acknowledged if coffee makers are used in resident rooms they must be directly plugged into a ground outlet and not a power extension cord. Surveyor checked with life safety and other safety concerns and found no safety concern for R12 to have a coffee maker. NHA A stated to Surveyor, I know there must be some regulation, and that is why we don't allow any residents to have coffee makers so [R12's] was taken away back when [R12] was using a coffee maker in room few months back. NHA A reported to Surveyor that NHA A will re-assess R12's environment for safety of a coffee maker in room.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not immediately report to the physician on call of R3's rib pain post fall for 1 of 4 residents (R) reviewed for falls (R3). R3 fell on [DATE] and had multiple complaints of rib pain on 03/23/26, 03/25/26, and 03/26/26. Facility did not notify the physician on call until 03/26/26. Findings include: R3 was admitted to the facility on [DATE] with diagnoses including unspecified hemiplegia affecting left nondominant side, anterior dislocation of left humerus, urinary tract infections, pain in left shoulder, unsteadiness on feet, and hypertensive with congestive heart failure. R3's Minimum Data Set (MDS) assessment, dated 04/15/26, identified R3's Brief Interview for Mental Status (BIMS) scored 1/15, indicating R3 has moderate cognitive impairment. Surveyor reviewed R3's medical record and found R3 sustained a fall on 03/19/26. Surveyor reviewed R3's progress notes relating to R3's fall on 03/19/26: -On 03/19/26 at 1:53 PM, Writer heard resident [R3] yelling from his room. Upon entering room writer discovered resident lying on his right side on the bathroom floor with the small trashcan on top of his legs. Resident stated that he was trying to get to the toilet, and he fell. Resident stated he did not hit his head, however upon inspection writer noted a small abrasion on the top of resident's head. Resident was repositioned onto his back with assist of 3-4 staff, a Hoyer sling was placed under him, and he was lifted off the floor and assisted into bed. Resident had no complaints of pain. Nursing continues to observe changes.-On 03/21/26 at 1:44 PM, Follow up fall: Resident [R3] denies any pain/discomfort from recent fall. Has had some congestion in lungs so having resident stay in room No fever or cough noted.-On 03/23/26 at 1:43 PM, Therapy reports that resident [R3] is having high pain on left side of rib cage. Writer unable to see area. Resident states it happens when he had his fall and landed on that side. Writer unable to see area sitting in his wheelchair. Will have the PM nurse look and see when he lies down. Facility did not notify provider on call of R3's new onset of rib pain. Surveyor reviewed R3's progress notes in relation to R3's fall on 03/19/26 continues: -On 03/25/26 at 1:16 PM, Resident [R3] states he has been having pain in right side. Writer looked at area and a small area looking like scratched. No bruising or swelling noted. Scheduled meds given as ordered. No other issues noted. Resident was working with therapy and therapy states he appears weaker, acting different. Will monitor and follow up as needed. Facility did not notify provider on call of R3's persistent rib pain. Surveyor reviewed R3's progress notes in relation to R3's fall on 03/19/26 continues: -On 03/26/26 at 6:40 AM, Resident [R3] complaining that he has broken ribs and hips are bothering him. He kept asking for pain pills, but he has none as needed at this time. They are all scheduled. I tried repositioning and ice pack but declined. Facility did not notify provider on call of R3's persistent rib pain. Surveyor reviewed R3's progress notes in relation to R3's fall on 03/19/26 continues: -On 03/26/26 at 12:36 PM, Oxycodone 2.5mg orally every 4 hours as needed for pain. Continue to administer schedule doses at 8am and 8pm.-On 03/26/26 at 12:40 PM, Provider is going to put in Xray orders for left sided ribs and wanted nurse to assess lung sounds every shift due to high risk for pneumonia.-On 03/27/26 at 5:17 AM, Resident [R3] complaining that he had pain in ribs. As needed, Oxycodone is given at 3:50 AM. Medication was effective. Resident resting comfortably with no further complaints of pain noted.-On 03/27/26 at 12:26 PM, Xray of ribs will be scheduled for March 30th, 2026.-On 03/30/26 at 1:49 PM, Resident [R3] received Xray. Impression: Acute appearing minimally displaced fracture of the anterior left 5th rib and possible nondisplaced fracture of the anterior left 6th and 7th ribs. Multiple chronic bilateral healed rib fracture deformities. On 05/19/26 at 2:02 PM, Surveyor interviewed R3 and asked about fall on 03/19/26. R3 reported R3 fell on [DATE] and hit his head and had rib pain from the fall until facility gave R3 pain medications. R3 stated, I was in a lot of pain, and it took them forever to accommodate my pain. R3 stated, They kept saying I had scheduled pain medication but would not help my pain any other way. On 05/19/26 at 2:24 PM, Surveyor interviewed Director of Nursing (DON) (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B and asked DON B to review R3's medical record. Surveyor and DON B reviewed R3's progress notes from R3's fall on 03/19/26 until present. DON B reviewed with Surveyor and R3 had a progress note dated 03/23/26, 03/25/26, and 03/26/26. which noted R3 to have noticeable pain in the rib area throughout. Physical therapy and a nurse documented R3 complaining multiple times of pain in the rib area. Nurse continued to document will monitor. Surveyor asked DON B if expectation would be for the nurse to contact a provider on call of the new pain in left side of ribs and because this was a new acute onset change in condition. DON B reported the nurse should never have waited and should have notified the provider on call right away of R3's rib pain after a recent fall. Surveyor asked DON B why staff waited to schedule x-ray. DON B reported being unsure, but this should have been scheduled within a reasonable timeframe with R3's new onset of rib pain. On 05/19/26 at 2:46 PM, Surveyor interviewed Nurse Practitioner (NP) P and asked if NP P was notified about R3's rib pain after R3's fall on 03/19/26. NP P reported NP P is sure she was notified. NP P asked DON B if DON B checked the binder for notification to provider. DON B stated to NP P and Surveyor, Yes, I looked and there is only communication about the sacrum with lab result of [methicillin resistant staff aureus] MRSA and the medication error of phenobarbital. NP P reported to DON B and Surveyor that NP P knows someone called NP P, but NP P does not document phone calls. Surveyor asked if NP P was notified via phone why pain medication or any further directions were not ordered to manage R3's rib pain after fall. NP P reported NP P ordered an x-ray once NP P knew R3 was in pain. Surveyor indicated to NP P that Surveyor found documentation NP P was notified on 03/26/26 of R3's rib pain after fall where NP P ordered x-rays to be done on 03/26/26. NP P stated, Well I am not sure, but I know I was called at some point. Surveyor asked DON B what the expectation for nursing staff is to document received orders from providers. DON B stated, Yes they should be documenting, and since it's not there, I am assuming the provider was not notified then until 03/26/26.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect resident's right to be free from physical and verbal abuse by a resident for 2 of 2 residents (R40 and R57.) R40 was not protected from physical abuse when R57 struck R40 on the face and head multiple times.R57 was not protected from verbal and mental abuse when R40 yelled, threatened, and threw items at R57.Findings include:Surveyor reviewed the facility's policy titled Abuse Prevention Program dated last revised 01/26 which states: .Intent: Each resident has the right to be free from abuse, neglect, and corporal punishment of any type by staff or anyone. The facility will provide a safe resident environment and protect residents from abuse.Definitions: Resident to Resident Abuse: A resident-to-resident altercation should be reviewed as potential situation of abuse. The facility Administrator and Director of Nursing will initiate an investigation of a potential allegation of abuse between residents. Investigations for potential abuse will not be dismissed in cases where either or both residents have a cognitive impairment. During the investigation it will be identified that the actions were willful were deliberate, regardless of whether the individual intended to inflict injury or harm.Characteristics-increased Risk of Abuse: This includes, but is not limited to:-Unsympathetic or negative attitudes towards residents.-Voicing disgruntled comments.-Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting, and intimidating.-Wandering into other's rooms/space; and-Resistive to care and services.Note: Resident escalated behaviors require immediate interventions for the safety of the residents. Staff and/or other residents will require the facility to immediately consult with the resident's physician about the behavioral symptoms, and the residents designated representative and provide the necessary supervision of the resident to ensure that the resident and other residents are protected.VI. Protection: Residents are protected from physical and psychological harm during and after the investigation. This includes:-Responding immediately to protect the alleged victim and integrity of the investigation.-Examining the alleged victim for any sign of injury, including a physical examination or psychological assessment if needed.-Increase supervision of the alleged victims and residents.-Room or staffing changes, if necessary, to protect the residents from the alleged perpetrator.-Providing emotional support to the residents during and after the investigation.-Revising the resident's care plan if the resident's medical, nursing, physical, mental, or psychological needs or preferences change as a result of an incident of abuse. R40 was admitted to the facility on [DATE] with diagnoses including unspecified fracture of left pubis, heart failure, type 2 diabetes, and cerebral infarction.R40's Minimum Data Set (MDS) assessment, dated 05/07/26, identified R40's Brief Interview for Mental Status (BIMS) scored 11/15 indicating R40 has moderate cognitive impairment.R57 (R40's spouse) was admitted to the facility on [DATE] with diagnoses including unspecified dementia with unspecified severity with agitation.R57's MDS assessment, dated 05/18/26, identified R57's BIMS scored 9/15, indicating R57 has moderate cognitive impairment. R40's progress notes included:-On 05/09/26 at 11:31 AM, R40 was admitted to the facility with a diagnosis of unspecified fracture of left pubis with subsequent encounter for fracture with routine healing. Resident [R40] is alert and oriented to self, situation. R40 does have noted confusion around time and place. R40 has periods of agitation but none this shift.-On 05/10/26 at 07:13 AM, Note left for provider regarding R40 having episodes of confusion and agitation, upon awaking, early AM x 2 days over this past weekend. First episode occurred early AM on Friday 5/8/26. Patient exit seeking, sitting at exits, stating repeatedly to leave, stating would walk out of facility. Staff are able to redirect with difficulty. Wanderguard was placed. Patient had a milder episode of same/similar statements on Sunday 5/10/26.-On 05/11/26 at 03:38 PM, New orders received from provider for a UA/UC (urinalysis/culture & sensitivity) today. Increased agitation and confusion.-On 05/12/26 at 12:11 PM, R40 will be changing rooms today. She was made aware and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	does agree to this. Her new roommate will be her husband [R57.] -On 05/15/26 at 09:50 AM, Nursing reported R40 observed to raise voice and yell at R57 this shift. Nursing Home Administrator (NHA A) and in-training Director of Nursing (DON) B interviewed R40 as well as R57. R40 stated, I want to kill him, but denies having actual plan or intent. See progress note from NHA A. R40 stated they have been married 57 years. R40 advised on appropriate verbal communication and the need to refrain from yelling or raising voice. Verbalized understanding and agreed to plan. R40was informed behavior monitoring will be initiated. Orders placed.-On 05/15/26 at 09:52 AM, NHA A met with R40 and her spouse, R57, along with nurse present in regard to How are things going with you and R57 being in the same room? Resident R40 reported, Well at home I could yell at him if I wanted to. Writer explained, Yelling should be avoided here and if she needs help with something she can ask staff. R40 in agreement. R40 reports, We have been married for 58 years and he's useless! Writer reiterated, Staff can help if she needs something. R57stated, Oh just get out. Writer and RN exited room.-On 05/15/26 at 10:03 AM, R40 is cooperative and pleasant with staff, however, she does yell at her roommate R57.-On 05/15/26 at 12:51 PM, R40 was upset that the coffee mug was not being delivered to the kitchen by spouse R57 and stated, Take the cup before I throw it at you. Did report this to DON and is now being monitored. No additional behaviors this shift.Surveyor reviewed R40's behavioral symptoms care plan with a problem start date of 05/15/26. Surveyor did not find any interventions put into place on 05/15/26 to protect R57 from R40's verbal outbursts.Surveyor reviewed R40's physician orders which included: -On 05/15/26, Monitor for behaviors and document, Yelling=1, Refusal of Care/Services=2, Combative=3, Hallucinations=4, Agitation=5, Delusions=6, Other=7 (if other please note specific behavior), None=8. Special Instructions: Intervention= calm/slow approach=1, avoid over-stimulation=2, reassurance=3, re-approach=4, re-direct=5, diversional activity=6, offer toileting/snack/drink=7, exercise=8, pain relief=9, other=10, n/a=11, every shift on AM shift, PM shift, and NOC shift.Surveyor reviewed R40's Treatment Administration Record (TAR) for the month of May 2026. Surveyor found multiple shifts between 05/15/26 and 05/18/26 with no documentation of behaviors and some shifts documenting 0, which is not a specific number to use for behaviors. Specific behaviors are numbered 1-11.On 05/18/26 at 1:27 PM, Surveyor interviewed DON B. Surveyor informed DON B that on 05/15/26 behavior monitoring was put into place after a verbal abuse altercation from R40 yelling at R57. Surveyor asked DON B about R40 and R57's May TAR which had a ?0' entered on the TAR. Surveyor asked DON B what this would mean. DON B reported to Surveyor that sometimes nurses can add comments. DON B reviewed R40's TAR and R57's TAR with Surveyor. DON B reported they did not see any behavior monitoring for R57. DON B reported in R40's TAR, staff should not be documenting ?0' as ?0' does not indicate anything. DON B assumes it means R40 did not have any behaviors during this time, but DON B will need to reeducate staff on proper documentation to adequately monitor R40 and R57 for behaviors. DON B reviewed R40's medical record and stated, I verified the ?0' entered on TAR and my expectations are staff are to follow the available corresponding number to chart exact behaviors. I will talk with staff to update.Surveyor reviewed R57's physician orders and did not find behavior monitoring in place.Surveyor reviewed R57's TAR and could not find any behavior monitoring in place.Surveyor continued review of R40's progress notes which included:-On 05/18/26 at 2:23 PM, Late entry for 05/16/26: DON B alerted via phone that resident R40 was involved in an incident with her spouse R57. R40 was separated from her spouse R57 immediately and kept safe with 1:1 supervision with staff. R40 was assessed for injury and no injury noted. R40's behaviors and mood per usual, no noted anxiety, confusion, or other changes noted. R40 denied pain. R40's door was left open in room, and R40 was not left alone in room with spouse for rest of shift. R40's door will be kept open unless staff are present. Behaviors will continue to be monitored as needed.On 05/18/26 at 10:51 AM, Surveyor interviewed CNA O and asked if they were aware of any incidents between R40 and R57. CNA O reported they were working on 05/16/26 but down a different hall. CNA O reported on Saturday 05/16/26 around 2:00 PM, while everyone was in report for the next shift, CNA J yelled out for assistance as R40's husband, R57, was (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	striking R40 in the head. CNA O reported to Surveyor that they did not observe the situation, so they do not have any other details to provide. Surveyor asked CNA O if there was any education completed about what to do next or any interventions to handle R40 and R57's incident on 05/16/26. CNA O reported there has been no education or direction for staff and R40 and R57 continue to be in the same room together. On 05/18/26 at 1:27 PM, Surveyor interviewed DON B and Registered Nurse (RN) and asked DON B how Surveyor would know there was an incident on Saturday 05/16/26 between R40 and R57. DON B reported to Surveyor, DON B is working on creating a soft file. Surveyor asked DON B to please explain the events that occurred between R40 and R57 on 05/16/26. DON B reported to Surveyor, DON B was called on Saturday 05/16/26 a few minutes after shift change from a nurse. DON B was told, Sounds like R57 was hitting R40. DON B then spoke with CNA J on the PM shift who stated to DON B, CNA J was sitting at desk doing charting, R40 and R57 came down hallway, and they wanted to go outside, R40 wanted to go to the back porch and R57 wanted to go to the front porch. R57 tapped R40 3 times on the head. DON B reported CNA J was asked if R40 was safe and CNA J told DON B, Yes. DON B then called NHA A and explained the situation and asked what facility needed to do. NHA A told DON B to call facility back and have the nurse interview R57 and R40. DON B reported the nurse on duty interviewed R57 and asked, Did you hit your wife? R57 responded, Yes. The nurse asked, What were you doing? Trying to get her attention? DON B then called NHA A to explain interviews. NHA A said to DON B, Have nurse on duty let [CNA J] hit nurse on duty on arm the way R57 hit R40, to do a recreation of the incident. DON B reported to Surveyor the nurse on duty recreated this event. DON B stated, I honestly don't know what the purpose of this was because the arm will feel different than the head. DON B reported back to NHA A and then spoke with Regional Clinical Director (RCD) Q who stated, Write down timeline and investigation and put together in a soft file that R57 was not trying to hurt R40. Surveyor asked DON B what the expectation is for staff if they witnessed any unsafe situation such as potential physical, emotional, or verbal abuse. DON B reported to Surveyor the expectation would be to keep residents safe, assess for injury, and report to RN/DON. Surveyor asked DON B if there was a reason the documentation of the incident on 05/16/26 was not in the medical record. DON B reported that the facility has a soft file, and CNAs can't document in chart, so they are to inform their charge nurses on duty of any incidents. Surveyor asked DON B why the incident on Saturday 05/16/26 was not reported. DON B reported RCD Q did not feel it was reportable after following the algorithm. Surveyor asked DON B what does monitoring behaviors look like and if any interventions were put into place after the first verbal abuse interaction on 05/15/26, if any interventions were put into place on 05/16/26 after the physical abuse incident happened, and then any other interventions to prevent R40 from abusing R57 and vice versa. DON B reported that all staff know that if both parties, R40 and R57, are in their room together, the door has to remain open at all times, and that staff are going up and down hallway often and checking in with R40 and R57. Surveyor asked DON B if these interventions were put into place on R40 and R57's care plan. DON B reported DON B does not know for sure and would need to check each care plan. DON B confirmed R40's interventions were not updated until days later pertaining to R40's frequent outbursts and verbal abuse towards R57. DON B reported R57's care plan was not updated until days later as well.On 05/18/26 at 1:50 PM, Surveyor interviewed NHA A and asked NHA A to explain events which occurred on 05/16/26, why this was not reported to the state, and why interventions were not put into place until days later to protect both parties from abusing one another. NHA A reported to Surveyor, NHA A thought through observations and findings it was not necessary to contact state or change R40 and R57's circumstances. Surveyor asked NHA A why there was no additional behavior monitoring or additional guidance put into place. NHA A reported NHA A was looking over algorithm and R57 was not intending harm on R40 when R57 struck R40 in the head multiple times. Surveyor requested NHA A to show Surveyor algorithm that NHA A was following.Surveyor reviewed algorithm titled, Resident-To-Resident Altercation Flowchart, dated last revised 06/18, which states: .Did the resident act willfully? Willful means that the individual's act was deliberate-not inadvertent or (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accidental-regardless of whether or not the individual intended to inflict injury or harm.NHA A stated to Surveyor NHA A did not conclude that R57 acted willfully and therefore did not think it would be abuse when reading the algorithm.On 05/18/26 at 2:51 PM, Surveyor interviewed CNA J and asked if CNA J could explain the events from the incident which happened on Saturday 05/16/26 between R40 and R57. CNA J stated she was the only one out at the nurses' station while everyone was providing care or in report. R40 and R57 were at the nurses' station asking if they could go outside on the porch. CNA J asked R40 and R57 which porch they would like to go on for fresh air. R40 stated R40 wanted to go to the south one, and R57 stated R57 wanted to go to the north porch. CNA J stated, when R40 stated R40 wanted to go to the opposite porch than R57, R57 became agitated and started slapping R40 alongside the head with open hands-on right side of face, then left side of face, and then began aggressively striking R40 from behind and on top of head multiple times with closed fist. CNA J stated she quickly jumped up and told him R57 to stop and placed herself between them to protect R40. CNA J reported to Surveyor if she had not stopped R57, then R57 would have kept going. CNA J reported she immediately separated R40 and R57, notified nurse in charge, and the charge nurse began making calls to DON B and NHA A. CNA J reported to Surveyor that while the charge nurse was on the phone the charge nurse had asked CNA J to visualize and assess R40's head where R57 struck R40. CNA J stated, Then the charge nurse on the phone reported to NHA A there were no injuries on R40's head. Surveyor asked CNA J if the charge nurse did an actual physical assessment on R40. CNA J shook her head no and stated it was CNA J who assessed R40's head. Surveyor asked CNA J how long R40 and R57 were separated before they came back together on that shift. CNA J was unsure when facility placed R40 and R57 back in room together as she had sat with them until she left the facility at 4 PM. Surveyor asked CNA J what the process was after observing a physical altercation between residents such as between R40 and R57, what next steps are to be taken to keep both parties safe. CNA J reported to Surveyor CNA J separated R40 and R57 and reported it to the nurse right away. CNA J was told to write a statement and so she did. Surveyor asked CNA J if the facility provided any education or if new interventions were put into place after R40 was struck in the head by R57. CNA J reported administration verbally told staff to make sure R40 and R57 were not alone in room with door closed and to check on them periodically. Surveyor asked CNA J how R40's presentation was after R57 struck R40 over the head. CNA J said R40 was crying and very upset. CNA stated R40 divulged to her, R40 and R57 used to live in a camper but had to move out of camper as R57 was too violent and it wasn't working. CNA J reported to Surveyor R40 was very distraught and upset R57 struck R40 in the head. R40 was crying uncontrollably for about 15 minutes. CNA J reported to Surveyor R57 kept coming out to the nurse's station antagonizing and making statements such as: .Are you done crying yet, and ready to go out to the porch? Quit crying and let's go already. Oh, quit your crying. R40's behavioral symptoms care plan dated 05/15/26 states, all approaches had a start date of 05/15/26 and interventions created on 05/17/26:Administer medications as ordered. Monitor and record effectiveness. Report on adverse side effects. Allow distance in seating other residents around resident as needed Assess whether the behavior endangers the resident and/or others. Intervene if necessary. Avoid over-stimulation (e.g., noise, crowding, other physically aggressive residents). If resident [R40] becomes physically abusive, keep distance between resident and others (e.g., staff, other residents, visitors) If resident becomes physically abusive, move resident to a quiet, calm environment. If resident delusions/hallucinations, do not try to reason with or confront resident. Offer reassurance. Maintain a calm environment and approach to the resident [R40]. Maintain a calm, slow, understandable approach with the resident. Observe for change in mental status, document and notify physician. Observe for changes in behavior, document, and report to doctor. Obtain a psych consult/psychosocial therapy as needed. Offer reassurance to resident as necessary. Prepare and organize supplies before caring for resident . Avoid delays and interruptions in care Provide opportunity for resident to vent feelings. Listen in non-judgmental manner. Remove resident from group activities when behavior is unacceptable. On 05/18/26 at 9:11 AM, Surveyor observed R40 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sitting in recliner with R57 next to her in a chair next to bed. Surveyor overheard R40 yelling at husband and stating, Don't change the channel, I am watching that show. Husband stated, I don't really care. R40 stated, I want to watch that. Surveyor observed R40 grab the remote off the table and throw the remote at R57. The remote glided past R57's face and hit the edge of the bed, then landed on the floor. Surveyor heard R57 yell, Why did you do that? Surveyor immediately walked down the hallway to get Licensed Practical Nurse (LPN) K. On 05/18/26 at 9:13 AM, Surveyor informed LPN K that R40 and R57 were arguing in their room and R40 threw the remote control for the TV at R57's head. LPN K walked straight down to R40's room and entered. Surveyor observed LPN K to ask both R40 and R57 if they were ok. R40 responded, We are fine. LPN K picked up the remote control and placed it on a bedside table and asked how the remote got on the floor. R40 stated, It fell off table. LPN K asked R40 and R57 if they needed anything while LPN K was in the room. R40 stated, No. R57 shook head no. LPN K exited R40 and R57's room. On 05/18/26 at 9:20 AM, Surveyor interviewed LPN K who indicated R40 and R57 are always bickering and R40 yells a lot at R57. Surveyor asked LPN K exactly what R40 yells means and how R57 responds. LPN K reported R40 states lot of things such as R57 is useless and how R57 irritates R40. Surveyor asked LPN K why the facility has the couple in the same room. LPN K reported R40 used to exit seek to try and find R40's husband, R57. Finally, when R57 was admitted they moved both together and R40 has been better with no exit seeking. Surveyor asked LPN K if she observed R40 and R57 have physical altercations with each other. LPN K reported she has not seen anything physical but heard there was an altercation last Saturday on 05/16/26 but does not know any details. LPN K reported this morning on 05/18/26 just about an hour ago, R40 was nit-picking at R57 and started yelling at him. Surveyor asked LPN K what R40 was yelling about. LPN K reported hearing them just yelling and so she walked in but was unsure what it was about. LPN K redirected R40 and R57 and exited room. Surveyor asked LPN K what the process is for handling R40 during moments of agitation and verbal abuse towards R57. LPN K reported to Surveyor of being unsure other than following the care plan to redirect R40 and document in R40's medical record. Surveyor indicated to LPN K that Surveyor could not find the documentation of the incident on 05/16/26 or from this morning on 05/18/26. Surveyor asked LPN K how the facility is protecting R57 and R40 from any further verbal and physical abuse. Surveyor asked LPN K how the documentation process works. LPN K reported LPN K is still documenting in R40's medical record on the incident from this morning. Surveyor asked if LPN K observed R40's behaviors should LPN K report this to management or just document in the computer. LPN K reported that she will review the orders for R40. LPN K reviewed medical records and stated the order states to assess behaviors and document them in the TAR. Surveyor asked if LPN K would normally report to anyone above LPN K of potential verbal abuse from R40. LPN K reported if it is severe enough and interventions such as redirecting do not work, then LPN K would report to administration for assistance on what to do. Surveyor asked LPN K if she would have reported the agitation and yelling from earlier this morning in R40's room, could this have prevented R40 from yelling and throwing remote at R57 in room. LPN K stated to Surveyor, I guess it could have but facility is aware of R40's yelling and outbursts as R40 has had several in the last week.On 05/18/26 at 10:47 AM, Surveyor interviewed Certified Nurse Assistant (CNA) H and asked if CNA H was aware of any incidents between R40 and R57. CNA H reported she overheard in report R57 struck R40 in the head multiple times. CNA H could not divulge any other information. Surveyor asked CNA H if there was any education completed about what to do next or any interventions. CNA H reported there has been no education or direction other than the common sense to leave the door open when they are together in room, walk by and check parodically, etc. Surveyor asked if CNA H has ever observed R40 and R57 get aggressive with each other. CNA H reported to Surveyor this morning, 05/18/26, at breakfast time, CNA H was bringing coffee in and asked both if they wanted coffee. R40 reported R40 was ok, and then suddenly R57 aggressively slapped R40's chest. CNA H stated, It wasn't like he was hitting her to hit her hard but aggressively swung his arm out and hit [R40] in the chest. Surveyor asked CNA H what CNA H's process for (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reporting R57 or R40's aggression towards one another. CNA H stated, It wasn't like he [R57] was hitting her [R40.] It's just [R57] kind of just swung his arm out aggressively to get her [R40]'s attention and swung hitting [R40's] chest. CNA H did not provide any other information. On 05/18/26 at 12:43 PM, Surveyor observed R40 yell at R57 and stated, Quit touching my cake, I want that. Surveyor observed R57 taking R40's cake off R40's lunch tray. R40 started yelling more, Don't touch my cake. NHA A walked by and overheard the yelling as well. Surveyor observed NHA A walk to the meal cart in hallway, grab a piece of cake, and then enter R40's room. Surveyor observed NHA A deliver R57 a cake and grab R40's cake from R57 then give it back to R40. R40 stated, Thank you. R57 continued to eat the new piece of cake for R57 that NHA A had given him. NHA A exited R40's room and walked down the hallway.On 05/18/26 at 1:50 PM, during Surveyor interview with NHA A, Surveyor informed NHA A of the observation that R40 continues to verbally and physically abuse R57 when Surveyor observed R40 throwing the TV remote at R57's face but missed. Surveyor informed NHA A there is no documentation of incidents in either R40 or R57's medical record and could NHA A explain. NHA A reported to Surveyor that after talking with Regional Resource, facility feels a referral to a memory care unit should be placed for R57. Surveyor explained the importance of immediacy with R40 and R57 being separated to prevent further potential abuse concerns. NHA A stated to Surveyor, We did talk about moving him [R57] to another room, but after recent hospitalization he was wandering looking for his wife, [R40] so we did not do this yet. Surveyor asked DON B with NHA A present to explain the behavior monitoring and how it is not clearly documented for staff to understand and how staff would know the concerns going on between R40 and R57 if none of this was changed in their care plans until today 05/18/26. DON B stated, Everybody is aware of what happened on Saturday and aware of the interventions the facility set in place. DON B reported understanding of documentation required to be in the medical record and placed in care plans and was not. NHA A stated to Surveyor, Hindsight now, I wasn't too comfortable with the incident that occurred, and we contacted [RCD Q] for guidance, and this was what we did for the incident. Surveyor requested soft file with investigation and all steps put into place after incident from 05/16/26. Surveyor received soft file on 05/18/26 from DON B, which included brief information that DON B compiled the morning of 05/18/26.On 05/18/26 at 2:46 PM, Surveyor interviewed R40 and asked R40 if her husband [R57] hurts R40. R40 stated, No, but we have been like this for 20 years. My husband hits me when I am not paying attention and that's ok, because sometimes I do not pay attention. Surveyor asked R40 if R40 felt safe with R57 and R40 reported R40 does feel safe and stated, This is not a big deal. He always gives me a smack if I am not paying attention. R40 asked Surveyor to leave as R40 did not want to answer any more questions. On 5/18/26 at 2:48 PM, Surveyor interviewed R57 and asked these questions:Have you always argued with your wife (R40)? R57 stated, Yeah, at least once a day.What kind of things are said when you argue? R57 stated, I don't know.Do you remember the conversation/argument that you had with your wife (R40) on Saturday? R57 stated, I don't know.Do you feel safe around your wife (R40) alone? R57 stated, Yes. Surveyor asked R57, are you concerned about her hurting you? R57 stated, No, I am not.Do your arguments ever get physical? R57 would not answer question. Surveyor asked R57, Has she [R40] ever thrown objects at you? R57 stated, No. Surveyor asked R57, has she ever slapped you? R57 stated, No.Further review of R40's progress notes indicated the following:-On 05/18/26 at 12:23 PM, This nurse was on Evergreen hallway around 0900 during morning medication pass. R40 was heard in her room arguing with her roommate, R57. Nurse stepped in to R40's room and asked if both parties were alright. R40 and R57 were sitting down about 4 feet away from each other and smiled at this writer. Both responded that they were fine. Nurse stated that if they needed anything to please put on call light and let staff know. Assured that call lights were within reach and left room.-On 05/18/26 at 3:44 PM, R40 and R57 were approached by DON B and nurse, and NHA A and asked if either would like to move to a different room. R40 and R57 stated, No, I am not moving. Social Services will be contacting Ombudsman for guidance. R40 and R57 were adamant at this point to not move rooms. Initiated 1:1 supervision while in room together.-On (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/18/26 at 5:12 PM, Writer was present in room completing 1:1 supervision with R40 and R57. R40 stated she did not like being under guard and writer explained this is for safety to ensure everyone is safe during interactions. R40 asked if she were to move rooms, Would the guard go away? Writer explained to R40 that if they were in separate rooms, we would only complete 1:1 supervision during times they were together. R40 stated, Then I'll move. Agreed to move to another room. Personal belongings were brought to room. R40 walked to room with 1 person assistance and walker. Both parties agreed to plan.R40's behavioral symptoms care plan initiated was initiated on 05/15/26. Interventions were created on 05/18/26:Keep the room door open unless staff are present.Placed on 1:1 with staff while awake in the presence of her husbandNotifying Ombudsman related to ongoing behaviors with husband.R40 has agreed to move to another room, away from spouse to decrease potential for negative interactions with spouse that have the potential for escalating. R40 has been encouraged to visit with spouse in public areas where staff are present.Should resident choose or like to visit with spouse, she and spouse will require 1:1 supervision by staff.15-minute checks. On 05/19/2026 at 10:26 AM, Surveyor interviewed NHA A who reported to Surveyor R40 and R57 are now separated and R40 chose to move to another room. On 05/19/26 at 8:25 AM, Surveyor observed law enforcement arrive at the facility to interview R57 and R40 about the incident with R57 striking R40 on the head and face on Saturday 05/16/26.On 05/19/2026 at 12:36 PM, Surveyor interviewed DON B about closing the communication loop pertaining to R40 and R57. DON B reported to Surveyor R40 and R57 have been separated now into separate rooms with supervision when both parties come together. DON B reported to Surveyor she understands the facility did not document the event from 05/16/26, facility did not educate all staff, and facility did not implement any interventions to protect R40 and R57 from any further potential abuse concerns but are implementing all said above now. R57's progress notes state:-On 05/18/26 at 2:40 PM, Late entry for 05/16/26 documented by DON B: R57 was involved in an incident with his spouse, R40. R57 was attempting to get R40's attention as he was behind her, and he was unable to see her face. Resident bumped his wife on the sides of the head and the top of the head to get her attention in order to decide what door to go out of. R40 and R57 were immediately separated. R40 denied pain, no emotional distress noted, behaviors per usual. Staff in room if R40 and R57 in room together while awake rest of this shift. Room door remains open unless staff are present.-On 05/18/26 at 3:48 PM, R57 and R40 were approached by DON B and RN G, and NHA A and asked if either would like to move to a different room. R57 and R40 stated, No, I am not moving. Social Services will be contacting Ombudsman for guidance. R57 and R40 were adamant at this point to not move rooms. Initiated 1:1 supervision while in room together.Surveyor did not find any documentation regarding the incident from 05/16/26 in R57's medical record until Surveyor informed NHA A and DON B of these concerns on 05/18/26.

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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 record review and interview, the facility must ensure each resident is free from unnecessary medications as evidenced by completing adequate behavior monitoring for 2 of 5 residents (R28, R1) reviewed for unnecessary medication reviews.R28 receives 4 psychotropic medications including, Aripiprazole tablet; 10 mg; amt: 10mg; oral Special Instructions: bipolar 1 disorder Once a Morning 08:00 AM 3/31/26, Clonazepam - Schedule IV tablet; 0.5 mg; amt: 0.25mg; oral Special Instructions: GAD (general anxiety disorder) At Bedtime 08:00 PM 3/31/26, Fluoxetine capsule; 40 mg; amt: 2 capsules; oral Special Instructions: GAD/OCD (obsessive compulsive disorder) Once A Morning 08:00 AM 3/31/26, and Mirtazapine tablet; 45 mg; amt: 1 tab; oral Special Instructions: GAD/OCD At Bedtime 08:00 PM 3/31/26 without behavior and effectiveness monitoring. R1 receives Duloxetine (antidepressant) capsule, delayed release; 30 milligrams (mg), once every morning without behavior and effectiveness monitoring. Findings include: The facility policy titled Psychotropic Medication Use, last reviewed 1/2026, states: Residents are not given psychotropic medication unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. 9. The effects of psychotropic medications on residents will be evaluated. This may be through physician evaluation, pharmacist routine medication review, nurse assessments and medication monitoring, and the plan of care. 10. The resident response to the mediation will be documented in the resident's medical record. Example 1 R28 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, generalized anxiety disorder, obsessive compulsive disorder, and hypothyroidism. R28's Brief Interview for Mental Status (BIMS) score was 15 out of 15, indicating R28 is cognitively intact. R28's Minimum Data Set (MDS) assessment, target date 4/3/26, indicated R28 needs supervision type assistance for activities of daily living and mobility. R28 has 4 psychotropic prescription medications ordered. They include: ~ aripiprazole tablet; 10 mg; amt: 10mg; oral Special Instructions: bipolar 1 disorder Once a Morning 08:00 AM 3/31/26 ~ clonazepam - Schedule IV tablet; 0.5 mg; amt: 0.25mg; oral Special Instructions: GAD (general anxiety disorder) At Bedtime 08:00 PM 3/31/26 ~ fluoxetine capsule; 40 mg; amt: 2 capsules; oral Special Instructions: GAD/OCD (obsessive (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	compulsive disorder) Once A Morning 08:00 AM 3/31/26 ~ mirtazapine tablet; 45 mg; amt: 1 tab; oral Special Instructions: GAD/OCD At Bedtime 08:00 PM 3/31/26 R28's care plan, dated 3/31/26, states: Problem: Resident receives antianxiety medication (clonazepam) R/T (related to) bipolar disorder, GAD, OCD. Category Psychotropic Drug Use. Start Date 03/31/2026. Last Reviewed/Revised 04/09/2026 11:59 AM. ~Approach: Monitor for drug use effectiveness and adverse consequences. Start Date 03/31/2026 Problem: Resident receives antidepressant medication (fluoxetine, mirtazapine) R/T bipolar disorder, GAD, OCD. Category Psychotropic Drug Use. Start Date 03/31/2026. Last Reviewed/Revised 04/09/2026 11:59 AM. ~Approach: Assess/record effectiveness of drug treatment. Monitor and report signs of sedation, hypotension, or anticholinergic symptoms. Start Date 03/31/2026 Problem: Resident receives antipsychotic medication (aripiprazole) R/T bipolar disorder. Category Psychotropic Drug Use. Start Date 03/31/2026. Last Reviewed/Revised 04/09/2026 11:59 AM. ~ Approach: Monitor resident's behavior and response to medication. Start Date 03/31/2026 Surveyor found no documentation in R28's medical record for behavior and medication effectiveness monitoring of R28's psychotropic medications. R28's monthly medication review (MMR) documentation, signed 4/21/26 by pharmacist, made the recommendation stating: R28 has bipolar disorder, anxiety, OCD treated with [Abilify (antipsychotic), Klonopin (anti-anxiety), Prozac + Remeron (antidepressants)]. Recommendation: Please make sure appropriate target behavior/mood monitoring is in place for the above psychotropic medications. The physician response on the bottom of form states: She is doing well at nursing home. Benefit outweighs the risk. No changes. On 5/19/26 at 1:44 PM, Surveyor interviewed Director of Nursing (DON) B about R28's psychotropic medications. DON B reviewed R28's medical record. DON B stated R28 does not have behavior monitoring in place. Surveyor asked DON B what the process is when the pharmacy makes a recommendation during the monthly medication review. DON B stated the usual process is the pharmacy makes a recommendation on the form, then DON B prints them out and gives them to the provider to review. DON B stated sometimes DON B acts on them herself if they are just an addition or guidance. DON B stated usually we (provider and DON B) go through it together. DON B stated DON B signs them all, whether DON B acts on them or just reviews them with the provider. Surveyor asked DON B about R28's and what was done regarding the pharmacy review with recommendation on 4/21/26 for behavior monitoring and what was the outcome. DON B pulled up the recommendation form and reviewed. DON B stated DON B's signature is not on it. DON B stated DON B usually prints them and gives them to the provider. DON B stated maybe it was in the back of the stack, and it was (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	missed. Surveyor asked if this is a recommendation not followed. DON B stated DON B did not sign it, so no. On 5/19/26 at 2:34 PM, Surveyor interviewed Nurse Practitioner (NP) P who stated NP P reviews the MMR with DON B monthly. NP P stated the process to ensure a medication is effective, is to meet with the resident, interview staff and family, and review medical records and charting. Surveyor asked NP P about the response to the MMR for R28 on 4/21/26. NP P stated it was NP P's response. NP P stated R28 is a new resident, and one followed by a Psychiatry Nurse Practitioner. NP P stated NP P is not going to adjust or change medications for a resident treated by psychiatry. Surveyor asked what the behavior monitoring was. NP P stated the facility didn't do that. NP P stated NP P would expect the facility would do that. Example 2 R1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, dementia, and depression. R1's Brief Interview for Mental Status (BIMS) score is 15/15, which indicates R1 is cognitively intact. Review of R1's medical record R1's Quarterly Minimum Data Set (MDS) dated [DATE] for High-Risk Drug Classes: Antidepressant. R1's medication orders include Duloxetine capsule, delayed release; 30 milligrams (mg), once every morning for depression. R1's care plan states:Problem: Resident [R1] displays verbal behavioral symptoms that impact resident by potentially interfering with participation in activities or social interactions and impacts others by placing them at risk for slander, behavior or reputation misunderstandings, issues. Resident was overheard making mean and untrue statements to another resident, swearing at other residents, yelling at other residents. Resident will not cause harm to any other residents, staff, or self. Resident will maintain appropriate behavioral functioning. Resident will converse with others without swearing or berating. Resident will be socially appropriate. Resident will be able to participate in facility functions and maintain appropriate behaviors. Approach: Observe for changes in behavior, document, and report to doctor. On 05/19/26 at 12:02 PM, Surveyor asked Nursing Home Administrator (NHA) A for behavioral charting as Surveyor was unable to find this in R1's Electronic Health Record (EHR). On 05/19/26 at 12:22 PM, Director of Nursing (DON) B informed Surveyor the facility does not have behavioral/effectiveness monitoring. On 05/19/26 at 12:28 PM, NHA A also informed Surveyor there is no behavioral monitoring for R1.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when an allegation of abuse was not reported immediately but not later than 2 hours after the allegation is made, to the administrator of the facility and to other officials for 1 of 2 resident reviewed for abuse. (Resident (R) 40 and R57). -On 05/16/26, R57 struck R40 along the side of head and top of head from behind multiple times. Facility did not report the physical abuse to state officials. Findings include: Surveyor reviewed facility policy titled, Abuse Prevention Program, dated last revised 01/26, states: .Intent: Each resident has the right to be free from abuse, neglect, and corporal punishment of any type by staff or anyone. The facility will provide a safe resident environment and protect residents from abuse.Definitions: Resident to Resident Abuse: A resident-to-resident altercation should be reviewed as potential situation of abuse. VII. Reporting/ResponseAll alleged or suspected violations are to be reported immediately to the Administrator or Director of Nursing, which are responsible to notify required officials, including State Survey Agency, Local Public Safety, and any other agencies in accordance with state law through established procedures. All alleged violations involving abuse are reported immediately, but no later than 2 hours after the allegation is made if events that cause the allegation involve abuse or result in serious bodily injury. Not later than 24 hours if the events that accuse the allegation do not involve abuse and do not result in serious bodily injury. R40 was admitted to the facility on [DATE] with diagnoses including unspecified fracture of left pubis, heart failure, type 2 diabetes, and cerebral infarction. R40's Minimum Data Set (MDS) assessment, dated 05/07/26, identified R40's Brief Interview for Mental Status (BIMS) scored 11/15, indicating R40 has moderate cognitive impairment. Surveyor reviewed R40's progress notes;-On 05/18/26 at 2:23 PM, Late entry for 05/16/26: Writer [DON B] alerted via phone that resident [R40] was involved in an incident with her spouse [R57]. Resident [R40] was separated from her spouse [R57] immediately and kept safe with 1:1 supervision with staff. Resident [R40] was assessed for injury and no injury noted. Resident [R40] behaviors and mood per usual, no noted anxiety, confusion, or other changes noted. Resident [R40] denied pain. Residents [R40] door was left open in room, and resident [R40] was not left alone in room with spouse present for rest of shift. Residents' [R40] door will be kept open unless staff are present. Behaviors will continue to be monitored as needed.-On 05/18/26 at 3:44 PM, Resident [R40] and spouse [R57] were approached by DON B and nurse, and NHA A and asked if either would like to move to a different room. Resident [R40 and R57] stated, No, I am not moving. Social Services will be contacting Ombudsman for guidance. Residents' [R40 and R57] adamant at this point to no move rooms. Initiated 1:1 supervision while in room together.-On 05/18/26 at 5:12 PM, Writer was present in room completing 1:1 supervision with patient [R40] and spouse/roommate [R57]. R40 stated she did not like being under guard and writer explained this is for safety to ensure everyone is safe during interactions. R40 asked if she were to move rooms, Would the guard go away? Writer explained to R40 that if they were in separate rooms, we would only complete 1:1 supervision during times they were together. R40 stated, Then I'll move. R40 did agree to move to another room. Personal belongings were brought to room. R40 walked to room with 1 person assistance and walker. Both parties agreed to plan. Surveyor did not find any documentation regarding the incident from 05/16/26 in R40's medical record until Surveyor brought to staff attention on 05/18/26. R57 was admitted to the facility on [DATE] with diagnoses including in part, unspecified dementia with unspecified severity with agitation. R57's Minimum Data Set (MDS) assessment, dated 05/18/26, identified R57's Brief Interview for Mental Status (BIMS) scored 9 indicating R57 has moderate cognitive impairment. Surveyor reviewed R57's progress notes, states:-On 05/18/26 at 2:40 PM, Late entry for 05/16/26 (continued on next page)

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	525665	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frederic Nursing and Rehab Community	205 United Way Frederic, WI 54837

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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	documented by DON B: Resident [R57] was involved in an incident with his spouse [R40]. Resident was attempting to get wife attention as he was behind her, and he was unable to see her face. Resident bumped his wife on the sides of the head and the top of the head to get her attention to decide what door to go out. Residents were immediately separated. Resident denied pain, no emotional distress noted, behaviors per usual. Staff in room if residents in room together while awake rest of this shift. Room door remains open unless staff are present.-On 05/18/26 at 3:48 PM, Resident [R57] and spouse [R40] were approached by DON B and RN G, and NHA A and asked if either would like to move to a different room. Resident [R57 and R40] stated, No, I am not moving. Social Services will be contacting Ombudsman for guidance. Residents' [R57 and R40] adamant at this point to no move rooms. Initiated 1:1 supervision while in room together. Surveyor did not find any documentation regarding the incident from 05/16/26 in R57's medical record until Surveyor brought to staff attention on 05/18/26. On 05/18/26 at 10:47 AM, Surveyor interviewed Certified Nurse Assistant (CNA) H and asked if CNA H was aware of any incidents between R40 and R57. CNA H reported CNA H overheard in report that R57 struck R40 in the head multiple times. CNA H could not divulge any other information. On 05/18/26 at 10:51 AM, Surveyor interviewed CNA O and asked if CNA O was aware of any incidences between R40 and R57. CNA O reported they were working that day on 05/16/26 but down a different hall. CNA O reported on Saturday 05/16/26 around 2:00 PM, while everyone was in report for the next shift, CNA J yelled out for assistance as R40's husband [R57] was striking R40 in the head. CNA J reported to Surveyor CNA J did not observe the situation, so CNA J does not have any other details to provide. On 05/18/26 at 1:27 PM, Surveyor interviewed DON B and Registered Nurse (RN) G and asked DON B about how Surveyor would know there was an incident on Saturday 05/16/26 between R40 and R57. DON B reported to Surveyor that DON B is working on creating a soft file. Surveyor asked DON B to please explain the events that occurred between R40 and R57 on 05/16/26. DON B reported to Surveyor DON B was called on Saturday 05/16/26 a few minutes after shift change from a nurse. DON B was told sounds like [R57] was hitting [R40]. DON B then spoke with CNA J on PM shift stated to DON B, was sitting at desk doing charting, they [R40 and R57] came down hallway, and they wanted to go outside, [R40] wanted to go to the back porch and [R57] wanted to go to the front porch. [R57] tapped [R40] 3 times on the head. DON B reported CNA J was asked if R40 was safe and CNA J told DON B, Yes. DON B then called NHA A and explained the situation and asked what facility needed to do. NHA A told DON B to call facility back and have the nurse interview R57 and R40. DON B reported the nurse on duty interviewed R57 and asked, Did you hit your wife? R57 responded, Yes. The nursed asked, What were you doing? Trying to get her attention. DON B then called NHA A to explain interviews. NHA A said to DON B, Have nurse on duty let [CNA J] hit nurse on duty on arm the way [R57] hit [R40], to do a recreation of the incident. DON B reported to Surveyor the nurse on duty recreated this event. DON B stated, I honestly don't know what the purpose of this was because the arm will feel different than the head. DON B reported back to NHA A and then spoke with Regional Clinical Director (RCD) Q who stated, Write down timeline and investigation and put together in a soft file [R57] was not trying to hurt [R40]. Surveyor asked DON B what the expectation is of staff witnessing any unsafe situation such as potential physical, emotional, or verbal abuse. DON B reported to Surveyor the expectation would be to keep residents safe, assess for injury, and report to RN/DON. Surveyor asked DON B if there was a reason the documentation of the incident on 05/16/26 was not in the medical record. DON B reported that the facility has a soft file, and CNAs can't document in chart, so they are to inform their charge nurses on duty of any incidents. Surveyor asked DON B why the incident on Saturday 05/16/26 was not reported. DON B reported RCD Q did not feel it was reportable after following the algorithm. On 05/18/26 at 1:50 PM, Surveyor interviewed NHA A and asked NHA A to explain events that occurred on 05/16/26, and why this was not reported to the state. NHA A reported to Surveyor NHA A thought through observations and findings it was not necessary to contact state or change R40 and R57's circumstances. NHA A reported NHA A was looking over algorithm and it was not intending harm on (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R40 when R57 struck R40 in the head multiple times. Surveyor requested NHA A to show Surveyor algorithm that NHA A was following. Surveyor reviewed algorithm titled, Resident-To-Resident Altercation Flowchart, dated last revised 06/18, which states: .Did the resident act willfully? Willful means that the individual's act was deliberate-not inadvertent or accidental-regardless of whether or not the individual intended to inflict injury or harm. On 05/18/26 at 1:50 PM, Surveyor's interview with NHA A continued and NHA A stated to Surveyor, I did not read it like that, and I am sorry. Surveyor informed NHA A that there is no documentation of this incident in either R40's or R57's medical record. On 05/18/26 at 2:51 PM, Surveyor interviewed CNA J and asked if CNA J could explain the events from the incident that happened on Saturday 05/16/26 between R40 and R57. CNA J stated, I was the only one out at the nurse's station while everyone was providing cares or in report. [R40] and [R57] were at the nurse's station asking if they could go outside on the porch. I asked [R40] and [R57] which porch they would like to go on for fresh air. [R40 stated] 'wanted to go to the south one,' and [R57] stated, 'wanted to go to the north porch.' CNA J stated, When [R40] stated that she wanted to go to the opposite porch than [R57], [R57] became agitated and started slapping [R40] alongside the head with open hands-on right side of face, then left side of face, and then began aggressively striking [R40] from behind and on top of head multiple times with closed fist. I quickly jumped up and told him [R57] to stop and I placed myself in between them to protect [R40]. CNA J reported to Surveyor if CNA J had not stopped R57, then R57 would have kept going. CNA J reported CNA J immediately separated R40 and R57, notified nurse in charge and the charge nurse began making calls to DON B and NHA A. On 05/19/26 at 8:25 AM, Surveyor observed law enforcement arrive at the facility to interview R57 and R40 of the incident with R57 striking R40 on the head and face on Saturday 05/16/26. On 05/19/2026 at 12:36 PM, Surveyor interviewed DON B about incident and not reporting to SA. DON B reported to Surveyor that DON B understands the facility did not document the event from 05/16/26, and the facility did not facility did not notify state officials or law enforcement,

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure a thorough investigation was completed to protect R40 and R57 from further potential abuse during a resident-to-resident interaction on 5/16/26 when R40 hit R57 on the head multiple times.Findings include: Surveyor reviewed facility policy titled, Abuse Prevention Program, dated last revised 01/26, states: .Intent: Each resident has the right to be free from abuse, neglect, and corporal punishment of any type by staff or anyone. The facility will provide a safe resident environment and protect residents from abuse.Definitions: Resident to Resident Abuse: A resident-to-resident altercation should be reviewed as potential situation of abuse. The facility Administrator and Director of Nursing will initiate an investigation of a potential allegation of abuse between residents. Investigations for potential abuse will not be dismissed in cases where either or both residents have a cognitive impairment. During the investigation it will be identified that the actions were willful were deliberate, regardless of whether the individual intended to inflict injury or harm.VII. InvestigationThe Administrator and or Director of Nursing are to initiate and coordinate completion of a thorough investigation. Investigations must be initiated immediately and concluded as soon as possible not to excess 5 days. Forms are available to assist the investigator and may utilized. The investigation must include but not limited to:-Identify alleged perpetrator, remove from resident care area immediately, suspend pending investigation conclusion, obtain statement.-Identify and begin investigating different types of alleged violations.-Identify and interview (witness statements) all involved persons including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation.-Interviews with coworkers or other supervisors.-Determining if abuse, the extent, and cause.-Body assessment and psychosocial status of the resident.-Methods of treatment and interventions.-Providing complete/thorough documentation of the investigation findings (timeline of events), summary or conclusion.-Follow-up actions to correct and prevent potential occurrence.-State and local agencies notified facility reportable incidents (FRI). 2. The Administrator, the Director of Nursing, or designee will then coordinate the activities required for completion of the Resident Abuse Investigation Summary and Conclusion.3. In order to complete the Resident Abuse Investigation, all information must be gathered and reviewed, with a final summary analysis with an action plan to prevent reoccurrence. R40 was admitted to the facility on [DATE] with diagnoses including unspecified fracture of left pubis, heart failure, type 2 diabetes, and cerebral infarction. R40's Minimum Data Set (MDS) assessment, dated 05/07/26, identified R40's Brief Interview for Mental Status (BIMS) scored 11/15 indicating R40 has moderate cognitive impairment. R40's progress notes state:-On 05/18/26 at 2:23 PM, Late entry for 05/16/26: Writer [DON B] alerted via phone resident [R40] was involved in an incident with her spouse [R57]. Resident [R40] was separated from her spouse [R57] immediately and kept safe with 1:1 supervision with staff. Resident [R40] was assessed for injury and no injury noted. Resident [R40] behaviors and mood per usual, no noted anxiety, confusion, or other changes noted. Resident [R40] denied pain. Residents [R40] door was left open in room, and resident [R40] was not left alone in room with spouse present for rest of shift. Residents' [R40] door will be kept open unless staff are present. Behaviors will continue to be monitored as needed.-On 05/18/26 at 3:44 PM, Resident [R40] and spouse [R57] were approached by DON B and nurse, and NHA A and asked if either would like to move to a different room. Resident [R40 and R57] stated, No, I am not moving. Social Services will be contacting Ombudsman for guidance. Residents' [R40 and R57] are adamant at this point to not changing rooms. Initiated 1:1 supervision while in room together.-On 05/18/26 at 5:12 PM, Writer was present in room completing 1:1 supervision with patient [R40] and spouse/roommate [R57]. R40 stated she did not like being under guard and writer explained this is for safety to ensure everyone is safe during interactions. R40 asked if she were to move rooms, Would the guard go away? Writer explained to R40 if they were in separate rooms, we would only complete 1:1 supervision during times (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they were together. R40 stated, Then I'll move. [R40] agreed to move to room [number of room]. Personal belongings were brought to room. R40 walked to room with 1 person assistance and walker. Both parties agreed to plan. Surveyor did not find any documentation regarding the incident from 05/16/26 in R40's medical record until Surveyor brought to facility's attention on 05/18/26. R57 was admitted to the facility on [DATE] with diagnoses including unspecified dementia with unspecified severity with agitation. R57's Minimum Data Set (MDS) assessment, dated 05/18/26, identified R57's Brief Interview for Mental Status (BIMS) scored 9/15 indicating R57 has moderate cognitive impairment. R57's progress notes state:-On 05/18/26 at 2:40 PM, Late entry for 05/16/26 documented by DON B: Resident [R57] was involved in an incident with his spouse [R40]. Resident was attempting to get wife attention as he was behind her, and he was unable to see her face. Resident bumped his wife on the sides of the head and the top of the head to get her attention to go decide what door to go out o. Residents were immediately separated. Resident denied pain, no emotional distress noted, behaviors per usual. Staff in room if residents in room together while awake rest of this shift. Room door remains open unless staff are present.-On 05/18/26 at 3:48 PM, Resident [R57] and spouse [R40] were approached by DON B and RN G, and NHA A and asked if either would like to move to a different room. Resident [R57 and R40] stated, No, I am not moving. Social Services will be contacting Ombudsman for guidance. Residents' [R57 and R40] both adamant about not changing rooms. Initiated 1:1 supervision while in room together. Surveyor did not find any documentation regarding the incident from 05/16/26 in R57's medical record until Surveyor brought to staff attention on 05/18/26. On 05/18/26 at 9:20 AM, Surveyor interviewed Licensed Practical Nurse (LPN) K and asked if LPN K has witnessed any incidents between R40 and R57. LPN K indicated to Surveyor R40 and R57 are always bickering and R40 yells a lot at R57. Surveyor asked LPN K exactly what R40 yells about and how R57 responds. LPN K reported R40 states lot of things such as R57 is useless and how R57 irritates R40. Surveyor asked LPN K why facility combined the couple in the same room. LPN K reported R40 used to exit seek trying to find R40's husband (R57). Finally, when R57 was admitted R40 and R57 were moved into the same room and R40 has been better with less exit seeking. Surveyor asked if LPN K has observed R40 and R57 get physical with each other. LPN K reported LPN K has not seen anything physical but heard there was an altercation this last Saturday on 05/16/26 but does not know any details. Surveyor asked LPN K what the process is for handling R40 during moments of agitation and verbal abuse towards R57. LPN K reported to Surveyor LPN K was unsure other than following the care plan to redirect R40 and document in R40's medical record. On 05/18/26 at 10:47 AM, Surveyor interviewed Certified Nurse Assistant (CNA) H and asked if CNA H was aware of any incidents between R40 and R57. CNA H reported CNA H overheard in report that R57 struck R40 in the head multiple times. CNA H could not divulge any other information. On 05/18/26 at 10:51 AM, Surveyor interviewed CNA O and asked if CNA O was aware of any incidents between R40 and R57. CNA O reported that CNA O was working that day on 05/16/26 but down a different hall. CNA O reported that on Saturday 05/16/26 around 2:00 PM, while everyone was in report for the next shift, CNA J yelled out for assistance as R40's husband (R57) was striking R40 in the head. CNA J reported to Surveyor that CNA J did not observe the situation, so CNA J does not have any other details to provide. On 05/18/26 at 1:27 PM, Surveyor interviewed DON B and Registered Nurse (RN) G and asked DON B about how Surveyor would know there was an incident on Saturday 05/16/26 between R40 and R57. DON B reported to Surveyor that DON B is working on creating a soft file. Surveyor asked DON B to please explain the events which occurred between R40 and R57 on 05/16/26. DON B reported to Surveyor DON B was called on Saturday 05/16/26 a few minutes after shift change from a nurse. DON B was told sounds like R57 was hitting R40. DON B then spoke with CNA J on PM shift who stated to DON B, Was sitting at desk doing charting, they [R40 and R57] came down hallway, and they wanted to go outside, [R40] wanted to go to the back porch and [R57] wanted to go to the front porch. [R57] tapped [R40] 3 times on the head. DON B reported CNA J was asked if R40 was safe and CNA J told DON B, Yes. DON B then called NHA A and explained the situation and asked what (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility needed to do. NHA A reported NHA A told DON B to call facility back and have the nurse interview R57 and R40. DON B reported the nurse on duty interviewed R57 and asked, Did you hit your wife? R57 responded, Yes. The nurse asked, What were you doing? Trying to get her attention. DON B then called NHA A to explain interviews. NHA A said to DON B, Have nurse on duty let [CNA J] hit nurse on duty on arm the way [R57] hit [R40], to do a recreation of the incident. DON B reported to Surveyor the nurse on duty recreated this event. DON B stated, I honestly don't know what the purpose of this was because the arm will feel different than the head. DON B reported back to NHA A and then spoke with Regional Clinical Director (RCD) Q who stated, Write down timeline and investigation and put together in a soft file that [R57] was not trying to hurt [R40]. Surveyor asked DON B what the expectation is when staff witness any unsafe situation such as potential physical, emotional, or verbal abuse. DON B reported to Surveyor the expectation would be to keep residents safe, assess for injury, and report to RN/DON. Surveyor asked DON B if there was a reason the documentation of the incident on 05/16/26 was not in the medical record. DON B reported facility has a soft file, and CNAs can't document in chart, so they are to inform their charge nurses on duty of any incidents. Surveyor asked DON B why the incident on Saturday 05/16/26 was not reported. DON B reported RCD Q did not feel it was reportable after following the algorithm. Surveyor requested facility investigation soft file. On 05/18/26 at 1:50 PM, Surveyor interviewed NHA A and asked NHA A to explain events which occurred on 05/16/26, why this was not reported to the state, and why interventions were not put into place until days later to protect both parties from abusing one another. NHA A reported to Surveyor that NHA A thought through observations and findings it was not necessary to contact state or change R40 and R57's circumstances. Surveyor asked NHA A why there was no additional behavior monitoring or additional guidance put into place. NHA A reported NHA A was looking over algorithm and it was not intending harm on R40 when R57 struck R40 in the head multiple times. Surveyor requested NHA A to show Surveyor algorithm that NHA A was following. Surveyor reviewed algorithm titled, Resident-To-Resident Altercation Flowchart, dated last revised 06/18, which states: .Did the resident act willfully? Willful means that the individual's act was deliberate-not inadvertent or accidental-regardless of whether or not the individual intended to inflict injury or harm. On 05/18/26 at 1:50 PM, interview continued. NHA A stated to Surveyor, I did not read it like that, and I am sorry. Surveyor informed NHA A that Surveyor observed R40 continued to be verbal and physically abusive to R57 when Surveyor observed R40 throwing TV remote at R57's face but missed. Surveyor informed NHA A there is no documentation of incidents in either R40's or R57's medical record and could NHA A explain. NHA A reported to Surveyor that after talking with RCD Q facility feels a referral to a memory care unit should be placed for R57. Surveyor explained the importance of immediacy with R40 and R57 being separated to prevent further potential abuse concerns. NHA A stated to Surveyor, We did talk about moving him [R57] to another room, but after recent hospitalization he was wandering looking for his wife [R40], so we did not do this yet. Surveyor asked DON B with NHA A present to explain the behavior monitoring and how it is not clearly documented for staff to understand and how staff would know the concerns going on between R40 and R57 if none of this was changed in their care plans until today 05/18/26. DON B stated, Everybody is aware of what happened on Saturday and aware of the interventions the facility set in place. DON B reported DON B understands it should have been documented in the medical record and placed in care plans and was not. NHA A stated to Surveyor, Hindsight now, I wasn't too comfortable with the incident that occurred, and we contacted [RCD Q] for guidance, and this was what we did for the incident. Surveyor requested soft file with investigation and all steps put into place after incident from 05/16/26. DON B reported DON B is just now getting to all of this today and will give Surveyor paperwork once completed. On 05/18/26 at 2:51 PM, Surveyor interviewed CNA J and asked if CNA J could explain the events from the incident that happened on Saturday 05/16/26 between R40 and R57. CNA J stated, I was the only one out at the nurse's station while everyone was providing cares or in report. [R40] and [R57] were at the nurse's station asking if they could go outside on the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	porch. I asked [R40] and [R57] which porch they would like to go on for fresh air. [R40] stated 'wanted to go to the south one,' and [R57] stated, 'wanted to go to the north porch.' CNA J stated, When [R40] stated that she wanted to go to the opposite porch than [R57], [R57] became agitated and started slapping [R40] alongside the head with open hands-on right side of face, then left side of face, and then began aggressively striking [R40] from behind and on top of head multiple times with closed fist. I quickly jumped up and told him [R57] to stop and I placed myself in between them to protect [R40]. CNA J reported to Surveyor if CNA J had not stopped R57, then R57 would have kept going. CNA J reported CNA J immediately separated R40 and R57, notified nurse in charge and the charge nurse began making calls to DON B and NHA A. CNA J reported to Surveyor while the charge nurse was on the phone, the charge nurse had asked CNA J to visualize and assess R40's head where R57 struck R40. CNA J stated, Then the charge nurse on the phone reported to [NHA A] that there were no injuries on [R40's] head. Surveyor asked CNA J if the charge nurse did an actual physical assessment on R40. CNA J shook her head no and stated, That was me who assessed [R40's] head. Surveyor asked CNA J how long were R40 and R57 separated before they came back together on that shift. CNA J reported CNA J had stayed an extra 2 hours and then left around 4 PM. CNA J was unsure when facility placed R40 and R57 back in room together as CNA J had sat with them until leaving at 4 PM. Surveyor asked CNA J what the facility process is when staff observe a physical altercation between residents such as between R40 and R57, and then what next steps are to be made to keep both parties safe. CNA J reported to Surveyor that CNA J separated the two and reported it to nurse right away. CNA J was told to write a statement and so CNA J did. Surveyor asked CNA J if there was any education or new interventions put into place after R40 was struck in the head by R57. CNA J reported administration verbally told staff to make sure R40 and R57 were not alone in room with door closed and to check on periodically. Surveyor asked CNA J how R40's presentation was after R57 struck R40 over the head. CNA J reported R40 was crying and very upset. CNA stated, [R40] divulged to me that [R40] and [R57] used to live in a camper but had to move out of camper as [R57] was too violent and it wasn't working out there. CNA J reported to Surveyor R40 was very distraught and upset R57 struck R40 in the head. R40 was crying uncontrollably for about 15 minutes. On 05/19/2026 at 10:26 AM, Surveyor interviewed NHA A who reported to Surveyor R40 and R57 are now separated and R40 chose to move to another room. On 05/19/26 at 8:25 AM, Surveyor observed law enforcement arrive at the facility to interview R57 and R40 about the incident with R57 striking R40 on the head and face on Saturday 05/16/26. On 05/19/2026 at 12:36 PM, interviewed DON B about closing the communication loop pertaining to R40 and R57. DON B reported to Surveyor DON B understands the facility did not document the event from 05/16/26, facility did not educate all staff, facility did not notify state officials or law enforcement, and facility did not implement any interventions to protect R40 and R57 from any further potential abuse concerns until today on 05/18/26.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility did not ensure acceptable parameters of nutritional status, such as usual body weight or desirable body weight range by obtaining routine weights routinely for 1 of 2 residents reviewed for nutrition (R28).R28 had an 8% weight loss in a month, which is a significant weight loss. The facility policy titled Unresolved Weight Loss, dated 1/2026, states: A. Definition of Weight LossWeight loss that is unresolved. (5% in 30 days, 7.5% in 90 days, and 10% in 180 days)B. Tips:~Residents that shows significant weight loss must be re-weighed to ensure accuracy.~Perform monthly weight on those residents that show stable weights and weekly weights on those residents that show any weight loss. R28 was admitted to the facility on [DATE], with diagnoses including unspecified protein-calorie malnutrition, and dysphagia. R28's Brief Interview of Mental Status (BIMS) score was 15 out of 15, indicating that R28 is cognitively intact. R28's Minimum Data Set (MDS) assessment, target date 4/3/26, indicated R28 needs supervision type assistance for activities of daily living and mobility. R28's care plan, last reviewed 4/9/26, states Problem: Resident at risk for dehydration D/T (due to) use of antipsychotic, antidepressant, antianxiety medications, C-diff infection with antibiotic use, nectar thick liquids which may not appeal to resident. Category Dehydration / Fluid Maintenance. Start Date 04/09/2026 Last Reviewed/Revised 04/09/2026 11:59 AM.~ Approach: Weigh resident as ordered and report significant changes to MD. Start Date 04/09/2026. R26 physician orders include: Weekly weights Once a Day on Wed; 08:00AM- 10:00AM. Started 5/1/26- open ended. On 5/18/26, Surveyor reviewed R28's weight record which documented:4/1/26 R28 was 94.6 pounds (lbs.).4/8/26- no weekly weight4/15/26- no weekly weight4/23/25 was 91 pounds (lbs.).5/1/26 R28 was 87 pounds (lbs.).5/1/26 is R28's last documented weight. Surveyor found no documentation of R28 refusing to be weighed. On 5/18/26, Surveyor reviewed R28's progress notes for documentation of R28's weights. No progress notes were found documenting weights for R28. On 5/18/26 at 1:18 PM, Surveyor interviewed R28, who stated R28 did lose weight before she came. R28 stated R28 has lost some more since R28 got here. Surveyor asked R28 how often R28 is weighed. R28 stated I think every week, but I can't remember. R28 denies refusing to be weighed. On 5/19/26 at 12:10 PM, Surveyor interviewed Director of Nursing (DON) B who stated R28 has lost weight, and they are working with the provider, dietary manager, and registered dietician. DON B states R28 has an order for daily weight. Surveyor stated the last documented weight was on 5/1/26. DON B stated after reviewing medical record, there is a box to check when you put in the order that needs to be checked, and it wasn't. DON B stated there was nowhere to write down the weights because of that. Surveyor asked DON B if there was no place to document R28's weights, then there are no weights since 5/1/26, which could be used for an assessment. DON B stated, no there is not but I have to check the progress notes. Surveyor asked DON B to print any progress notes from 5/1/26 she finds for the Surveyor. Surveyor did not receive any progress notes for R28 from DON B. On 5/19/26 at 2:34 PM, Nurse Practitioner (NP) P who stated NP P is aware of R28's weight loss. R28 came in with weight loss and C.diff., (a gastrointestinal illness). NP P stated the facility is doing all they can to help R28 gain weight. NP P stated R28 is on weekly weights. NP P stated NP P thinks there is a mistake in R28's weights. Surveyor asked what the expectation of the facility would be if there was a suspected error with taking the weight. NP P said the resident should be re-weighed. Surveyor informed NP P the last recorded weight was on 5/1/26. NP P stated they should be taking weekly weights.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections with the potential to affect all 23 residents on the Maple hallway in facility.~CNA H used soiled gloved hands to clean care area in R7's room, wipe out the wash basin, and put the basin in a clean garbage bag for next use.~CNA I used soiled hands to assist R7 with eating.~CNA I placed R7's catheter on the floor of the SPA room without barrier, while preparing R7 for his bath.~RN G and CNA F did not carry the dirty linen and garbage bags away from their bodies. The facility policy titled Hand Washing/Hand Hygiene, dated 1/2025, states Practicing [Hand Hygiene] is a simple effective way to present infections by preventing the spread of germs. Wash hands and other skin surfaces when: 1. After immediate contamination with blood, other boy fluids or potentially contaminated articles. 2. After removing gloves or other personal protective equipment 3. After the care of each resident 4. Before and after nursing treatments or procedures. 5. After handling urinals, bedpans, catheters, sputum, or any other body fluid; . 7. Before and after eating, preparing or handling food: Example 1 R7 was admitted to the facility on [DATE] with diagnoses including failure to thrive, one fractured rib, compression fractures of multiple vertebrae, intermittent asthma, epilepsy, heart failure, bipolar disorder, and Wernicke's encephalopathy. On 4/13/2026, R7 was admitted to hospice due to progression of diseases. R7 is cognitively impaired and fully dependent on the facility for mobility and activities of daily living. On 5/18/26 at 8:30 AM, Surveyor observed Certified Nursing Assistant (CNA) H provide morning cares to R7. CNA H completed hand hygiene and donned gloves and gown when CNA H entered R7's room. CNA H removed all the pillows from around R7 and pulled blankets off. CNA H provided R7 with an upper body bed bath. CNA H removed R7's soiled brief and completed peri cares. With the same gloved hands, CNA H placed a clean brief on R7, pulled up R7's blankets to his chin, and adjusted R7's oxygen nasal cannula to fit in R7's nose. CNA H proceeded to clean the room up, tasks included picking up and collecting dirty linen and clothes. CNA H took the wash basin, emptied it out, washed it, took a clean washcloth and wiped it out. CNA H took the cleaned basin and placed it in a plastic bag and placed it on a shelf. The entire task from bed bath to cleaning up the basin was completed with CNA H wearing the same gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/26 at 8:48 AM, Surveyor interviewed CNA H and asked when hand hygiene should be performed. CNA H stated hand hygiene should be performed when leaving and entering a room, before and after cares, before eating, all the time. Surveyor asked about gloves and if and when the gloves should be changed. CNA H stated gloves should be changed if they are dirty, in-between tasks, or if you change tasks. Surveyor informed CNA H about the observation of cares, applying clean brief and pulling up covers to resident's chin, and adjusting R7's oxygen. CNA H stated CNA H should have washed CNA H's hands and changed gloves. Surveyor informed CNA H of the observation of cleaning up dirty clothes and linens, touching garbage, and then rinsing and cleaning out a basin, drying it, and putting it in a garbage bag. CNA H stated CNA H was cleaning up the basin for next use. CNA H stated, I should have changed my gloves and washed my hands after cares and before cleaning up the basin. On 5/19/26 at 11:29 AM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectation is with hand hygiene and glove changes. DON B stated the expectation is nursing staff complete hand hygiene before providing cares, after cares, when visibly soiled, and between glove changes. DON B stated best practice would be foam in and foam out. Surveyor shared observation. DON B stated CNA H should have completed hand hygiene after peri care, touching garbage, and before rinsing out the basin. Example 2 On 5/19/26 at 7:56 AM, Surveyor observed CNA I provide care to R7 and transfer R7 to chair. Hand hygiene and infection control were not breeched during R7's cares. CNA I washed hands after the task; however, CNA I then went to pick paper towel off the floor and tie up the garbage, soiling CNA I's hands again. CNA I then pushed R7 out to the dining room, retrieved a clothing protector from the cupboard and assisted R7 with eating breakfast. CNA I did not wash her hands after the garbage or before assisting R7 with eating. On 5/19/26 at 9:08 AM, Surveyor interviewed CNA I who stated hand hygiene should be before cares and after, before gloves and after, before you go in a room and after, before and after you assist a resident with eating, all the time. Surveyor informed CNA I of the observation. CNA I stated, I should have washed my hands. On 5/19/26 at 11:29 AM, Surveyor interviewed DON B regarding observation of CNA I handling garbage, pushing R7 to dining room, and assisting in dining room without hand hygiene. DON B shook head and stated it shouldn't happen, and DON B stated CNA I should have washed her hands after the garbage and before assisting R7 with meal. Example 3 The facility competency titled Atrium Centers Catheter Care Competency shared by the facility is related to applying a catheter and does not address infection control during care of a catheter. On 5/19/26 at 8:58 AM, Surveyor observed CNA I provide a bath for R7 in spa room, R7's catheter was lying on the spa (bath) room floor, with no barrier between catheter and the floor. CNA I noted Surveyor looking around room and stated, Oops, let me pick this up. Yeah, that should not be on the floor. On 5/19/26 at 9:06 AM, Surveyor interviewed CNA I who stated staff are taught about catheter care in school. CNA I stated CNA I had training here during orientation also. CNA I stated the catheter should (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not touch the ground directly. CNA I stated CNA I should have had a barrier between the catheter and the ground or made sure it was on the chair right away. On 5/19/26 11:29 AM, Surveyor interviewed DON B who stated the CNAs are taught how to do peri care when a resident has a catheter and taught how to empty catheters. This includes using alcohol swabs, barriers, and not touching the spout of the catheter on anything. A catheter should be hanging on side of the bed or wheelchair, not dragging behind. Surveyor informed DON B of observation and DON B stated there should have been a barrier between the catheter and the floor. Example 4 The facility policy titled, Linens Processing, Transporting, Storage Revised 5/2017 stated in part: Standard:The facility will maintain clean bd and bath linens in good condition and available. Facility personnel must handle store, process, and transport linen in a manner that prevents the spread of infection .Linens are to be kept [way] from the body as to prevent contamination. On 05/18/16 at 7:01 AM, Surveyor observed Registered Nurse (RN) G walk down the hall with garbage bag with dirty linen in it under her left armpit and stopped at the hand sanitizer and performed hand hygiene. RN G then entered clean utility room but dropped the bag of dirty linen on the floor outside of this room. RN G picked up a clean flat sheet from this room and then picked up the bag of dirty linen against her body and walked the length of Maple hallway to dispose of the linen in the soiled holding room. On 05/19/26 at 11:18 AM, Surveyor explained the observation of RN G carrying the dirty linen bag against her body. RN G replied, Ideally we would carry this away from the body. But, in this circumstance, I needed to clean my hands after leaving the room. If this was a resident with enhanced barrier precautions I would have for sure carried the dirty linens away from my body. Example 5 On 05/18/26 at 9:26 AM, Surveyor observed Certified Nursing Assistant (CNA) F carry garbage and dirty linens in garbage bags against her body the length of the hallway to the soiled holding room. On 05/19/26 at 11:40 AM, Surveyor informed Nursing Home Administrator (NHA) A of the observations made of the two staff carrying dirty linen and garbage bags against their bodies walking down the hall. NHA A informed the Surveyor that it was not appropriate.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure each resident is offered a pneumococcal and influenza immunization, unless the immunization is medically contraindicated, or the resident has already been immunized for 1 of 5 residents (R7) reviewed for immunizations.R4 signed a consent for pneumococcal and influenza immunizations and did not receive them.Findings include:Facility policy titled, Influenza Vaccine Policy, with a reviewed date of 01/2025, states: Policy Explanation and Compliance Guidelines: 2. Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated.Facility policy titled, Pneumococcal Vaccine Policy, with a reviewed date of 01/2025, states: Policy Explanation and Compliance Guidelines: 2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated.R4 was admitted to the facility on [DATE].On 03/05/26, R4 signed a consent to receive a pneumococcal and influenza vaccination.On 05/19/26, Surveyor reviewed R4's medical record and was unable to find documentation of R4 receiving a pneumococcal or influenza vaccination.On 05/19/26 at 10:16 AM, Surveyor interviewed Director of Nursing (DON) B regarding vaccinations. DON B stated once a resident signs a consent for a vaccine, it is usually administered within a couple weeks. Surveyor asked why R4's pneumococcal or influenza vaccination was not administered after signing the consent on 03/05/26. DON B stated she did not know because it should have and would check to see if there was any additional documentation. DON B did not provide Surveyor any additional documentation.