STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525706	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Community Home of Osceola, Inc	2650 65th Ave Osceola, WI 54020

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility did not report an allegation of neglect to the State Survey Agency or local law enforcement within 24 hours after being made aware of the allegation for 1 of 1 resident (R1) reviewed.On 05/10/26 at 10:56 PM, Director of Nursing (DON) B was notified via email by Certified Nursing Assistant (CNA) D of a neglect concern regarding R1. DON B did not submit a Misconduct Incident Report to the State Survey Agency after being made aware of concern.This is evidenced by:On 05/26/26 at 8:39 AM, Surveyor interviewed Certified Nursing Assistant (CNA) D regarding quality of care of residents and reporting grievances. CNA D stated on 05/10/26, CNA D sent an email to DON B (Director of Nursing) regarding concerns of neglect. CNA D stated upon starting her PM shift, CNA D entered R1's room and found R1's incontinent brief to be overly saturated with urine and R1's legs and chest were wet with urine. CNA D stated she checked the CNA report sheet, and no one had documented changing R1's incontinent briefs since 8:15 AM. Surveyor asked CNA D if the DON had followed up with her after sending the email. CNA D stated no. Surveyor asked CNA D if a copy of the email could be accessed. CNA D forwarded the email to Surveyor.On 05/26/26 at 8:58 AM, CNA D forwarded the email that was sent to DON B to Surveyor. Surveyor noted the original email was time and date stamped as 05/10/26 at 10:56 PM. The email stated: .[R1] was completely soaked in urine that seeped through the pad.soaker completely wet.and went down [R1's] leg. While completing cares, [CNA K] entered room, and [CNA D] asked [CNA K] the last time [R1] was changed. [CNA K] stated having no time.[CNA D] stated this was unacceptable and felt this was neglect.Surveyor reviewed the facility's complaint/grievance log and noted no reported allegations of neglect.On 05/26/26 at 3:23 PM, Surveyor interviewed Nursing Home Administrator (NHA) A regarding incident reporting. Surveyor asked NHA A if any allegations of neglect had been reported in the last 3 months. NHA A stated no.On 05/26/26 at 5:02 PM, Surveyor interviewed DON B regarding allegations of neglect. Surveyor asked DON B if any allegations of neglect had been reported in the last 3 months. DON B stated no. Surveyor clarified with DON B no allegations of neglect or concerns with quality of care from staff had been reported in person, email, or other written communication. DON B stated being positive no concerns like that had been brought to her attention. On 05/27/26 at 7:30 AM, Surveyor interviewed NHA A and DON B. DON B stated after our initial conversation, DON B reviewed emails and found the email from CNA D on 05/10/26. Surveyor asked DON B why this allegation of neglect was not reported. DON B stated CNA D frequently makes unvalidated complaints about co-workers, is not credible, and did not see the word ?neglect' when initially reviewing the email. NHA A stated in retrospect, regardless of who made the allegation, this should have been reported to the State Agency within 24 hours.

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 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 complete a thorough investigation after being made aware of a concern of neglect for 1 of 1 resident (R1) reviewed.On 05/10/26 at 10:56 PM, Director of Nursing (DON) B was notified via email by Certified Nursing Assistant (CNA) D of a neglect concern regarding R1. The facility did not immediately begin a thorough investigation of reported neglect, collect information that corroborates or disproves the incident, and document the findings.This is evidenced by: On 05/26/26 at 8:39 AM, Surveyor interviewed Certified Nursing Assistant (CNA) D regarding quality of care of residents and reporting grievances. CNA D stated on 05/10/26, CNA D sent an email to DON B regarding concerns of neglect. CNA D stated upon starting her PM shift, CNA D entered R1's room and found R1's incontinent brief to be overly saturated with urine and R1's legs and chest were wet with urine. CNA D stated she checked the CNA report sheet, and no one had documented changing R1's incontinent briefs since 8:15 AM. Surveyor asked CNA D if the DON had followed up with her after sending the email. CNA D stated no. Surveyor asked CNA D if a copy of the email could be accessed. CNA D forwarded the email to Surveyor. On 05/26/26 at 8:58 AM, CNA D forwarded the email was sent to DON B (Director of Nursing) to Surveyor. Surveyor noted the original email was time and date stamped as 05/10/26 at 10:56 PM. The email stated: .[R1] was completely soaked in urine that seeped through the pad.soaker completely wet.and went down [R1's] leg. While completing cares, [CNA K] entered room, and [CNA D] asked [CNA K] the last time [R1] was changed. [CNA K] stated having no time. [CNA D] stated this was unacceptable and felt this was neglect. R1 was admitted to the facility on [DATE]. R1's care plan, dated 05/05/25, states: Vulnerabilities: Potential for abuse/neglect from self or others. No goals or interventions documented. No additional care plan interventions were implemented after allegation of neglect was reported on 05/10/26. Surveyor reviewed R1's progress notes: Surveyor reviewed R1's medical record and noted no behavior monitoring implemented after allegation of neglect was reported on 05/10/26. No documentation of allegation of neglect was documented. No documentation notifying R1's Power of Attorney of neglect allegation was noted. Surveyor reviewed the facility's complaint/grievance log and noted no reported allegations of neglect. On 05/27/26 at 7:30 AM, Surveyor interviewed DON B regarding investigation of reported allegation of neglect with R1. DON B stated receiving the email from CNA D on 05/10/26 but did not see the wording alleging neglect. DON B stated she attempted on 5 different occasions to interview CNA D and CNA K but they did not show up for the interviews. Surveyor asked DON B if any documentation for an investigation being completed. DON B stated only having what she had documented on her computer. DON B stated as of 05/27/26, no interviews had been completed with R1, CNA D, CNA K or any other staff or residents regarding the allegation of neglect.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, facility did not implement professional standards of practice to ensure a resident does not develop pressure injuries (PIs), receives necessary treatment and services to promote healing and prevent new PIs from developing for 1 of 3 residents (R1) reviewed.R1 was assessed as high risk for PI development. The facility failed to implement interventions to prevent PI development, ensure treatment orders were completed as ordered, and failed to complete a comprehensive assessment upon discovery of a new avoidable PI on R1's buttocks. This is evidenced by:Facility policy titled, Skin Alteration Policy and Procedure, with no date, states: Purpose: To establish a comprehensive facility program to maintain optimal skin condition for the residents.Policy: Nursing assessment will be utilized to identify residents at risk for the development of pressure injuries and appropriate plans of care for these residents will be established. Through the use of a skin protocol, all pressure areas will be identified and treatment begun immediately. All other skin alterations will be assessed and treated immediately. D. Repositioning. a. Reposition residents at least every two hours consistent with overall goals of care. c. Care plan the resident specific repositioning schedule.Skin Alteration/Wound Assessment/Documentation: B. Licensed nurses will evaluate skin plan, institute treatment methodologies specific to the resident.Weekly skin checks are documented in PCC.Skin Alteration Documentation: B. Initial wound assessment and weekly updates are documented in the Medical Record via EHR. C. A temporary care plan is initiated upon identification of an open area or added to the care plan if a skin alteration care plan already exists.R1 was admitted to the facility on [DATE] with abnormalities of gait and mobility.R1's quarterly Minimum Data Set (MDS) assessment, dated 02/24/26, noted a Brief Interview for Mental Status (BIMS) score of 04/15, indicating cognition is severely impaired. R1 requires substantial/maximum assistance with rolling left to right and dependent assist with lying to sitting and chair/bed transfers. R1 did not have a PI present, was assessed to be at risk for PIs, and skin treatments implemented included a turning/repositioning program and application of ointments/medications other than to feet.R1's care plan, dated 05/05/25, with a target date of 05/05/26, states: Skin integrity: Alteration or potential for alteration in integrity with a goal of no skin breakdown through review date. Interventions include Pressure relieving mattress (05/27/26). Pressure relieving cushion in recliner (05/27/26). Pressure relieving cushion in w/c (05/27/26). Reposition Q [every] 2-3 hours. R1 often refuses this (05/27/26). R1's nursing orders, dated 05/05/25, include turning and repositioning every shift.-Of note: turn and reposition order does not specify frequency to be completed during each shift.Surveyor reviewed R1's Certified Nursing Assistant (CNA) Kardex for completion of turning and repositioning R1. Surveyor noted the following:-On 05/05/26 and 05/21/26, no turning and repositioning was documented as completed.-On 05/03/26, 05/04/26, 05/07/26, 05/08/26, and 05/16/26, turning and repositioning were documented as completed only once.-On 05/01/26, 05/02/26, 05/06/26, 05/09/26, 05/10/26, 05/11/26, 05/13/26, 05/14/26, 05/15/26, 05/20/26, 05/22/26, 05/23/26, 05/25/26, and 05/26, turning and repositioning were documented as completed twice.-On 05/12/26, 05/18/26, 05/19/26, and 05/24/26, turning and repositioning were documented as completed three times.R1's progress notes state:-04/16/26 Skin/Wound Note - right buttock; no staging; 2.2 x 2 cm; denuded area on buttock related to (r/t) sheering; is dried; does have chronic skin breakdown on buttock.No additional skin assessment documentation completed until 05/11/26.-05/11/26 Skin/Wound Note - coccyx red, cleaned, and barrier cream applied.No additional skin assessment documentation completed until 05/26/26.-On 05/26/26 at 5:43 AM - weekly skin check with bath yesterday on evening shift. No new skin concerns noted per RN, who was completing RN's shift. R1's weekly bath skin evaluation sheets state:-On 05/04/26 - noted a skin tear was present on R1's buttocks. No additional skin assessment was documented. No documentation notifying the wound nurse noted.-On 05/11/26 - noted, bottom (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	open/red,; nursing progress note entered. No additional skin assessment noted. No documentation notifying the wound nurse noted.-On 05/18/26 - noted concern on R1's bottom by circling the buttock area; the indication for concern is marked under Other (specify below) with no additional comments entered. No additional skin assessment documented. No documentation notifying the wound nurse noted.-On 05/25/25 - noted no skin concerns present. On 05/26/26 at 8:39 AM, Surveyor interviewed Certified Nursing Assistant (CNA) D regarding R1's skin and cares. CNA D stated she noticed R1 had some skin concerns in the beginning of April this year and reported it to the nurse. Surveyor asked CNA D what interventions were implemented after the new finding of skin impairment. CNA D stated nothing, just to continue applying ointment. Surveyor asked CNA D if there were any standard protocols used to help prevent skin breakdown for residents. CNA D stated yes staff should be rounding on residents at least every 2-3 hours and checking incontinent briefs, but this is not always done by some staff. Surveyor asked CNA D if staff document when residents are repositioned or if incontinence briefs are changed. CNA D stated only on the CNA shift report sheets, but not everyone does it. Surveyor asked CNA D if R1 had any current skin breakdown. CNA D stated yes, on R1's buttocks.On 05/26/26 at 2:39 PM, Surveyor interviewed Wound Nurse C regarding R1's skin assessments. Surveyor asked Wound Nurse C about the documentation on 04/16/26 of a new skin concern on R1's right buttock. Wound Nurse C stated that was the only assessment completed regarding skin concerns as R1 has chronic maceration skin issues. Surveyor asked if chronic concerns should be observed more closely. Wound Nurse C stated yes, but during weekly bath checks and not with wound assessments. Surveyor asked Wound Nurse C about the skin issue documented on 05/11/26. Wound Nurse C stated it was reported to her as a fungal issue, so she did not assess the area. Surveyor asked Wound Nurse C about the expectations for nursing staff regarding skin assessments and reporting concerns. Wound Nurse C stated Certified Nursing Assistants (CNA) are supposed to look at the skin on bath day weekly, document areas of concern on the bath sheet, and report any concerns to the nurse. The nurse is then supposed to complete a communication sheet form and submit it to the Wound Nurse for review. Surveyor asked Wound Nurse C who reviews the bath sheets for concerns. Wound Nurse C stated she believed the DON (Director of Nursing) did this.On 05/26/26 at 4:16 PM, Surveyor interviewed DON B regarding skin assessments and reporting new skin concerns. DON B stated the expectation is for CNAs and the nurse to look at the skin weekly on bath day and report new concerns to the wound nurse for review. Surveyor asked DON B if anyone would review the weekly bath sheets for completion or concerns. DON B stated the nurse should be doing this.On 05/26/26 at 4:26 PM, Surveyor interviewed CNA E and CNA F regarding R1's skin. Both CNA E and CNA F stated not being aware of any skin breakdown on R1.On 05/26/26 at 5:02 PM, Surveyor requested DON B and Wound Nurse C assess R1's skin. Upon entering R1's room, Surveyor observed R1 lying on left side in bed. R1's mattress was a static mattress with no additional pressure relieving devices in place. Surveyor observed R1's recliner to have a gel cushion, approximately 1 inch thick, sitting on the seat with a moisture-wicking pad on top of it. Wound Nurse C removed R1's incontinent brief and Surveyor observed on R1's left inner gluteal fold/sacral area. The area was dark red, non-blanchable area measuring approximately 1 inch in width and diameter. On R1's right inner buttock were 2 small red, blanchable marks which were intact. The peri-wound area was reddened, blanchable and intact. Surveyor asked Wound Nurse C if this was a new wound. Wound Nurse C stated yes. Surveyor asked Wound Nurse C how this new wound would be documented. Wound Nurse C stated it would be stage 1 PI. Surveyor asked Wound Nurse C about R1's current mattress. Wound Nurse C stated R1 has a standard mattress. Surveyor asked Wound Nurse C if any other mattresses were tried to help alleviate pressure. Wound Nurse C stated no and R1 typically preferred to sit in the recliner or wheelchair. Surveyor asked Wound Nurse C about the gel cushion sitting in the recliner. Wound Nurse C stated it was a typical cushion that would be used. Surveyor asked Wound Nurse C if any other pressure relieving device had been used to help prevent PIs in R1's wheelchair or recliner. Wound Nurse C stated no, she didn't think so.On 05/27/26 at 8:26 AM, Surveyor interviewed Physician (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant (PA) H regarding R1's new stage 1 PI. PA H stated not being aware of this new PI at this time. Surveyor asked PA H if R1's new PI was preventable. PA H stated PA H's belief is all PIs should be preventable. Surveyor asked PA H if any alternative interventions were attempted to prevent PIs for R1. PA H stated no, but that another outside resource was used by the facility to assist with additional interventions. Surveyor asked PA H if this resource was used regarding R1. PA H stated no the Wound Nurse handles it.On 05/27/26 at 9:54 AM, Surveyor interviewed Licensed Practical Nurse (LPN) I regarding skin assessments. LPN I stated CNAs fill out a skin sheet on each resident once a week on bath day and report any concerns to the nurse. Surveyor asked LPN I if the nurse is expected to assess the skin with the CNA on bath day. LPN I stated no, only the CNAs do it. Surveyor asked LPN I if nurses are expected to complete a weekly skin assessment. LPN I stated no, unless the CNA reports a concern. Surveyor asked LPN I if the nurse reviews the completed weekly bath sheets. LPN I stated no, not unless the CNA says there is a concern.On 05/27/26 at 11:55 AM, Surveyor interviewed Clinical Nurse Manager (CNM) J regarding skin assessments and preventative measures for breakdown. CNM J stated the expectation would be for nurses to document at least weekly on skin condition after the bath sheet is completed. Surveyor asked CNM J if anyone is reviewing or monitoring if the weekly skin checks are documented or if the bath sheets are completed. CNM J stated no. Surveyor asked CNM J how staff document when residents are repositioned or if incontinence briefs are checked/changed. CNM J stated there is no current practice in place for staff to document this, but staff are expected to turn and reposition residents frequently. Surveyor asked CNM J how they monitor residents at risk for PIs or currently have PIs are being turned and repositioned frequently. CNM J stated no process is currently in place to do this.On 05/27/26 at 12:01 PM, Surveyor interviewed Wound Nurse C regarding the additional resource for PIs. Wound Nurse C stated that this resource is a wound specialty provider that comes onsite monthly to review residents with PIs and other skin issues. Surveyor asked Wound Nurse C if this resource was contacted regarding R1. Wound Nurse C stated no.

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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 interview and record review, the facility did not ensure that falls were thoroughly investigated to determine root cause, new safety interventions implemented, staff education, and monitoring of effectiveness of interventions for 1 of 3 residents (R4) reviewed.-On 12/03/25, R4 sustained a fall. Facility determined root cause of fall was that staff did not follow R4's care plan interventions of:Pressure alarms in place on bed and chair (10/02/25). Pressure and laser alarm (10/02/25). Tab alarm (10/02/25).-After fall on 12/03/25, new intervention of checking R4 every 2 hours at bedtime for alarm placement was implement. No documentation on staff education following fall and new intervention.-On 12/23/25, R4 had a fall. No new interventions were implemented. No documentation on staff education. Interventions implemented after -On 02/02/26, R4 had a fall. No new interventions were implemented. No documentation on staff education.-On 03/19/26, R4 had a fall. Care plan was not updated after fall. No documentation on staff education.This is evidenced by: Facility policy titled, Fall/Injury Reporting, with a revised date of 11/2025, states: Policy: Falls.will be documented in the resident medical records. Nurses are responsible to document any reports, investigations and assessments relating to the falls.IDT representatives are responsible for investigating any needed areas to assure no abuse or neglect was suspect and for ensuring interventions are implemented.Appropriate investigations, follow-up and reporting to state and deferral agencies will be accomplished per Administrator/designee if deemed necessary. Procedure: 11. The IDT will then evaluate the fall and recommend intervention. The change in plan will then be documented in the resident care plan and CNA care plan. R4 was admitted to the facility on [DATE] with neurocognitive disorder with Lewy bodies. R4's comprehensive Minimum Data Set (MDS) assessment, dated 04/15/26, noted a Brief Interview for Mental Status (BIMS) score of 0/15, indicating severe cognitive impairment. R4 had one fall without injury. R4's care plan, dated 10/01/25, with a target date of 08/17/26, states: [R4] has had an actual fall with unsteady gait with a goal to resume usual activities. Interventions include Pressure alarms in place on bed and chair (10/02/25). Pressure and laser alarm (10/02/25). Tab alarm (10/02/25). Rounding every 2 hours when in bed and overnight (12/10/25). Gripper socks in place (12/26/25). Check with resident for preference to go to bed before 8 PM (05/26/26). Assist of 2 with 2WW (05/26/26). R4's fall investigations state: On 12/03/25 at 7:20 PM, R4 had an unwitnessed fall in room. Certified Nursing Assistant (CNA) found R4 lying on the floor and R4's floor alarm was found sitting on tray table in OFF position. No injuries noted. Immediate follow-up interventions include gripper socks. On 12/10/25, IDT (Interdisciplinary Team) reviewed fall and noted root cause to be self-transfer and confusion. New intervention to check on R4 every 2 hours. -Of note: Surveyor reviewed R4's medical record and was unable to find documentation for 2-hour checks being completed. No documentation on staff training after incident was provided. No review of why the alarm was off. On 12/23/25 at 11:20 AM, R4 had an unwitnessed fall in room. CNA found R4 lying on floor with no shoes or gripper socks on. No injuries noted. On 12/24/25, IDT reviewed fall and determined root cause to be self-transfer. New intervention implemented was gripper socks in place. -Of note: immediate interventions implemented after 12/03/25 fall included gripper socks. No new interventions were implemented. On 02/02/26 at 4:00 PM, R4 had an unwitnessed fall in bathroom. CNA found R4 lying on floor. No injuries noted. On 02/03/26, IDT reviewed fall and noted root cause to be self-transfer, confusion and communication deficit. New intervention noted for Physical Therapy (PT) assessment. -Of note: Fall investigation did not include interviews with staff to determine how resident got to bathroom or last time toileted. Surveyor reviewed PT note, dated 02/04/26, noted R4's mobility is variable and Contact Guard Assist (CGA) to minimal/moderate assistance without 2 wheeled walker recommended. R4's care plan was not updated to reflect PT's recommendation. On 03/19/26 at 8:00 PM, R4 had an unwitnessed fall in Great (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Room. Nurse heard R4's alarm and found R4 lying on ground. No injuries noted. On 03/20/26, IDT reviewed fall and determined root cause to be R4 being up at 8:00 PM and self-transferred. New intervention of discussing with resident preferred bedtime and putting to bed at that time. Note: R4's care plan not updated until 05/26/26. On 05/27/26 at 12:00 PM, Surveyor interviewed Director of Nursing (DON) B and Clinical Nurse Manager (CNM) J regarding R4's falls. DON B stated all the documentation provided to Surveyor included the complete investigations of each incident. Surveyor asked DON B and CNM J how they ensure interventions are in place and effective. Both DON B and CNM J were unable to provide an answer. Surveyor asked DON B and CNM J if there was any documentation of staff completing 2-hour checks as stated in care plan. CNM J stated no.