STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525671	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schmitt Woodland Hills	1400 W Seminary St Richland Center, WI 53581

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:15Number of residents cited: 2 OF 15 SAMPLED Based on observation, record review and staff interview, the facility did not ensure the resident's care plan was updated to reflect current care needs for 2 Resident (R33 and R41) of 15 sampled residents. R33's care plan reflected R33 should always have bilateral hand splints on except for at mealtime. Surveyor made observations of R33 without hand splints on. Staff had discontinued hand splints and started using washcloths in place of hand splints and had not updated the care plan. R41's care plan contained precautions from a Norovirus outbreak that occurred in the facility from December into January. The care plan was not discontinued once the outbreak was over. R41's care plan also contained a care plan for the use of an antidepressant which R41 is no longer taking. Findings: Facility policy titled Comprehensive Care Plan, last revised 1/2026 states in part. Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified on the resident's comprehensive assessment and meet professional standards of quality. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS (minimum data set) assessment. Example 1 On 1/24/2022, the Surveyor reviewed R41's medical record. R41 was admitted to the facility 11/30/2023. R41's diagnoses included coronary artery disease, HTN (hypertension), BPH (benign prostatic hyperplasia), arthritis, non-Alzheimer's dementia, stroke, and hemiplegia. R41's BIMS score on 2/27/2026 is documented as 04 indicating R41 has severe cognitive impairment. R41's care plan states in part. Focus: The resident is at risk for transmission of infection r/t (related to) vomiting/diarrhea. Date Initiated: 12/29/2025. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: Initiate contact precautions per provider order and infection control policy. Monitor for signs and symptoms of infection. Coordinate enhanced environmental cleaning of high-touch surfaces. Disinfect shared equipment between uses per policy. Observe staff compliance with PPE (personal protective equipment) use. Perform hand hygiene before and after resident contact. Post contact-precautions signage outside resident room. Provide resident and visitor education regarding hand hygiene and limiting contact. Review lab results and cultures as ordered and report to physician. Staff to don gown and gloves upon room entry. Use dedicated or disposable resident-care equipment when possible. All goals initiated on 12/29/2026. Note: The facility concluded its Norovirus outbreak on 1/29/2026. Focus: The resident uses antidepressant fluoxetine r/t depression and poor prognosis. Date Initiated: 12/14/2023 Goal: Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of anti-depressant drugs being given. Monitor/document/report PRN adverse reactions to ANTIDEPRESSANT therapy: Change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt (weight) loss, n/v (nausea/vomiting), dry mouth, dry eyes. All goals initiated on 12/14/2023. Note: R41's antidepressant medication was discontinued on 5/16/2025 and not removed from R41's plan of care. On 3/4/2026 2:51 PM, Surveyor interviewed DON B (Director of Nursing) and NHA A (Nursing Home Administrator) regarding care plan revisions not done when R41 no longer taking antidepressant medication and the facility no longer in a Norovirus outbreak which since January. Surveyor asked DON B and NHA A who updated the plan of care. DON B states, all the nurses. If the nurse is not able or does not have time to update the care plan they fill out a form on changes that need to be made to the care plan and then the ADON or MDS nurse, make the change for them. Surveyor asked DON B and NHA A if changes in residents plan of care should the care plan be updated to reflect those changes. DON B and NHA A both indicate that is correct. Surveyor asked DON B when a medication is discontinued, or an outbreak is over should those care plans be resolved in the resident care plan. NHA A states, they should be resolved when discontinued or resolved. On 3/5/2026 at 8:55 AM, Surveyor interviewed CNA C (Certified nursing assistant). Surveyor asked CNA C where she would look at to know how to care for a resident. CNA C states, I would look at the residents care plan and we also have walking care plans. Surveyor asked CNA C if changes need to be made to the care plan who makes those changes. CNA C states that if a change needs to be made to the care plan, I will tell the nurse, then she will update the care plan or the MDS Nurse, DON or ADON will. Surveyor asked CNA C how she knows if changes are made to a residents care plan. CNA C states, a lot is passed down in report, we do walk around report going room to room and then we also listen to nursing report at the beginning of our shift. If changes are made during the shift the nurses will let us know or we report changes to the nurse for changes on the care plan. On 3/5/2026 at 9:03 AM, Surveyor interviewed CNA H. Surveyor asked CNA H where she would look (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to know how to care for a resident. CNA H states, we have walking care plans or look at the care plans on computer. Surveyor asked CNA H who would make the changes to care plan. CNA H states, changes to the care plan updated by the nurse or the nurse will give to MDS, ADON, or DON to make the changes for her. Surveyor asked CNA H how she is made aware of changes to a residents care plan. CNA H states, during report the nurse will tell us if there are any changes or when doing shift to shift report with off-going shift. On 3/05/2026 at 9:10 AM, Surveyor interviewed RN I (Registered Nurse). Surveyor asked RN I where she would look to know how to care for a resident. RN I states, I would begin by reviewing care plan, doing assessments, asking other staff, and through report. Surveyor asked RN I who is responsible for making changes to the care plan. RN I states, any changes will be passed on through report. The nurses will remove items from the care plan when there are changes or at times if the nurse is not able to get to it the DON, ADON (Assistant Director of Nursing) or MDS Coordinator will make the changes. Surveyor RN I how is made aware of any changes to a residents plan of care. RN I states, I would get that through report and if you pull up the 24 hour report you can see when changes were made and update the care plan. Surveyor asked RN I about medication changes. RN I states that any medication changes would also be placed on the 24 hour board too so that changes can be made to the plan of care. Example 2: R33 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's Disease (a progressive, irreversible brain disorder that damages neurons, causing cognitive decline, memory loss, and behavior changes) and torticollis (a twisted, tilted neck caused by tightening of the sternocleidomastoid muscle). R33's BIMS score on 11/16/26 is documented as 00 indicating R33 has severe cognitive impairment. R33's Care Plan states, in part: . Focus: The resident has limited physical mobility related to weakness. Date Initiated: 4/14/2022. Goal: The resident will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury through the next review date. Date Initiated: 8/01/2022. Interventions: . *The resident wears blue hand/digit splint to the right hand at all times except for mealtimes. Address hand hygiene with each removal of splint. No splints to the left hand at this time. Date Initiated: 8/04/2025. Focus: The resident has an alteration in musculoskeletal status related to contractures of the neck, UES (upper extremities) and LES (lower extremities) . Interventions: . * At night, the resident is to wear bilateral elbow splints. During the day, the resident is to wear bilateral hand splints. Off at meals. Monitor for any redness. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/03/26, at 9:29 AM, Surveyor observed R33 in Broda chair with bilateral hands curled closed with no hand splints or wash clothes and no cervical neck pillow or rolled blanket around neck. On 3/04/2026 at 10:23 AM, Surveyor observed R33 lying in bed on back with rolled blanket around neck and no bilateral hand splints in hands. On 3/04/2026 at 10:58 AM, Surveyor interviewed DON B (Director of Nursing) and ADON F (Assistant Director of Nursing). Surveyor asked ADON F and DON B, according to R33's Care Plan, is R33 to always have blue hand splints on to bilateral hands? ADON F indicated wash clothes were put into place this past fall. ADON F indicated she changed the blue hand splints to wash clothes after speaking with therapy due to the rough edges on the splints. The splints were leaving redness to R33's palms. Surveyor read R33's care plan to ADON F and DON B, The resident wears blue hand/digit splint to the right hand only, at all times except for mealtimes, and At night, the resident is to wear bilateral elbow splints. During the day, the resident is to wear bilateral hand splints. Off at meals . Surveyor pointed out the care plan shows two different interventions regarding hand splints. ADON F indicated she did not change it on the care plan to reflect to use wash clothes to bilateral hands and should have. Surveyor informed ADON F and DON B of observations of R33 without hand splints/wash clothes and the cervical neck pillow not placed on R33. Surveyor asked ADON F and DON B if they would expect care plans to be followed. ADON F indicated yes. DON B indicated his expectation is for care plans to be updated right away with any changes and followed. ADON F indicated she will update the care plan for R33 right away.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure residents with limited range of motion, received appropriate treatment and services to increase range of motion/mobility and/or to prevent further decrease in range of motion/mobility for 1 of 2 residents (R33) reviewed for range of motion (ROM).R33 did not receive her bilateral hand splints/wash clothes, cervical pillow per comprehensive care plan and therapy recommendations.This is evidenced by:The facility policy entitled Prevention of Decline in Range of Motion, dated 1/10/26, states, in part: . Policy: Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable.Policy Explanation and Compliance Guidelines:1. The facility in collaboration with the medical director, director of nurses and as appropriate, physical/occupational consultant shall establish and utilize a systemic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventative care.3. Appropriate Care Planning a. Based on comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motion. b. The facility will provide treatment and care in accordance with professional standards of practice. This includes, but is not limited to: i. Appropriate services (specialized rehabilitation, restorative, maintenance). ii. Appropriate equipment (braces, splints) . c. Care plan interventions will be developed and delivered through the facility's restorative program. d. Interventions will be documented on the resident's person-centered care plan. Documentation should include, but not limited to: i. Type of treatments; ii. Frequency and duration of treatments; . R33 admitted to the facility on [DATE] and has diagnoses that include Alzheimer's Disease (a progressive, irreversible brain disorder that damages neurons, causing cognitive decline, memory loss, and behavior changes) and torticollis (a twisted, tilted neck caused by tightening of the sternocleidomastoid muscle).R33's Brief Interview for Mental Status (BIMS) score on 11/16/26 is documented as 00 indicating R33 has severe cognitive impairment.R33's Care Plan states, in part: . Focus: The resident has limited physical mobility related to weakness. Date Initiated: 4/14/2022.Goal: The resident will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury through the next review date. Date Initiated: 8/01/2022.Interventions: .*After each meal, lay the resident down in bed on her right side. Ensure appropriate support to head, neck, and back for positioning. Date Initiated: 5/30/2024.*Ensure hand stretches are being completed per the program listed on bathroom door twice daily, one time each AM and PM shift. Complete stretches with both hands. Date Initiated: 8/28/2025.*Ensure proper neck placement with cervical pillow or rolled blanket for proper neck alignment. Date Initiated: 9/19/2024.*The resident wears blue hand/digit splint to the right hand only at all times except for mealtimes. Address hand hygiene with each removal of splint. No splints to the left hand at this time. Date Initiated: 8/04/2025.Focus: The resident has an alteration in musculoskeletal status related to contractures of the neck, UES (upper extremities) and LES (lower extremities) .Interventions: .* At night, the resident is to wear bilateral elbow splints. During the day, the resident is to wear bilateral hand splints. Off at meals. Monitor for any redness. On 3/3/26 at 9:29 AM, Surveyor observed R33 in Broda chair with bilateral hands curled closed with no hand splints or wash clothes and no cervical neck pillow or rolled blanket around neck. On 3/4/26 at 10:23 AM, Surveyor observed R33 lying in bed on back with rolled blanket around neck and no bilateral hand splints in hands.On 3/4/26 at 10:26 AM, Surveyor interviewed CNA C (Certified Nursing Assistant) and asked if the CNAs do restorative cares such as passive and active range of motion exercises with residents. CNA C indicated yes with morning cares. CNA C indicated the active and passive range of motion exercises are documented in the computer system by the CNAs. Surveyor asked is R33 to have a cervical pillow around her neck at (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all times. CNA C indicated yes, the staff uses a rolled-up blanket for the cervical pillow per husband request. Surveyor asked if R33 is to have blue hand splints to bilateral hands. CNA C indicated the blue hand splints were discontinued, and they now use rolled wash clothes in place of the blue hand splints. Surveyor asked if R33 should have the wash clothes in place now, CNA C indicated the reason R33 did not have the washcloths in place at this time was because R33 had a shower this morning and staff are waiting for the areas to R33's hands to dry. CNA C indicated staff will place the wash clothes later when R33 gets up for lunch. Surveyor asked CNA C if R33 is care planned to lay on right side. CNA C indicated she was not aware of that; the staff rotates positioning in bed from sides to back. CNA C indicated R33 cannot lay on her right side; staff places a pillow under her sides. Surveyor asked CNA C if R33 is lying flat on her back now and CNA C indicated yes.On 3/4/26 at 10:09 AM, Surveyor interviewed DR G (Director of Rehab). DR G indicated therapy had recommended R33 has bilateral resting hand splints to be placed during the day at all times except at meals to prevent further contracture and an elbow splint at night. DR G indicated R33 has a curvature of the neck which is more related to tightness and tone vs. contracture. Surveyor asked DR G if she would expect nursing staff to follow therapy recommendations and DR G indicated yes.On 3/4/26, at 10:58AM, Surveyor interviewed DON B (Director of Nursing) and ADON F (Assistant Director of Nursing). Surveyor asked if R33 is to be laid down after meals on her right side. DON B indicated R33 cannot lay on her right side. Surveyor read to DON B R33's care plan: After each meal, lay the resident down in bed on her right side. Ensure appropriate support to head, neck, and back for positioning. ADON F indicated yes, it is care planned to lay R33 on her right side. Surveyor asked DON B what his expectation is for R33 to be positioned in bed. DON B indicated staff are to prop a pillow under left side to bring tension off neck to help align R33's neck and back. Surveyor informed DON B and ADON F R33 is lying flat on her back now with no pillow and the CNAs are not aware of the care plan indicating R33 is to lay on her right side. Surveyor asked ADON F and DON B if R33 is to have blue hand splints placed at all times. ADON F indicated wash clothes were put into place this past fall. ADON F indicated she changed the blue hand splints to wash clothes after speaking with therapy due to the rough edges on the splints. The splints were leaving redness to R33's palms. Surveyor indicated to ADON F and DON B that Surveyor interviewed DR G and she informed Surveyor the recommendation in the computer was for bilateral hand splints. Surveyor read R33's care plan to ADON F and DON B, The resident wears blue hand/digit splint to the right hand only at all times except for mealtimes, and At night, the resident is to wear bilateral elbow splints. During the day, the resident is to wear bilateral hand splints. Off at meals . Surveyor pointed out the care plan shows two different interventions regarding hand splints. ADON F indicated she did not change it on the care plan to reflect to use wash clothes to bilateral hands and should have. Surveyor informed ADON F and DON B of observations of R33 without hand splints/wash clothes and the cervical neck pillow not placed on R33. Surveyor asked ADON F and DON B if they would expect care plans and therapy recommendations to be followed. ADON F indicated yes. DON B indicated his expectation is for care plans to be updated right away with any changes and followed. ADON F indicated she will update the care plan for R33 right away.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure a resident with a catheter receives appropriate treatment and services to prevent urinary tract infections for 1 of 1 resident (R6) reviewed for catheter care.Staff failed to perform proper hand hygiene with R6's catheter care. Staff did not perform hand hygiene in between removing soiled dressing, cleansing catheter site, and applying new dressing. Evidenced by:The facility policy entitled Hand Hygiene, dated 2023, states, in part: . Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors.Policy Explanation and Compliance Guidelines:1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table.-Before and after handling clean or soiled dressings, linens, etc.-After handling items potentially contaminated with blood, body fluids, secretions, or excretions-When, during resident care, moving from a contaminated body site to a clean body site. R6 admitted to the facility on [DATE] and has diagnoses that include neuromuscular dysfunction of the bladder (occurs when nerve damage from conditions like spinal cord injury, multiple sclerosis, or diabetes disrupts brain-bladder communication).R6's Minimum Data Set (MDS) assessment, dated 12/4/25, shows that R6 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R6 is cognitively intact.R6's Care Plan states, in part: . Focus: The resident has an altercation in elimination related to Neurogenic bladder with placement of supra pubic catheter and history of UTI (urinary tract infection). Date Initiated: 6/08/2016 Revision on 2/02/2022.Goal: .*The resident will be/remain free from catheter-related issues through review date. Date Initiated: 6/08/2016. Revision on: 9/26/2025. Target Date: 5/28/2026.Interventions: .*Resident has a 20 French catheter with a 5 cc (cubic centimeter) balloon. Date Initiated: 9/10/2025.*Resident has a suprapubic catheter dressing change to the catheter site daily and as needed, monitor for infection. Date Initiated: 8/17/2016. Revision on: 3/31/2025.On 3/4/26 at 9:09 AM, Surveyor observed CNA C (Certified Nursing Assistant) perform catheter care on R6. CNA C removed the soiled drain sponge dressing around the suprapubic catheter site, cleansed the suprapubic catheter site and the catheter. CNA C proceeded to place new drain sponge dressing around the catheter without performing hand hygiene.On 3/4/26 at 9:23 AM, Surveyor interviewed CNA C and asked when hand hygiene should be performed with catheter care. CNA C indicated before and after the procedure. Surveyor asked if hand hygiene should be performed from going from dirty to clean. CNA C indicated yes. Surveyor asked CNA C if hand hygiene should have been performed before a new dressing was applied. CNA C indicated hand hygiene should have been performed after removing soiled dressing and cleansing catheter site and before applying new dressing to site. On 3/4/26 at 10:20 AM, Surveyor interviewed DON B (Director of Nursing) and asked if he would expect hand hygiene to be performed with change of gloves. DON B indicated he would expect hand hygiene to be performed prior to starting a procedure, going from dirty to clean and with dressing changes.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:15Number of residents cited:1 o2 for hospiceBased on interview and record review, the facility did not ensure hospice collaboration and communication processes were established to ensure continuity of care between hospice and the facility for 1 of 2 resident (R1) reviewed for hospice.R1's current hospice plan of care was not available to facility staff.This is evidenced by: The facility's Coordination of Hospice Services policy, reviewed/revised 1/2/26, states, in part: .3. The plan of care will identify the care and services that each entity will provide in order to meet the needs of the resident and his/her expressed desire for hospice care. The hospice provider retains primary responsibility for the provision of hospice care and services that are necessary for the care of the resident's terminal illness and related conditions. The facility retains primary responsibility for implementing those aspects of care that are not related to the duties of hospice. R1 was admitted to the facility on [DATE] with diagnoses including, but not limited to, acute monoblastic/monocytic leukemia not having achieved remission (cancer), anemia (low red blood cells), dysphagia (difficulty swallowing), facial weakness following cerebral infarction (stroke), hemiplegia (severe or total paralysis of one side of the body) and hemiparesis (weakness or partial paralysis of one side of the body).On 1/23/26 R1 was enrolled in hospice services.The facility did not have a record of R1's hospice plan of care. Upon Surveyor's request for the information, the facility contacted hospice to request this documentation.On 3/4/26 at 2:10 PM, Surveyor spoke with RN D (Registered Nurse). Surveyor asked RN D where the facility keeps R1's hospice plan of care. RN D stated it is in a hospice binder at the nurses' station. Surveyor and RN D observed the hospice binders at the nurses. Both Surveyor and RN D observed that neither binder contained R1's hospice plan of care. RN D notified Hospice RN E who was in the facility at the time.On 3/4/26 at 2:15 PM, Surveyor spoke with Hospice RN E (Registered Nurse). Surveyor asked Hospice RN E what the process is when a resident enrolls in hospice care. Hospice RN E stated that the hospice plan of care gets faxed to the facility. Surveyor asked RN E, should the facility have R1's hospice plan of care available for staff. RN E stated, yes. On 3/4/26 at 2:40 PM, Surveyor spoke with NHA A (Nursing Home Administrator) and DON B (Director of Nursing). Surveyor asked DON B if the facility should have R1's hospice plan of care in the facility and available to staff. DON B stated, yes. DON B stated the hospice plan of care is usually scanned under the miscellaneous tab in the electronic health record. Surveyor observed R1's hospice plan of care is not scanned under miscellaneous or elsewhere in R1's electronic health or hard chart. Surveyor asked DON B if there is a designated staff member to coordinate the plan of care with the hospice provider and ensure documentation is received and available to facility staff. DON B stated yes, ADON F (Assistant Director of Nursing) is responsible.On 3/5/26 at approximately 12:25 PM, Surveyor spoke with ADON F (Assistant Director of Nursing). Surveyor asked ADON F if she is the designated staff member to coordinate the plan of care with the hospice provider. ADON F stated, she tries to be the point person; if there are issues she emails Hospice RN E who gets back to her immediately if there's something the facility needs. ADON F stated, hospice will usually fax 10,000 sheets of paper and medical records will scan the documents into the electronic health record. ADON F stated, she works on the facility plan of care and assists the MDS (Minimum Data Set) Nurse. Surveyor asked ADON F if she follows up to ensure the hospice plan of care is received from hospice and made available to facility staff. ADON F stated, I don't have an answer, if it's an order it comes to me. ADON F stated, she does not confirm that the facility has received the hospice plan of care. ADON F stated, she reaches out to hospice for issues or supplies.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and staff interview, the facility did not post the actual hours for licensed and unlicensed staff scheduled and did not update the postings in real time on the daily nurse staffing postings during the months of February and March 2026. This has the potential to affect all 40 residents in the facility.The facility's Nursing Staff postings were not updated and do not reflect actual hours worked and were not updated in real time to reflect any admission, discharges or staff call ins or additions.Evidenced by:Division of Quality Assurance (DQA) memo 12-020 titled Clarification Concerning Posting Requirements for Nurse Staffing documents: Required Staffing Information .Nursing homes must post information about the number of staff directly responsible for resident care on each shift. This information must be posted in a prominent place, readily accessible to residents and visitors at the start of each shift .The information that is posted must include the following .1. Facility name.2. The current date.3. The total number of staff directly responsible for resident care per shift for each of the following categories: licensed (RNs (Registered Nurse), LPNs (Licensed Practical Nurse)), and unlicensed (CNAs (Certified Nursing Assistant)). (For example, 1 RN, 2 LPNs, and 4.5 CNAs.) The number of RNs must be separate from the number of LPNs. 4. The actual hours worked per shift for each of the following categories: licensed (RNs, LPNs), and unlicensed (CNAs).5. Resident census. Timing: Information is to be posted daily and must be present at the start of each shift. Nursing homes can choose to post staffing information for the entire day or for the current shift. Nursing homes are required to update the posted staffing if any changes arise, for example, if a nursing assistant calls in sick or goes home sick and is not replaced.The facility posts individual forms of the daily Nursing Staff sheet. Surveyor reviewed the facility's Nursing Staff and the facility's Staff Schedules for February 15th thru March 2nd, 2026, noting the following discrepancies: Staff posting do not include the actual hour staff worked and are not updated when staffing changes occur.On 3/5/26 at 9:19 AM, Surveyor interviewed NHA A (Nursing Home Administrator) and DON B (Director of Nursing). Surveyor asked NHA A and DON B to explain the process for completing the daily census postings for staff. DON B stated, The postings are completed on night shift. They night shift nurses look at the schedule and complete the census postings. Surveyor asked if the Nurse Staff postings should be updated to reflect any changes related to staff call-in's and total the actual hours worked as they occur, NHA A stated, I was aware it needed to include the hours worked but did not notice it was not there. DON B stated, I was not aware, no one has ever said anything. I have been completing them the same way for the last six years. I did not know that the posting needed to contain the total hours.The facility's Nursing Staff posting do not reflect actual staffing hours and are not updated with changes and should be.