STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525681	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Nazareth LLC	814 Jackson St. Stoughton, WI 53589

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, staff and resident interview, and record review, the facility did not ensure meals were served at regular times and in accordance with residents' preferences. This practice had the potential to affect all 64 residents residing in the facility.The facility consistently served meals later than posted mealtimes and residents' preferences.Findings include:The facility policy, titled Frequency of Meals, dated 2/2025 with last revision date of 2/2026, states in part: Policy: The facility will ensure that each resident receives at least three meals daily without extensive time lapses between meals. Policy Explanation and Compliance Guidelines: 1. The facility has scheduled three regular meal times, comparable to normal mealtimes in the community, per day.The facility Schedule of Meal Times, Locations provided to the survey team by the facility states:1st Floor Dining Room Meal Times:Breakfast: 7:50 AMLunch: 11:50 AMDinner: 5:45 PM2nd Floor Dining Room Meal Times:Breakfast: 7:40 AMLunch: 11:40 AMDinner: 5:35 PM3rd Floor Dining Room Meal Times:Breakfast: 7:30 AMLunch: 11:30 AMDinner: 5:25 PM On 3/30/26, Surveyor observed lunch in the 2nd floor dining room, which was to start at 11:40 AM. Surveyor observed that lunch service did not begin until 12:23 PM.On 3/30/26, Surveyor observed meal trays being delivered in the 1st floor hallways for lunch at 12:54 PM.On 3/30/26, Surveyor observed lunch in the 1st floor dining room, which was to start at 11:50 AM. Surveyor observed that lunch service did not begin until 12:55 PM.On 3/30/26 at 12:55 PM, Surveyor interviewed R2 in the dining room, who commented that lunch was really late today.On 3/30/26 at 12:56 PM, Surveyor interviewed R3 in the dining room, who stated that meals are always late.On 3/31/26 at 10:00 AM, during resident council meeting, R2, R3, and R19 all indicated that meals are a big problem at the facility and that the facility is aware, but nothing is getting done about it. R3 stated that dinner is usually served well after 6:00 PM, and that meals are served more often late than on time. R19 stated that the meals are always late, and by the time the food is actually served to them it is cold.On 4/1/26, Surveyor observed meal trays being delivered in the 1st floor hallways for breakfast at 8:42 AM.On 4/2/26 at 2:12 PM, Surveyor discussed the late meal service with NHA A (Nursing Home Administrator). NHA A agreed the lateness of meals this week had been excessive, and stated he had never seen them served that late before.

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This has the potential to affect all 64 residents.The sanitizing solution in the kitchen's three compartment sink did not meet manufacturer parts per million (PPM) requirements.Food items were found to be improperly dated or not dated.Findings include:Example 1The facility's main kitchen uses a three compartment sink to wash larger pots, pans and utensils. One of these compartments uses a sanitizing agent to complete the dishwashing process. Sanitizer dispenses from a machine through a hose into the sink basin.On 4/1/26 at 11:53 AM, Surveyor observed the three-compartment sink in the kitchen to have a large pile of dishes (small pots, pans and utensils) at the end. These appeared to be clean with no discernable traces of debris or food. Surveyor used a thermometer to test the temperature of the water that contained the sanitizing solution, which read 115 degrees Fahrenheit. On the wall above the sink, Surveyor observed signs prepared by the sanitization manufacturer that stated the sanitization of the three-compartment sink was to be tested with a test strip submerged for 10 seconds at a temperature of 65 to 75 degrees Fahrenheit with manufacturer recommendations of reaching150 and 400 PPM (Parts Per Million. Surveyor then put sanitizer in a cup and waited for the sanitizing solution temperature to cool. At 12:28 PM, Surveyor, along with CDM L (Certified Dietary Manager), who is assisting from another facility, tested the solution at a temperature of 77 degrees Fahrenheit. The manufacturer recommended test strips were used to test the solution and did not change color, indicating the solution's PPM was 0. CDM L observed and agreed the test strip did not change color.On 4/2/26 at 10:49 AM, DM K (Dietary Manager) stated to Surveyor that she had been testing the PPM of the sanitizing sink last night and was unable to get it to reach the necessary sanitization level, so she had temporarily put the sink out of commission and contacted the manufacturer for additional assistance. Example 2On 3/30/26 at 8:58 AM, Surveyor observed the following in the facility's main kitchen refrigerator:*5-6oz vanilla nutritional shakes, thawed with no thaw date*2-4oz chocolate nutritional shakes, thawed with no thaw date*2 grilled cheese sandwiches wrapped in aluminum foil with no datesSurveyor also observed, at 10:15 AM in the second-floor medication room refrigerator, 8-4oz nutritional juices with no thaw dates.It should be noted that the nutritional juices and shakes the facility uses are stored frozen and indicate on the packaging that they must be used or discarded within 14 days of being thawed.On 4/2/26 at 10:49 AM, Surveyor interviewed DM K who stated that shakes or nutritional juices that are not dated and are thawed need to be discarded as there is no way of knowing when they were pulled from the freezer.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview, the facility did not ensure that garbage and refuse was disposed of properly. This has the potential to affect all 64 residents.Surveyor observed the dumpers area to have garbage/refuse around the dumpster.Evidenced by:On 3/30/26 at 8:46 AM, Surveyor and CK J (Cook) observed the following outside on the ground, near and under the facility's main garbage dumpsters:*2 empty egg crates*Empty tissue boxes*Plastic forks, spoons, and knives*Cardboard boxes*Various sauce/condiment packets*An empty plastic bag of coffee*Empty used garbage bags (appeared to have been tied and discolored)*Surgical masksAt this time, CK J stated that the area was Gross.On 4/2/26 at 10:49 AM, DM K (Dietary Manager) stated the task of cleaning the dumpster area is completed regularly but would ensure consistent proper disposal and cleaning is carried out.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This has the potential to affect all 64 Residents residing in the facility. The facility may have allowed staff to return to work too soon after reporting gastrointestinal/respiratory symptoms. Employee surveillance list is incomplete. It has vague symptoms (i.e.: sick, sick-stomach, not feeling well.), did not accurately report onset date and has no end dates for symptoms, and has no last day worked. R46 had a sign posted on her door that she was under isolation for contact precautions, however a staff member entered R46's room without following the contact precaution protocol or wearing the appropriate Personal Protective Equipment (PPE). Evidenced by: The facility policy titled Employee Work Restrictions-Infectious Diseases revised 1/2026 states in part: .Policy Explanation and Compliance Guidelines: 5. Employees who are restricted from work shall remain away from work until no longer contagious or cleared by a medical professional as needed. The facility policy titled Infection Prevention and Control Program revised 1/2026 states in part: .3. Surveillance: a. A system of surveillance is utilized for controlling infections and communicable diseases for all staff. b. The Infection Preventionist serves as the leader in surveillance activities. Example 1: The facility provided Surveyor with the facility staff line list. According to the line list, 14 staff members had GI symptoms including vomiting and/or diarrhea. January 2026 line list showed 2 staff members with GI symptoms -neither had start date, end date, or last day worked. February 2026 line list showed 7 staff members with GI symptoms-none had end dates. 5 staff members had no last day worked. March 2026 line list showed 1 staff member with GI symptoms-had no end date. 5 staff members with no last day worked. 2 staff members with no return date. On 4/2/26 at 1:10 PM, Surveyor interviewed IP/ADON C (Infection Preventionist/Assistant Director of Nursing). Surveyor asked If a staff member calls in with GI symptoms how do you determine when they can come back to work. IP/ADON C states she would find out when GI symptoms ended. Once no further GI symptoms, it would be 48 hours after that, kitchen staff has to stay out for 72 hours. Surveyor asked IP/ADON C, how do you determine if there is an outbreak with staff? IP/ADON C stated that she would look to see where the sick staff worked, did they work together on the same day, or same hall, did they eat lunch together, etc. Surveyor asked IP/ADON C How do you know if (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	this is an outbreak if you don't have their last day of work? Well, I could talk with the HR director and see if she has that information. Surveyor asked IP/ADON C with all the missing information on your line list how are you evaluating when people are returning to work. IP/ADON C stated we just started using this new spreadsheet, between HR and I. When I called the staff, I got an end date and determined the RTW (return to work) date. I just didn't always write it down. Surveyor asked IP/ADON Would you expect that you could not determine a RTW date using this spreadsheet if there is no end date listed? IP/ADON C stated yes. On 4/2/26 at 1:30 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked would you expect that a spreadsheet for staff infection surveillance to be filled out completely in order to track infections. DON B stated absolutely. Example 2: Facility policy, titled, Infection Prevention and Control Program dated 1/2025, with last review date of 1/2026, states, in part: Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Policy Explanation and Compliance Guidelines: . 4. Standard Precautions: . b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. 5. Isolation Protocol (Transmission-Based Precautions): a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines. 16. Staff Education: b. All staff shall demonstrate competence in relevant infection control practices. Facility policy, titled, Hand Hygiene dated 1/2025, with last review date of 1/2026, states, in part: Policy: All staff perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. 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. Hand Hygiene Table. Between resident contacts. After handling contaminated objects. After handling items potentially contaminated with blood, body fluids, secretions or excretions. For conditions involving a resident, or the resident's environment, who is isolated for Clostridioides difficile or other infection diarrhea, handwashing with soap and water is required. R46 was admitted to the facility on [DATE]. R46's Nursing Progress Notes include the following: On 3/29/26 at 4:54 AM: CNA (Certified Nursing Assistant) called writer to check on pt (patient) at 0430 (4:30 AM) d/t (due to) pt with emesis. pt had 3 coffee ground emesis and then during cares pt had mucous, bloody discharge from rectum. pt refused VS (vital signs), but writer able to get temp-97.6. writer updated [Hospice Name] and currently awaiting a nurse visit. pt given PRN (as needed) Zofran per Hospice triage RN. pt was cleaned up and was Hoyered into Broda chair. will continue to monitor . updated Nurse Manager. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/29/26 at 2:18 PM: Hospice nurse came for a visit. Hospice nurse stated to continue administering Zofran for nausea if not effective or resident continuous to have emesis and rectal bleeding to call and update Hospice. On 3/29/26 at 2:20 PM: Resident is on a change of condition for coffee ground emesis/ bloody mucous discharge from rectal. VSS (vital signs stable), no emesis noted on this shift. Resident had scant bloody mucous discharge from rectal. On 3/30/26 at 2:17 PM: remains on coc (change of condition) for recent emesis episode. No emesis events today. Resident able to keep nutrition, some food down. No BM (bowel movement) today. VSS. On contact precautions per policy. On 3/30/26 at 8:19 PM: resident remains on coc of recent emesis, coffee ground emesis episode. No new emesis events today. VSS, resident did appear hot and clammy however room is uncomfortably warm. Temp normal. changed into short sleeve and set up fan. resident much more comfortable. remains on contact prophylactically. R46's Physician Orders include, in part: Contact isolation for loose stool/emesis. Full PPE (personal protective equipment). all services brought to room. Start Date: 3/30/26. End Date: 4/2/26. R46's Care Plan: Focus: The resident has an alteration in gastrointestinal status r/t (related to) coffee ground emesis/mucus release from rectum, Date Initiated: 3/29/26 Revision on: 3/29/26 Goal: The resident will remain free from discomfort, complications or s/sx (signs/symptoms) related to gastrointestinal alterations through review date. Date Initiated: 3/29/26 Target Date: 5/05/26 Interventions: VITAL SIGNS, Notify MD of significant abnormalities ie: (rapid pulse, shallow, rapid or labored respirations, low blood pressure. Date Initiated: 3/29/26 Revision on: 3/29/26 . Give medications as ordered. Monitor/document side effects and effectiveness. Date Initiated: 3/29/26. Obtain and monitor lab/ diagnostic work as ordered. Report results to MD and follow up as indicated. Date Initiated: 3/29/26. On 4/1/26 at 8:38 AM, Surveyor observed that R46 had a Contact Precaution sign on her door that indicated everyone must hand hygiene when entering and leaving the room and wear gloves and gown when entering the room. Surveyor observed CNA D (Certified Nursing Assistant) enter R46's room without wearing a gown, gloves, or performing hand hygiene. Surveyor observed CNA D pick up a used tissue from the floor of R46's room, place it in the garbage can inside R46's room, and come back out into the hallway without performing any hand hygiene. Surveyor interviewed CNA D and asked what kind of PPE should be worn in R46's room. CNA D stated she was told in report that R46 was off contact precautions today. Surveyor asked CNA D if she should have worn gloves and performed hand hygiene after picking up a soiled tissue with her bare hands. CNA D indicated that yes that she probably should have. On 4/2/26 at 8:39 AM, Surveyor interviewed LPN E (Licensed Practical Nurse) and asked about R46's contact precautions. LPN E stated that R46 had been on contact precautions for having emesis and some bloody mucous stool. Surveyor asked LPN E, if PPE should be worn in R46's room. LPN E stated yes, PPE should be worn in R46's every time you enter the room. On 4/2/26 at 9:55 AM, Surveyor interviewed LPN F and asked what PPE should be worn with a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident on contact precautions. LPN F stated that gloves and gowns should be worn before going into the room, every time the room is entered. On 4/2/26 at 9:57 AM, Surveyor interviewed CNA G and asked what is done for a resident who is on contact precautions. CNA G stated that there is a cart outside those rooms with PPE and they are to gown up and wear gloves every time before going into the room. On 4/2/26 at 9:59 AM, Surveyor interviewed CNA H and asked about R46's contact precautions. CNA H stated that R46 had been on contact precautions for some vomiting and diarrhea. CNA H indicated that they should always wear PPE, including gown and gloves, before going into her room. On 4/2/26 at 10:05 AM, Surveyor interviewed ADON C (Associate Director of Nursing) and asked her about R46's contact precautions. ADON C stated that R46 was on contact precautions because she had an emesis and some loose stools. Surveyor asked ADON C what is required in caring for someone on contact precautions. ADON C stated that staff should wear gowns and gloves when doing cares. Surveyor asked ADON C to clarify if staff should be wearing PPE with a resident on contact precautions every time they enter the room or only if they are doing cares? ADON C replied every time they go in the room. ADON C stated that it was her expectation that, at a minimum, staff would be wearing a gown and gloves and perform hand hygiene before exiting the room of a resident on contact precautions. ADON C indicated that she talks about hand hygiene with all new staff at orientation and that she recently performed hand washing audits, at which time she discussed with staff that they should be washing with soap and water whenever a resident has GI (gastrointestinal) symptoms. On 4/2/26 at 10:12 AM, Surveyor interviewed DON B (Director of Nursing) and asked her about R46's contact precautions. DON B stated that whenever a resident has an emesis, they are put on precautionary contact precautions for 72 hours. DON B indicated that R46 had an order to be on contact precautions that ended this morning at 5:59 AM. Surveyor shared with DON B her observation of CNA D entering R46's room yesterday without wearing any PPE and picking up a soiled Kleenex and not performing any hand hygiene. Surveyor asked DON B if it was her expectation that staff wear the appropriate PPE when entering the room of a resident on contact precautions and perform appropriate hand hygiene. DON B stated yes, that was her expectation, and that all staff should follow the contact precaution signage when they enter the room for any reason.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:18Number of residents cited:4Based on observation, interview and record review, the facility did not ensure that the menu was followed for 2 of 18 sampled residents (R34, R24) and 2 of 2 supplemental (R54 &R32). R54's diet instructions indicate R54 is to receive gravy to all ground meat. Surveyor observed R54's breakfast ground meat with no gravy. Surveyor observed that R34 received oatmeal instead of cold cereal at breakfast. R34's Meal ticket indicated R34 received cold cereal. Surveyor observed that R24 received oatmeal at breakfast. R24's Meal ticket indicated oatmeal is a dislike of R24. R24's Meal ticket indicated R24 received cold cereal. Surveyor observed that R32 did not receive extra gravy/sauce or fruit per his dietary preferences for his noon meal. Evidenced by: The facility policy entitled Meal Identification, undated, states, in part: . Policy: An electronic meal identification and food preference slip is used to properly identify each individual's needs and desires for food. Procedure: 1. The food service manager visits a newly admitted individual to obtain food and beverage preferences, dislikes and food allergies/intolerances before an electronic meal identification and preference card (meal ID card) is written. 3. The electronic Meal ID includes the name of the individual, room number, diet order, beverage preferences, food dislikes and any other specific diet information. Food allergies should be written in red or printed boldly to call attention to them. 4. Meal ID are used during meal service to ensure the correct diet is being served and food preferences are honored. 5. Meal ID are placed on corresponding meals to ensure delivery to the correct individual. 7. The food service manager/RD (Registered Dietician) is responsible for keeping ID up to date. Example 1: R54 admitted to the facility 6/16/2021 and has diagnoses that include abnormal weight loss and type 2 diabetes mellitus (chronic condition causing high blood sugar due to insulin resistance or insufficient insulin production). (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R54's Quarterly Minimum Data Set (MDS) Assessment, dated 12/29/25, shows that R54 has a Brief Interview of Mental Status (BIMS) score of 3 indicating R54 has severe cognitive impairment. R54's Physician Orders, dated 4/01/26, states, in part: . Dietary Diet: Consistent Carb Diet (CCD) diet Mechanical Soft texture, regular (Thin) consistency, gravy to all ground meat, NO BREAD, NO RICE, Mashed potatoes as replacement for all starches. R54's Meal ID ticket, dated 4/01/26, states, in part: . Dislikes: oatmeal, biscuits and gravy NO RICE MASHED POTATOES AND GRAVY INSTEAD, GRAVY ON ALL MEATS, Oatmeal, CHILI, BISCUITS/GRAVY, Mandarin oranges. Instructions: . gravy to all ground meat. Served: Cold cereal, scrambled egg (liquid eggs), choice of juice, cold cereal, cheese omelet, ground bacon, toast. On 4/1/26 at 8:48 AM, Surveyor observed R54's breakfast to include ground meat with no gravy. Note: Per R54's diet instruction R54 is to receive gravy to all ground meat. R54 did not receive gravy on his ground meat. On 4/1/26 at 8:52 AM, Surveyor interviewed CNA H (Certified Nursing Assistant) and asked if R54's MEAL ID ticket states gravy on all ground meat. CNA H indicated yes. Surveyor asked if R54 's ground meat has gravy on it. CNA H indicated no. Surveyor asked if the ground meat should have gravy on it and CNA H indicated yes, it should. Example 2: R34 admitted to the facility on [DATE] and has diagnoses that include Alzheimer's Disease with late onset (progressive memory loss, cognitive decline, and behavioral changes caused by amyloid plaques and [NAME] tangles (the two hallmark brain abnormalities in Alzheimer's that disrupt neuron communication and cause cell death) and dysphagia (difficulty swallowing). R34's Physician Orders, dated 4/1/26, states, in part: . Dietary Diet: Regular diet Mechanical Soft Texture, Thickened Liquid Nectar consistency. R34's Meal ID Ticket, dated 4/1/26, states, in part: .Served: cold cereal. On 4/1/26 at 9:04 AM, Surveyor observed R34's breakfast to consist of an omelet, ground sausage, oatmeal. Note: Oatmeal is not what R34's ID Meal ticket indicates she received. Example 3: (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R24 admitted to the facility on [DATE] and has diagnoses that include type 2 diabetes mellitus (chronic condition causing high blood sugar due to insulin resistance or insufficient insulin production) and dysphagia (difficulty swallowing). R24's Physician Orders, dated 4/1/26, states, in part: . Dietary Diet: Consistent Carb Diet (CCD) diet Regular/non modified texture, Regular (Thin) consistency, larger portions for all meals. R24's Meal ID Ticket, dated 4/1/26, states, in part: .Dislikes: cabbage, oatmeal. Served: Orange juice, cold cereal, cheese omelet. On 4/1/26, at 8:53 AM, Surveyor observed R24's breakfast to include oatmeal. Of note: R24's Meal ID ticket shows oatmeal as a dislike on R24's Meal ID Ticket. On 4/1/26 at 8:53 AM, Surveyor asked R24 if she likes oatmeal. R24 stated, I don't like oatmeal. Surveyor asked R24 if she would rather have cold cereal and R24 indicated yes. On 4/1/26 at 9:03 AM, Surveyor interviewed CNA H and asked, does R24's Meal ID ticket indicates oatmeal as a dislike? CNA H indicated yes. Surveyor asked CNA H if R24 had oatmeal on her breakfast tray. CNA H indicated yes. CNA H indicated this happens all the time with the kitchen. The kitchen staff always mix up the cold cereal and the oatmeal; the kitchen staff get so busy. Surveyor asked CNA H if a resident does not like a certain food and the Meal ID Ticket indicates the dislike, should the resident receive that food item. CNA H indicated no. On 4/1/26 at 1:29 PM, Surveyor interviewed DM K (Dietary Manager). Surveyor asked if R54 has on his meal ticket to receive gravy with all ground meat, would she expect all ground meat to have gravy on. DM K looked at R54's meal ticket with Surveyor and indicated that gravy on all ground meat is indicated as instructions to R54's diet. DM K indicated yes, R54 should receive gravy to all ground meat. Surveyor informed DM K R54 did not receive gravy on breakfast's ground meat. Surveyor asked DM K if a resident has a food item listed as a dislike if a resident should receive the disliked food. DM K indicated she cannot change the diet order. The dietary staff sends the disliked food out to the residents. The residents do not have to eat it. The residents can ask for something else. Surveyor asked if substitutions should be offered to residents for disliked foods. DM K indicated yes residents should have substitutions to choose from. DM K indicated the system does not pull forward food substitutions that the residents can choose from, so she sends the dislikes out to follow the residents' orders. Surveyor asked DM K if it is the expectation that the residents receive what the Meal Id ticket indicates. DM K indicated yes. Surveyor informed DM K R24 received oatmeal at breakfast and R24's ticket indicated she was to receive cold cereal. R24's Meal ID ticket indicated R24 does not like oatmeal. Surveyor informed DM K that R34 also received oatmeal instead of cold cereal. DM K indicated she would have the Meal ID Tickets updated and have the RD follow up with the residents. Example 4: R32's meal ticket has instructions to provide extra gravy/sauce. Also states that he dislikes vegetables, offer fruit. The facility failed to provide extra gravy/sauce or fruit to R32 resulting in him not being able to eat his noon meal on 04/01/26. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R32 was admitted to the facility on [DATE]. His diagnoses include hemiplegia/hemiparesis (neurological conditions caused one-sided body weakness due to brain or spinal cord injury). Type II Diabetes Mellitus (body can't effectively use insulin or produce enough insulin leading to high blood sugar levels,) R32's latest Minimum Data Set (MDS) indicates his Brief interview of Mental Status (BIMS), is 11/15 , indicating a moderate level of impairment. It also indicates he understands others and is understood by others. R32's physician orders, dated 04/01/26, states in part: . Consistent Carb Diet (CCD) Regular/non modified texture, Regular thin consistency. R32's meal ID ticket, dated 04/01/26, states in part: . Instructions: EXTRA GRAVY/SAUCE. DISLIKES VEGETABLES, OFFER FRUIT. On 4/1/26 at 12:49 PM, Surveyor observed R32 with his lunch meal. There was no extra gravy for his pork chop, and he had vegetables on his plate. No fruit was provided. R32 stated that he could not eat this meal without the gravy and he doesn't like vegetables. He pushed it away, was upset. Surveyor asked if he would like an alternative, and R32 just shook his head and swatted his hand towards the plate. On 4/01/26 at 3:51 PM, Surveyor asked DON B (Director of Nursing) if it is her expectation that diet staff follow diet orders, menus, and Meal Id tickets? DON B indicated yes. Surveyor asked if foods listed as dislikes on the meal tickets, should residents receive those disliked food items. DON B indicated no. Surveyor informed DON B of the concern with food preferences and the Meal Id tickets. The dietary staff are serving disliked foods to residents. The food listed as served to residents is not what residents are receiving.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that each resident receives food that is palatable. This has the potential to effect 2 of 18 sampled residents (R25 & R5) and 2 of 2 supplemental residents (R32 & R55) reviewed for food palatability. R25, R5, R32, and R55 voiced concerns with their food being not palatable.Surveyor conducted a test tray, and the pork chop was not palatable. Evidenced by: Facility policy titled: Dining Subject: Preparation: states in part: . C. Foods shall be prepared by methods that conserve nutritive value, flavor and appearance and should be served at the proper temperature.Example 1R5 most recent Minimum Data Set (MDS) indicates a Brief Interview for Mental Status (BIMS) of 14/15 indicating R5 is cognitively intact. On 04/01/2026 at12:38 PM Surveyor asked how lunch was. R5 reported it was terrible. The pork chop was hard; you can't even eat it.Example 2R25 was admitted to the facility on [DATE]. R25 most recent Minimum Data Set (MDS) indicates a Brief Interview for Mental Status (BIMS) of 15/15 indicating R5 is cognitively intact. On 4/1/26 at 12:45 PM Surveyor observed that R25 was eating a peanut butter and jelly sandwich. Her full meal was on a plate in front of her. I can't eat that, it is terrible. The pork chop is so touch I can't even cut through it. Example 3R32's latest Minimum Data Set (MDS) indicates his Brief interview of Mental Status (BIMS) is 11/15, indicating a moderate level of impairment. It also indicates he understands others and is understood by others. On 4/1/26 at 12:49 PM, R32 his lunch table. Surveyor asked how his lunch was as the plate was pushed up on the table. He just pushed his plate further away and just shook his head. He had pork chops and green beans, R32 said he was supposed to get extra gravy, and he didn't get it so he for sure would not be able to eat the pork chop because it was too hard. Example 4R55's latest Minimum Data Set (MDS) indicates his Brief Interview of Mental Status (BIMS) is 9/15, indicating moderate impairment. It should be noted that R55 was able to ask and answer questions with good understanding on this day.On 4/1/26 at 12:52 PM Surveyor observed resident at lunch table. Asked R55 how his meal was today. R55 took his fork and said, I'll show you. He then stabbed his fork into his pork chop and R55 stated that he couldn't eat it. Example 5:On 4/1/26 at 12:53 PM, Surveyor received a test tray from the kitchen. The pork chop, the featured item on the menu, was very hard and dry. Surveyor found it difficult to chew and was unable to swallow it. On 4/2/26 at 10:56 AM, DM K (Dietary Manager) stated that the issues with the pork chop may have been because it was prepared, then frozen, and then re-cooked.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure adequate interventions were in place for safety to prevent accidents from occurring for 1 of 5 residents (R37) reviewed for falls. R37 has had three falls sliding out of her Broda chair. The care planned intervention was to remove the Hoyer sling and not leave it under her in the Broda chair. Surveyor made several observations with the Hoyer sling left under R37 in her Broda chair. The facility did not ensure care planned interventions were followed to prevent R37 from further falls. Evidenced by: The facility's policy titled Facility Fall Protocol and Risk Assessment, dated 1/2025 with last revision date of 1/2026, states, in part: Policy: It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents. Policy Explanation and Compliance Guidelines: 1. The risk assessment will be completed by the nurse or designee upon admission, quarterly, or when a significant change is identified. 3. An At Risk for Falls care plan will be completed for each resident to address each item identified on the risk assessment and will be updated accordingly. 4. Updates to At Risk for Falls care plan will be reviewed quarterly and with any new fall incidents. 5. The At Risk for Falls care plan will include interventions, including adequate supervision, consistent with a resident's needs, goals, and current standards of practice in order to reduce the risk of an accident. 6. All staff will follow fall facility protocol. 7. IDT (Interdisciplinary Team) will review each fall incident for root cause of fall and determine appropriate interventions to be implemented and update At Risk for Falls care plan with each incident. 8. Monitor the effectiveness of the care plan interventions, and modify the interventions as necessary, in accordance with current standards of practice. The facility's policy titled Comprehensive Care Plan, dated 2/2025 with last revision date of 2/2026, states, in part: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident. Policy Explanation and Compliance Guidelines: . 3. The comprehensive care plan will describe, at a minimum, the following: . f. Resident specific interventions that reflect the resident's needs and preferences.6. With any changes to the care plan the Unit Manager and DON (Director of Nursing) will update the care plan at time of implementation. 7. Unit Manager will educate all nursing staff on unit regarding any new interventions. 10. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. R37 admitted to the facility on [DATE] on hospice services following a fall at home resulting in a fractured hip. R37's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/20/26 indicates Brief Interview of Mental Status (BIMS) score of 00 out of 15, indicating R37 has severe cognitive impairment. R37's Fall Risk Assessments Include:12/16/25 score of 8 low risk for falls3/17/25 score of 6 low risk for falls3/19/26 score of 6 low risk for falls R37's comprehensive care plan includes, in part:-Focus: The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) closed left hip fracture and dementia. Date Initiated: 11/6/25. Revision on: 11/7/25.-Intervention: Broda chair primary mode of transportation, staff to propel to desired locations. Date Initiated: 12/2025.-Intervention: Transfer: Hoyer lift transfer assist of (2) staff. Date Initiated: 2/9/26. Revision on: 2/9/26. -Focus: The resident is at risk for falls r/t dementia, history of falls with left hip fracture. 3/19: -witnessed fall w/o (without) injury. Date Initiated: 11/6/25. Revision on: 3/20/26.-Interventions: Follow facility fall protocol. Date Initiated: 11/16/25.-Intervention: Staff to ensure Broda chair is in reclined position when resident in WC (wheelchair) unattended. Date Initiated: 3/18/26.-Intervention: Staff to remove Hoyer sling when resident is up in Broda. Date Initiated: 3/20/26. R37's Fall Documentation includes the following:On 12/16/25 at 7:30 PM: CNA (Certified Nursing Assistant) observed resident slide out of chair on to the floor in resident's bedroom while (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	walking past. Resident did not hit her head. Laceration noted to be reopened on left leg near the knee. Root cause of fall resident slides out of Broda. On 3/17/26 at 3:00 PM: One of floor's Resident (sic) was wheeling self and saw [Resident Name] on the floor. She alerted Staff someone is on the floor. Staff ran to check who it was and saw [Resident Name] sitting on her bedroom floor with legs crossed next to her Broda chair at 1500 (3:00 PM). Prior to resident's fall hospice staff gave her a shower and left her on [sic] Broda chair in bedroom. On 3/18/26 an IDT (Interdisciplinary Team) Note indicated: IDT note concerning unwitnessed) fall without injury on 3/17/26. The resident was located in her room at time of incident sitting on her buttock next to her Broda chair.This fall has been discussed, and the IDT feels [Resident Name] would benefit from reclining her Broda chair back when she is left unattended. On 3/19/26 at 7:58 PM: Writer called to resident's room by CNA staff. Upon arrival, resident was noted sitting on the floor in front of her Broda chair. CNAs report resident slowly slid out of the chair while they were providing care to the roommate. They witnessed the descent and confirmed there was no impact or hitting her head. On 3/20/26 an IDT Note indicated: IDT note concerning witnessed fall without injury on 3/19/26. The resident was located in her room at time of incident with staff present. [Resident Name] was sitting upright in her Broda while staff were getting her roommate ready for bed, [Resident Name] slid forward and slid out of floor to her buttock. Nursing assessed the resident and noted no injuries occurred. Neuros at baseline and no pain noted. Immediate intervention was assisting resident off the floor via facility protocol. This fall has been discussed, and the IDT feels resident would benefit from staff to remove Hoyer sling when resident is up in Broda. On 3/30/26 at 12:05 PM, Surveyor observed R37 at the table in the dining room eating lunch. Surveyor observed that R37 had a Hoyer sling under her in the Broda chair. Surveyor observed that R37 appeared restless and was repeatedly sitting forward and backward and was slouching down in her chair. On 4/1/26 at 8:41 AM, Surveyor observed R37 at the table in the dining room waiting for breakfast to be served. Surveyor observed that R37 had a Hoyer sling under her in the Broda chair. On 4/1/26 at 12:35 PM, Surveyor observed R37 at the table in the dining room waiting for lunch to be served. Surveyor observed that R37 had a Hoyer sling under her in the Broda chair. On 4/2/26 at 8:24 AM, Surveyor observed R37 at the table in the dining room waiting for breakfast to be served. Surveyor observed that R37 had a Hoyer sling under her in the Broda chair. On 4/2/26 at 8:31 AM, Surveyor interviewed CNA I (Certified Nursing Assistant) and asked her what fall interventions were in place for R37. CNA I indicated that she wasn't sure, as she was an agency CNA and this was her first morning working with R37. Surveyor asked CNA I where she could find R37's fall interventions. CNA I stated that she was given a PCC (Point Click Care) login, but that she hadn't looked at R37's care plan yet. On 4/2/26 at 8:32 AM, Surveyor interviewed CNA H and asked her what fall interventions were in place for R37. CNA H stated that she did not know what R37's fall interventions were. Surveyor asked CNA H where she could find R37's fall interventions. CNA H stated she would ask the nurse or nurse manager or find them in PCC. On 4/2/26 at 8:35 AM, Surveyor interviewed LPN E (Licensed Practical Nurse) and asked her what fall interventions were in place for R37. LPN E stated that she was working when R37 fell recently, and that she remembered that hospice gave her a shower and left her in her Broda chair in her room without telling any staff. LPN E indicated that it was another resident that was passing by R37's room and saw her on the floor and came and brought it to her attention. LPN E stated that they put in an intervention that if hospice gives her a shower, they are to let staff know that she is up or in bed, and they try not to leave her in the Broda chair by herself. LPN E stated that if R37 is up in her Broda chair they will keep her near the nurse's station or engaged in activities. Surveyor asked LPN E how she is made aware of changes to a resident's care plan. LPN E stated that the Nurse Manager usually updates the care plan and will let the staff know of changes. On 4/2/26 at 8:53 AM, Surveyor interviewed DON B (Director of Nursing) about R37's falls. DON B indicated that after every fall they complete a post fall assessment and risk management which the IDT team will review. DON B stated that a root cause is identified after each fall, and that fall interventions are reviewed with each fall. DON B indicated that R37 has had three falls, two within (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the last month. DON B stated that the recent falls were from her Broda chair, and that she was found on the floor in front of the Broda chair. DON B stated that per staff, hospice had given R37 a shower and placed her in her room, and then when they assessed R37 the Broda was fully upright so it was determined that the Broda should be reclined slightly when she is in her chair. DON B indicated that two days later staff was in the room attending to R37's roommate when they witnessed R37 slowly slide out of the Broda chair onto the floor. DON B stated that the intervention for that fall was to remove the Hoyer sling after transfers and to make sure it is out from underneath her. Surveyor asked DON B how updates to the care plan were communicated to the frontline staff. DON B indicated that the Unit Managers or herself update the care plans, and the interventions are included on the CNA Kardex, which are printed and kept in a binder at the nurse's station. DON B stated that they let the frontline staff know there is a new intervention, and they highlight the intervention in the binder. Surveyor asked DON B how agency staff are made of how to care for the residents. DON B stated that she makes sure agency staff know how to access and bring the Kardex up in PCC. Surveyor shared her multiple observations of R37 in the dining room with her Hoyer sling under her in the Broda chair, as well as interviews with staff not being aware of R37's current care planned interventions. Surveyor asked DON B if she would expect that R37's care plan interventions be followed. DON B stated yes, always, and that falls were something that she was currently educating staff on. The facility failed to ensure that fall interventions were being followed for R37, thereby failing to keep R37 safe from future falls.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents are free of significant medication errors for 1 (R61) out of 14 residents reviewed during the medication administration task.Surveyor observed R61 receiving her roommate's metoprolol. R61 does not have an order for metoprolol.Evidenced by:The facility policy entitled Medication Administration, dated 1/2025, states, in part: . Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.Policy Explanation and Compliance Guidelines: .10. Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right route d. Right route e. Right time f. Right documentation.12. Compare medication source (bubble pack, vial, etc.) with MAR [Medication Administration Record] to verify resident name, medication name, form, dose, route, and time. The policy entitled Medication Errors, dated 1/2025, states, in part: . Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors.Definitions: . Significant medication error means one which causes the resident discomfort or jeopardizes his/her health and safety.Policy Explanation and Compliance Guidelines:1. The facility shall ensure medications will be administered as follows: a. According to physician's orders.b. Per manufacturer's specifications regarding preparation, and administration of the drug or biological.c. In accordance with accepted standards and principles which apply to professionals providing services.7. To prevent medication errors and ensure safe medication administration, nurses should verify the following information: a. Right medication, dose, route, and time of administration; b. Right resident and right documentation. R61 was admitted to the facility on [DATE] and has diagnoses that include vascular dementia (decline in thinking skills caused by conditions that block or reduce blood flow to the brain, damaging brain tissue) and hemiplegia (severe or total paralysis affecting one side of the body) and hemiparesis (partial weakness or reduced motor function on one side of the body, often causing difficulty with walking, balance, and fine motor tasks).R61's Quarterly Minimum Data Set (MDS) Assessment shows R61 has a Brief Interview of Mental Status (BIMS) Score of 00 indicating R61 has severe cognitive impairment.R61's March Medication Administration Record (MAR) shows the following medications ordered for AM:-Aspirin 81 milligrams (mg)-Furosemide 20 mg-Miralax 17 grams powder-Vitamin D3 2000 units-metformin 500 mg-Senna-Docusate 8.6-50 mg-Acetaminophen 1000 mg R61's Physician Orders, dated 4/01/26, does not include an order for Metoprolol.On 3/31/26 at 8:28 AM, Surveyor observed LPN M (Licensed Practical Nurse) administer Metoprolol succinate extended release 50 mg tablet to R61.On 3/31/26 at 9:15 AM, Surveyor reconciled R61's medication administration to find R61 did not have an order for Metoprolol. Surveyor did note R61's roommate did have an order for Metoprolol. On 3/31/26 at 9:24 AM, Surveyor approached DON B (Director of Nursing) and informed DON B that LPN M administered metoprolol to R61 during the observation of medication administration. Surveyor does not see an order for Metoprolol when reconciling R61's medications. DON B looked at R61's MAR and verified R61 does not receive Metoprolol. DON B reviewed R61's roommate's medication administration record and indicated R61's roommate does have an order for the Metoprolol. DON B indicated that by looking at both R61 and her roommates MARs, LPN M administered R61 her roommates Metoprolol. DON B indicated this was a significant medication error. DON B indicated she would expect nurses to perform the five rights during medication administration. DON B indicated she would start education with LPN M and notify R61's physician of the medication error. DON B indicated the staff will monitor R61 throughout the day.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility did not ensure that all drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles. This affected 1 of 5 medication rooms.During the medication storage observation task, there were five medications found to be with expired dates.Evidenced by:The facility policy entitled Medication Storage, dated 1/2026, states, in part: . Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations.Policy Explanation and Compliance Guidelines: .8. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy. On 4/2/26 at 9:02 AM, during the Medication Storage Task, Surveyor observed in the Main Medication Stock Room:-6 Mylanta Antacid Liquid 12 fluid ounce bottles with expired dates. -4 bottles with expiration dates of 11/25 -1 bottle with an expiration date of 11/24 -1 bottle with an expiration date of 5/25- 3 bottles of 60 Melatonin 1 milligram tablets with an expiration date of 8/25- 1 bottle of 100 Aspirin 325 milligram tablets with an expiration date of 1/26-3 bottles of 100 multivitamin tablets - 2 bottles with an expiration date of 2/26 - 1 bottle with an expiration date of 11/25- 1 bottle of 100 vitamin b12 100 microgram tablets with an expiration date of 2/26On 4/2/26 at 9:21 AM, Surveyor interviewed LPN E (Licensed Practical Nurse) and asked if the six bottles of Mylanta have expired dates. LPN E indicated yes. Surveyor asked if the expired bottles should be in the medication rotation. LPN E indicated no. LPN E indicated she will dispose of them in the Drug Buster. Surveyor asked LPN E if the three bottles of Melatonin, one bottle of Aspirin, three bottles of Multivitamin and the one bottle of vitamin B12 have expired dates. LPN E looked at each bottle and verified they were all expired. LPN E indicated the expired bottles should not be in the stock medication room. LPN E indicated she would remove and destroy the expired bottles.On 4/2/26 at 10:40 AM, Surveyor asked DON B (Director of Nursing) if expired medications should be in the stock medication rotation. DON B indicated no. DON B indicated it is the facility expectation for staff to check the expiration date when taking the medication from the stockroom and placing the medication in the medication carts.