STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525712	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care and Rehab - Cumberland	1100 7th Ave Cumberland, WI 54829

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 0686 Level of Harm - 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 observation, interview and record review, the facility did not ensure that 1 of 3 residents (R) reviewed for pressure injuries (PI) (R32) received care consistently with professional standards of practice to prevent further deterioration and promote healing of an existing PI. R32 was at risk for PI development. The facility failed to provide adequate and consistent wound care treatments, did not complete comprehensive weekly assessment, and did not notify provider of new PI.Findings include: R32 was admitted to the facility on [DATE] with diagnoses including in part, atrial fibrillation, nonrheumatic aortic insufficiency, hypertensive heart disease, peripheral vascular disease, unilateral osteoarthritis left ankle and foot, hypertension, weakness, and presence of right artificial hip joint.R32's Minimum Data Set (MDS) assessment, dated 12/13/25, identified R32 required substantial maximal assistance for bed mobility, taking on and off footwear, rolling left to right, sit to lying, chair to bed, toileting, and for transfers. MDS indicated R32 was at risk for PIs.Surveyor reviewed R32's impaired skin integrity related to history of Stage 2 pressure injuries to bilateral buttocks on admission. Date Initiated: 12/12/2024 Revision on: 12/24/2024: in part:-Apply moisturizer to skin with cares and as needed. Do not massage over bony prominences and use mild cleansers for peri-care/washing. Date Initiated: 12/12/2024.-Educate resident and family as to the potential causes of skin breakdown; including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Date Initiated: 12/12/2024.-Encourage resident to reposition at least every two hours and sooner if needed. Date Initiated: 12/12/2024.-Follow facility policies/protocols for the prevention/treatment of skin breakdown. Date Initiated: 12/12/2024.-Notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care. Date Initiated: 12/12/2024.-Resident has a pressure relieving mattress and has a roho cushion in w/c and recliner. (Check inflation per TAR) Date Initiated: 12/12/2024.-Skin treatments per TAR Date Initiated: 12/12/2024.-The resident requires supplemental protein, and nutritional shakes as ordered to promote wound healing. Date Initiated: 12/12/2024.-Wound nurse to monitor chronic wounds and pressure injuries weekly Date Initiated: 12/12/2024.Surveyor reviewed R32's discontinued physician orders:-On 01/03/26, revised on 1/11/26, and discontinued 01/21/26. Monitor scabbed area to the side of left fifth toe and change padded dressing if necessary. -On 01/18/26: Change every day. Minor wound care as needed (PRN). Nursing able to use the following as appropriate: Bacitracin, Telfa and Gauze, until healed/resolved. every evening shift.R32's current physician orders:-On 02/14/26; Cleanse both areas of left foot, skin prep and apply bordered foam and change every 3 days. every evening shift every 3 day(s) for unstable pressure from when cast was on.Surveyor reviewed R32's Braden skin assessments:-On 12/12/25: At risk for skin breakdown, score of 17.Surveyor reviewed R32's progress notes, stated in part, .-On 12/29/25 at 11:00 AM, PT/OT [Physical Therapy/Occupational Therapy] approached nursing to report that resident states she had severe pain to her right lower leg during therapy session to transfer off the toilet in preparation for her home visit. Resident examined and noted to have swelling to BLE [bilateral lower extremities] 1-2+, right slightly more swollen than left and tight socks in place creating pressure just below shin where she states that she had the sharp pain during (continued on next page)

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

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	transfer. Removed socks and placed tubigrip to create light even compression. Residents have good ROM but still state some moderate pain at rest and states I felt my leg snap. There are no obvious deformities other than slightly more swelling to right shin area. Assisted resident to rest her leg, apply ice and elevation until rounding MD here to evaluate early this afternoon. Acetaminophen analgesia offered as well.-On 12/29/25 at 6:04 PM, Resident returned from ER [emergency room] with DX [diagnosis] of tib/fib [tibia/fibula] fractures to [NAME] [lower extremities]. She arrived back in facility with glassed cast to LLE [left lower extremity]and orders to remain NWB non weight bearing] to the affected [NAME]. Ortho consult has been sent. Resident evaluated by writer with transferring with EZ stand to ensure that she was able to maintain NWB to LLE and she is able to do this safely with assist of 1 and EZ stand, may use 2 PRN. CMST [circulatory, motor, sensory testing] to be checked q [every] shift and PRN. Education provided to resident on importance of keeping [NAME] elevated and updating nursing if she has increased pain, tingling or numbness to [NAME]. Resident in agreement to alert staff if changes occur. Resident provided with facility WC [wheelchair] as her personal WC does not have elevating footrests and will not accommodate her need to keep [NAME] elevated.-On 01/13/26 at 12:38 PM, Resident seen by Ortho today.Findings: Left tib/fib fx, left lower extremity pressure- lateral leg below knee, medial foot and lateral foot. Recommendations include:1. TTWB [toe touch weight bearing] LLE, PT for safety and UE [upper extremity] strengthen, gait, and balance.2. Keep cast CDI [clean, dry, intact]. May shower with cast covered.3. Ice and elevation (toes above nose if possible).4. F/u2 weeks. Next appointment 01/27/26.Facility did not implement any new interventions for the development of 2 new PIs.R32's progress notes, continued, stated in part, .-On 01/17/26 at 9:58 PM, Resident has an open area on the left lateral outer 5th toe. It has a small sanguineous drainage dried around the wound edges. Wound is approximately .75 in X1 inch. It had border foam dressing on it.Action: Removed the old dressing. Cleansed wound and covered with bacitracin, telfa and gauze to protect from the cast.Facility did not implement any new interventions for R32's PI of the lateral 5th toe. Surveyor did not find that the facility updated a provider on call or completed a comprehensive weekly assessment.R32's progress notes, continued, stated in part, .-On 01/25/26 at 10:24 AM, Sore/scabbed area to left fifth pinky toe observed to be larger in size under cast. Unable to accurately measure sore d/t [due to] cast being in the way. Denies' presence of pain or discomfort. Free of s/sx of infection. Denies' presence of numbness and tingling to left foot. Area cleansed with wound cleanser, bacitracin applied, and layer of gauze placed over sore to protect area from cast. Message left with infection control RN regarding changes in wound size.Facility did not update provider on call when R32's lateral 5th toe deteriorated. Facility did not implement any new interventions for R32's PI of the lateral 5th toe. The facility did not complete a comprehensive weekly assessment.R32's progress notes, continued, stated in part,Consultation report dated 02/10/26 at 9:30 AM,Exam: Cast removed, scab to lateral proximal lower leg, lateral and medial foot. Xeroderma present. Sensation intact to light touch, toes warm, and well perfused. Ankle ROM not tested secondary to acute injury.May remove temporary splint and transition to Cam walking boot. May remove boot for skin hygiene, showers, and ROM. Continue wound care.WBAT in boot for transfers. 25% WB for distance in boot, Ankle and knee ROM.Skin Care-wounds from first splint with inadequate padding.Follow up in 5 weeks.On 02/11/26 at 2:26 PM, 003: New skin Issue. Location: Left lateral foot. Laterality / Orientation: Left. Issue type: Pressure ulcer / injury. Progress: New: new wound. Pressure ulcer staging: Unstageable pressure ulcer / injury. Unstageable ulcer due to slough and / or eschar. Wound acquired in-house. Exact date: 02/10/2026 Signs and symptoms of infection: None. Painful: No. Staged by: In-house nursing. Length (cm): 3.25 Width (cm): 3.46 Depth (cm): 0 Area (cm2): 7.29 Undermining: No. Tunneling: No. Eschar: 100%.#004: New skin Issue. Location: Left medial foot. Issue type: Pressure ulcer / injury. Progress: New: new wound. Pressure ulcer staging: Unstageable pressure ulcer / injury. Unstageable ulcer due to slough and / or eschar. Wound acquired in-house. Exact date: 02/10/2026 Signs and symptoms of infection: None. Painful: No. Staged by: In-house nursing. Length (cm): 2.05 Width (cm): 1.8 Depth (cm): 0 Area (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	(cm2): 2.96 Undermining: No. Tunneling: No. Eschar: 100%.Skin Issues Note: Will add to wound rounds for 2/18. Pressure area from cast. Cast removed 2/10/26. Wound provider notified.On 02/17/26 at 9:04 PM, Skin warm & dry, skin color WNL and turgor is normal.Resident does not have an external device.#003: Skin issue has not been evaluated. Location: Left medial foot. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Unstageable pressure ulcer / injury. Wound acquired in-house. Exact date: 02/10/2026 Staged by: In-house nursing. Undermining: No. Tunneling: No.#004: Skin issue has not been evaluated. Location: Left lateral foot. Laterality / Orientation: Left. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Unstageable pressure ulcer / injury. Wound acquired in-house. Exact date: 02/10/2026 Staged by: In-house nursing. Undermining: No. Tunneling: No.Skin Issues Note: No new skin issues noted. Pressure ulcers evaluated by wound nurse on rounds on Wednesday. See notes.On 02/16/26 at 3:21 PM, Surveyor observed R32 to have a post op shoe with posterior splint on left foot.On 02/16/2026 at 3:29 PM, Surveyor interviewed R32 and asked how R32 injured her foot. R32 reported to Surveyor that she had a transfer in bathroom with physical therapy on 12/29/25 where R32 felt and heard a pop with burning sensation. Later that day, the provider came to visit R32 who stated yes, it is in fact broken and R32 was sent to the ER. R32 reported that she came back with a cast on. R32 stated, I feel like facility has not been taking care of my leg as its growing crooked and never gets looked at. I am lucky to even have the ace wrap come off once a week. If I ask staff to wash leg then they will but not often.On 02/17/26 at 2:31 PM, Surveyor interviewed Director of Nursing (DON) B and asked DON B what resident's wounds look like on left foot. DON B reported that DON B is unsure at this time as DON B thinks it is being initially evaluated by wound provider and Infection Control (IC) Registered Nurse (RN) C tomorrow on 02/18/26. Surveyor asked DON B to go with Surveyor to peek at R32's left foot, brace, and skin.On 02/17/26 at 2:35 PM, Surveyor entered R32's room with DON B, and DON B began taking the Ace wrap and post op boot off. DON B confirmed that R32 still had post op boot and posterior splint instead of the Cam boot recommended back on 02/10/26. When DON B took ace wrap off, Surveyor observed 3 different wounds: 1 wound on lateral side of foot, medial side of foot, and a dressing on left heel with no dates or initials on dressings. Surveyor asked DON B what left heel dressing was on R32's foot. DON B reported that DON B is unsure as DON B did not know R32 had an issue on R32's left heel. Surveyor asked DON B when the dressings were last changed. DON B reported that DON B is unsure but some nurses document and some don't on dressings. Surveyor asked for expectation of nurses signing correct date on dressing of wound dressing change. DON B reported that staff should be labeling dressings. R32 reported to DON B that resident is about to take a shower so that DON B could leave brace off until after shower. DON B left post op shoe and ace wrap off.On 02/17/26 at 2:41 PM, Surveyor interviewed IC RN C and asked how R32's wounds look on left foot. Surveyor inquired about the foam border dressing on R32's left heel. IC RN C reported to Surveyor that IC RN C did not know about R32's left heel wound, and that Wound Provider K will be onsite to assess R32's new wound tomorrow on 02/18/26.On 02/18/26 at 8:45 AM, Surveyor called Orthopedic Surgeon I to inquire about the resident's new wounds under cast. Surveyor left message for return call.On 02/18/26 at 9:08 AM, Surveyor interviewed IC RN C who also completes wound assessments weekly. IC RN C reported that IC RN C and wound provider will not be assessing wounds until 1pm-2pm today.On 02/18/26 at 9:32 AM, Surveyor interviewed Orthopedic Surgeon I and asked if Orthopedic Surgeon I could walk Surveyor through consultation visits Orthopedic Surgeon I had with R32 over the last couple months. Orthopedic Surgeon I reported that R32's initial consultation visit was on 01/13/26 when R32 arrived with a cast placed by the ER weeks prior. R32 was noted to have substantial eschar from the initial cast placed from the ER for the initial fracture and splint. Surveyor asked Orthopedic Surgeon I if Orthopedic Surgeon I could see the toes when resident came into clinic consultation. Orthopedic Surgeon I reported that the resident's toes would have been dorsally and laterally visible. Orthopedic Surgeon I reported that since resident had unstageable pressure injuries to the left medial foot and left lateral foot, the team decided to apply an old-fashioned cast that covered the whole foot and lower leg to assist the wounds in healing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor asked Orthopedic Surgeon I if R32 had any concerns with R32's left heel. Orthopedic Surgeon I reported only 3 issues with left medial foot, left lateral foot, and left upper shin area where cast had hit with pressure. R32 was seen recently on 02/10/26 and fracture looked good, so recommendations were to put temporary posterior splint on with post op shoe but change to a Cam boot once facility receives Cam boot. Orthopedic Surgeon I reported that at the time of visit R32's wounds were infection free and had full thickness eschar so wasn't able to stage.On 02/18/26 at 2:49 PM, Surveyor observed wound care with IC RN C and Wound Provider K. IC RN C removed 3 dressings at the left medial foot, left lateral foot, and heel. Surveyor asked IC RN C what is going on with R32's left heel and IC RN C stated, Oh I did not know resident had a heel injury. Surveyor asked IC RN C if the heel was documented in R32's medical record since a staff member was applying a dressing to R32's left heel with border foam. IC RN C reported that IC RN C has not seen any information pertaining to skin issues on R32's left heel. Wound Provider K reported after assessment that resident now has a new stage 1 PI on dorsal of left foot, and a new stage 3 on left heel. Wound Provider K reported to Surveyor that Wound Provider K is calling it pressure from the post op shoe strap over top of R32's foot and Wound Provider K stated, I am assuming that the stage 3 on heel is from pressure of the temporary splint. Wound Provider K reported R32's PI on the left lateral foot after debridement is still unstageable necrosis, and the medial left foot could not debride but unstageable necrosis as well. Wound Provider K changed dressing change orders to Medi honey, alginate, prep, and border foam change three times a week. Wound Provider K reported to Surveyor that IC RN C will take measurements and report this to Surveyor.On 02/18/26 at 3:15 PM, IC RN C gave Surveyor PI documentation with measurements.Surveyor reviewed measurements:-Left medial foot: unstageable PI, 1.63cm x1.64cm. Eschar 100%. in house acquired.-Left lateral foot: unstageable PI, 1.94cm x 3.13 cm. Slough and/or eschar in house acquired.-Left heal Stage 3 Full thickness skin loss, 0.98cm x 0.79cm x0.1 cm. Slough 100% in house acquired.-Left medial midfoot: Stage 1 PI, 0.57 cm x 0.98cm. non blanchable erythema or intact skin. in house acquired.On 02/18/26 at 3:17 PM, Surveyor asked IC RN C's expectations for staff documenting a new wound and who notifies the provider. IC RN C reported to Surveyor that all new wounds or skin issues are documented in the medical record and then IC RN C comes in every morning and reviews charting to see any new skin issues residents may have. IC RN C reported that whoever applied dressing to R32's left heel did not document that there was an issue, so IC RN C was not made aware of the new left heel PI.Surveyor found no interventions put into place after the discovery of R32's left heel PI.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility must ensure each resident is free from unnecessary medications as evidenced by completing adequate behavioral monitoring for 2 of 5 residents (R7 and R16) reviewed for unnecessary medications.Findings:Facility policy titled, PSYCHOTOPIC MEDICATIONS, revised 1/26, stated in part: 6. The specific targeted behaviors for which the drug is being administered will be entered by the nurse on the behavior monitoring record. The effectiveness of the psychotropic drug will be documented on the behavior sheet each shift. Total occurrences may be based on the personal observation or the observation of other staff members 8. The effectiveness of the psychotropic drug on the targeted behavior will be addressed at least monthly in the interdisciplinary notes .10. The behavior monitoring record will be reviewed quarterly . Example 1R7 was admitted on [DATE] with a Brief Interview of Mental Status (BIMS) score of 14/15 which indicated R7 was cognitively intact. R7 had diagnoses of anxiety and depression. R7's physician orders included in part:. Trazadone give 50 milligrams (mg) by mouth at bedtime for sleep related to major depressive disorder.Fluoxetine give 60 mg by mouth in the morning for depression related to major depressive disorder . R7's care plan stated in part: . Resident has potential for adverse effects r/t psychotropic medications Administer psychotropic medications as ordered by physician. Observe for and report to nurse any side effects and effectiveness. If medication is not effective, notify the nurse.Care team to review, consult with pharmacy and MD to consider dosage reduction if clinically appropriate at least every six months.Educate the resident/family/caregivers about risks, benefits and potential side effects Observe for and report to the nurse any occurrence of behavior symptoms: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards care team members/others etc.Observe for and report to the nurse any of the following adverse reactions of psychotropic medications: unsteady gait, 'chewing motion' movement of jaw, shuffling gait, rigid muscles, shaking, difficulty swallowing, complaints of dry mouth, depression, complaints of blurred vision, fatigue, complaints of inability to fall asleep or remain asleep), complaints of loss of appetite, weight loss, vomiting, behavior symptoms that are 'not usual' for this resident. Resident has potential for altered mood Administer medications as ordered. Monitor/document for side effects and effectiveness.Consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly.Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms medications and sign consent to give medications at least every 15 months or sooner.INTERVENTIONS TO LESSEN MY POTENTIAL FOR OR ACTUAL MOOD/BEHAVIOR SYMPTOMS: 1) Offer/provide 1:1 for me to express my feelings/thoughts/concerns. 2) Encourage involvement in daily decision making 3) Reinforce strengths 4) Report pain indicators 5) Report changes in ability 6) Invite and assist with activities 7) Encourage reminiscence Monitor/document/report to Nurse/MD signs and symptoms of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. Observe for and report to nurse any behaviors such as: tearfulness, anxiousness, pacing, wandering, exit-seeking behavior, making negative statements about wanting to be here, decrease/lack of social interaction with others Refer (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to activity care plan for activities of interest . On 02/17/2026 at 11:12 AM, Surveyor asked Infection Control (IC) C nurse for behaviors for this resident as she is on psychotropics. IC C replied, Well I think this resident is just on an antidepressant, but I will check on that. On 02/17/2026 at 1:19 PM, Director of Nursing (DON) B informed this Surveyor, We just do behavior monitoring and charting by exception as needed. On 02/17/2026 at 2:29 PM, Surveyor asked DON B, When do the nursing staff monitor and document behaviors when a resident is on psychotropic medications? DON B replied, We only monitor resident's behavior with antidepressants if they start showing depressive behaviors and that would trigger the monitoring at that time. On 02/18/26 at 10:38 AM, Surveyor reviewed the facility's policy and R7's care plans regarding psychotropic medications. Surveyor then asked DON B for documentation for behavioral monitoring for R7. DON B replied, We do not have any further documentation for behavioral monitoring on this resident. Example 2 R16 was admitted to the facility on [DATE] with diagnoses including in part, type 2 diabetes mellitus with hyperglycemia, hypertensive kidney disease stage 1-4, Alzheimer's disease, benign neoplasm of cerebral meninges, nonrheumatic aortic stenosis, dementia, personal history of methicillin resistant staph aureus (MRSA), and muscle weakness. R16's Minimum Data Set (MDS) assessment, dated 11/06/25, identified R16 had Brief Interview for Mental Status (BIMS) of 10/15 that identified R16 with moderate cognitive impairment. R16's psychotropic medication care plan: Resident has potential for adverse effects r/t psychotropic medications initiated on 10/25/24: -Administer psychotropic medications as ordered by physician. -Observe for and report to nurse any side effects and effectiveness. If medication is not effective, notify the nurse. -Care team to review, consult with pharmacy and MD to consider dosage reduction if clinically appropriate at least every six months. - Educate the resident/family/caregivers about risks, benefits and potential side effects. -Observe for and report to the nurse any occurrence of behavior symptoms: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards care team members/others etc. -Observe for and report to the nurse any of the following adverse reactions of psychotropic medications: unsteady gait, 'chewing motion' movement of jaw, shuffling gait, rigid muscles, shaking, difficulty swallowing, complaints of dry mouth, depression, complaints of blurred vision, fatigue, complaints of inability to fall asleep or remain asleep), complaints of loss of appetite, weight loss, vomiting, behavior symptoms that are 'not usual' for this resident. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's physician orders included in part:.Venlafaxine HCl Oral Tablet 75 MG (Venlafaxine HCl), Give 75 mg by mouth two times a day related to unspecified depression. Surveyor reviewed Gradual Dose Reduction (GDR) dated 10/17/25 included in part: .Recommendation to assess for trial GDR of Effexor or provide documentation below if a GDR contraindicated. Surveyor found that the provider only discontinued Aricept and did not address R16's Effexor or trial a GDR. On 02/17/2026 at 11:12 AM, Surveyor asked IC C for behaviors for this resident as he is on psychotropics. IC C replied, Well I think this resident is just on an antidepressant, but I will check on that. On 02/17/2026 at 1:19 PM, Director of Nursing (DON) B informed this Surveyor, We just do behavior monitoring and charting by exception as needed. On 02/17/2026 at 2:29 PM, Surveyor asked DON B, When do the nursing staff monitor and document behaviors when a resident is on psychotropic medications? DON B replied, We only monitor residents' behavior with antidepressants if they start showing depressive behaviors and that would trigger the monitoring at that time. On 02/18/26 at 10:38 AM, Surveyor reviewed the facility's policy and R16's care plans regarding psychotropic medications. Surveyor then asked DON B for documentation for behavioral monitoring for R16. DON B replied, We do not have any further documentation for behavioral monitoring on R16.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not provide the proper discharge documentation for 2 of 2 residents (R44 and R4) reviewed for discharge.Facility did not have bed hold or notice of transfer documentation for R44.Facility did not have Ombudsman notification and notice of transfer documentation for R4.Findings:Example 1R44 was admitted to the facility on [DATE] with a Brief Interview of Mental Status (BIMS) of 13/15, which indicated R44 was cognitively intact. R44 had Minimum Data Set (MDS) stating ?Discharge Return Anticipated' dated on 01/14/26 and 12/21/25.On 02/18/26 at 9:13 AM, Surveyor was unable to find a bed hold for discharge date of 01/14/26 and a notice of transfer form. Surveyor asked Director of Nursing (DON) B for these documents.On 02/18/26 at 9:43 AM, DON B came into the conference room asking Surveyor what needs to be on the ?Notice of Transfer.' Surveyor informed DON B, The Notice of Transfer needs to have 1) in writing, 2) in language they understand, 3) the reason for the transfer.On 02/18/26 at 10:01 AM, Nursing Home Administrator (NHA) A informed Surveyor there is no bed hold for the transfer to the hospital dated 01/14/26 because the resident and the resident's representative did not want this resident to return to the facility. Surveyor replied, In the future there has to be a bed hold that says, ?No' to indicate this. NHA replied, Oh, I get it, so it specifies that they do not want the bed held.On 02/18/26 at 10:03 AM, NHA A informed Surveyor, We do not have the notice of transfer documentation. We tell the resident/representative why we are sending the resident out and document in the medical chart, but we don't give them a notice in writing in language they understand why they are being sent to the emergency room.Example 2R4 was admitted to the facility on [DATE] with a BIMS of 00 which indicated R4 had severe cognitive impairment. R4 had MDS dated [DATE] stating ?Discharge Return Anticipated.'On 02/18/26 at 9:13 AM, Surveyor was unable to find an Ombudsman notification and notice of transfer form for R4's discharge date [DATE]. Surveyor asked DON B for these documents.On 02/18/26 at 9:43 AM, DON B came into the conference room asking Surveyor what needs to be on the ?Notice of Transfer.' Surveyor informed DON B, The Notice of Transfer needs to have 1) in writing, 2) in language they understand, 3) the reason for the transfer.On 02/18/26 at 10:03 AM, NHA A informed Surveyor, We do not have the notice of transfer documentation. We tell the resident/representative why we are sending the resident out and document in the medical chart, but we don't give them a notice in writing in language they understand why they are being sent to the emergency room.On 02/18/2026 at 10:04 AM, NHA A informed Surveyor that because this resident was transferred out on 10/31/25 we do not remove the resident from our computer system in case they are only gone for a short stay. Our social services sends the ombudsman notification out on the 3rd day of the month. Unfortunately, there was an overlap from the transfer and the social worker's ombudsman notification. So, this resident's ombudsman notification never happened.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not conduct a Preadmission Screening Resident Review (PASRR) Level II screen for R1, who has a serious mental disorder and is taking psychotropic medication to treat symptoms of major mental disorder to ensure he received care and services to meet his needs. The facility practice affected 1 of 1 resident (R) reviewed (R1).Findings include:Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that Medicaid-certified nursing facilities:Evaluate all applicants for serious mental illness (SMI) and/or intellectual disability (ID)Offered all applicants the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings)Provide all applicants the services they need in those settingsPASRR screenings determine whether applicants might have an intellectual/developmental disability (ID/DD) and/or mental illness. This is a Level I Screen. The purpose of a Level I Screen is to identify individuals whose total needs require they receive additional services for their ID/DD and/or mental illness. Individuals who test positive at Level I are then evaluated in depth to confirm the determination of an ID/DD and/or mental illness for PASRR purposes. This is a Level II Screen. This assessment produces a set of recommendations for necessary services that are meant to inform the individual's plan of care. Nursing facilities may seek county exemption (DHS form F-20822), for applicants with ID/DD and/or mental illness whose stay in the facility is expected to be recuperative care or short-term. R1 was admitted on [DATE] with diagnoses that include schizoaffective disorder. R1 was prescribed the following psychotropic medications: Buspirone HCL, Clozapine, and Lorazepam.On 03/24/25, a Level I PASRR screening noted R1 had a major mental disorder and has taken psychotropic medications to treat symptoms or behaviors of a major mental disorder, indicating a Level II PASRR should be completed. The Level I PASARR done nearly one year ago, indicated yes for hospital discharge 30 day exemption from a Level II screening. On 02/17/26, Surveyor asked Director of Nursing (DON) B for a copy of R1's abbreviated PASRR level II.On 02/18/26 at 7:40 AM, DON B stated the facility does not have a PASARR II for R1. DON B reported the facility Social Worker is on vacation. However, DON B did call her and is still not able to locate or confirm that a PASARR II was ever completed for R1.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not develop and implement a person-centered care plan for a resident consistent with resident rights including services to attain or maintain the resident's highest or practicable physical, mental or psychosocial needs for 1 of 5 residents (R5). R5 did not have a comprehensive person-centered care plan for the use of a high-risk medications of Apixaban, which is an anticoagulant, Furosemide, which is a diuretic, and Lantus subcutaneous solution, which is an insulin. Findings include:Facility policy titled, Care Planning, revised 12/25, states in part, See AMDA guidelines. American Medical Directors Association (AMDA) guidelines states in part, Care Plan .Interventions: Specific, actionable steps for nursing staff, including monitoring, non-pharmacological interventions, and pharmacological management.R5 was admitted on [DATE]. R5's diagnosis included diabetes mellitus with chronic kidney disease, atrial fibrillation, congestive heart failure, obstructive and reflux uropathy, and weakness.Review of R5's quarterly Minimum Data Set (MDS) assessment, completed on 12/10/25, indicated R5 is on the following high-risk medications, an anti-coagulant, a diuretic, and a hypoglycemic medication. MDS also indicated R5 had a brief interview of mental status (BIMS) score BIMS of 14/15, indicating intact cognition.R5's medications include an anticoagulant, Apixaban 2.5 mg by mouth two times a day for atrial fibrillation, a diuretic, Furosemide 20 mg by mouth one time a day for chronic kidney disease and congestive heart failure and a hypoglycemic, Insulin- Lantus subcutaneous solution 100 unit/ml, inject 50 unit subcutaneously one time a day related to type 2 diabetes mellitus with diabetic chronic kidney diseaseReview of R5's care plans and medication administration record did not document a plan of care for bleeding risk, diuretics risks, or insulin/hypoglycemic risks.On 02/18/2026 at 11:10 AM, Surveyor interviewed Certified Nurse Assistant (CNA) D who reported the CNAs do not have specific guidelines to look for residents but instead would report anything out of the ordinary. On 02/18/2026 at 11:18 AM, Surveyor interviewed Director of Nursing (DON) B who stated any changes noted for any resident, such as bleeding or side effects of any high-risk medication, would be reported to the nurse from the CNA and followed up on, just as any change in condition would be reported. DON B stated they do not have specific side effects or risks identified in residents' care plans or on the medication administration record. DON B stated to Surveyor there are no specific care plan interventions or specific monitoring identified for nursing staff to watch for with R5's high-risk medications.

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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** Based on interview and record review, the facility did not ensure care plan was revised to reflect resident's current needs and direct staff in providing necessary care and services. The facility practice affected 1 of 15 residents' care plans reviewed (R5).R5 had changes in mood and increased depression. R5's care plan was not updated to reflect changes identified, interventions, and monitoring of R5. Findings include:According to the Resident Assessment Instrument, The comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving.R5 was admitted to the facility on [DATE] with diagnosis that included type 2 diabetes mellitus, chronic kidney diseases, prostate cancer, and weakness.R5's Minimum Data Set (MDS) of 9/9/25 indicated R5's Resident mood interview/ Patient Health Questionaire-9 (PHQ- 9) R5 scored 01, indicating no or minimal depression.R5's most recent quarterly Minimum Data Set (MDS) dated [DATE] documented R3 scored 14/15 on a Brief Interview for Mental Status (BIMS), indicating intact cognition.On 12/15/25, R5 had another PHQ-9 with a score of 10 indicating moderate depression. Social Service note on 12/15/25 documents, Quarterly plan of care (POC) completed. PHQ-9 completed, and resident scored a 10, indicating moderate depression. Resident does admit to finding little interest in doing things, feeling depressed, trouble sleeping, and feeling tired. He has also had thoughts that he would be better off dead but would not hurt himself. Resident admits to dealing with a lot of changes medically, which has been hard on him. Writer did offer him the option of doing talk therapy with Encounter tele-health. He stated that he would think about it and let writer know if he would like to try it. Resident remains a full code status and his goal still remains to go home in the Spring. Writer will continue to offer support and assist as needed.Documentation indicates there was communication with medical doctor (MD), resident, durable power of attorney (DPOA), guardian, and dietary on plan of care. However, behavior/mood was not addressed in R5's care plan or treatment record.R5's medical record stated on 12/21/2025 resident reminiscing with nurse this AM and expressed past episodes of depression and thoughts of suicide. He did assure that he was not presently having any thoughts or plans of suicide but expressed that this is a difficult time of year for him with holidays. Will place on q shift behavioral monitoring x 7 days throughout holidays.R5's treatment record charted on 12/21/25, 12/22/25, 12/23/25,12/24/25, and 12/27/25 indicating no comments or behaviors noted. On 12/22/25, R5's medical record stated, Resident expressed that he is depressed about his situation of being in the nursing home and not being able to be home. Encouraged resident to focus on things that bring him joy in life at this time and working towards achievable goals (such as getting to a living situation where he can enjoy his cats). He agreed and stating understanding and did express that he was enjoying movies playing today and reminiscing. Spoke with Director of Nursing (DON) about offering services such as talk therapy. Resident was out to see his primary provider today and no paperwork returned. A late entry was documented as follows, 2/14/2026 05:10 Behavior/Mood Note, Late Entry: Resident made statement I pay you enough to do just enough so I don't kill myself. Writer ensured that resident had no safety or self-harm concerns and resident confirmed that he made statement out of frustration.On 2/17/2026 at 8:05 AM, Surveyor interviewed R5 who in conversation reported he has contemplated suicide. R5 reported he had verbalized a plan to get narcotics and stated he has also spoke to facility staff including the Social Worker. On 2/17/2026 at 8:10 AM, Surveyor interviewed SW designee/CNA, who reported she was aware of R5's verbalization of suicide in the past and is not sure what has been done. Referred Surveyor to DON B.On 2/17/2026 at 8:13 AM, Surveyor interviewed DON B, who denied awareness of R5's contemplations of suicide. After reviewing (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation, DON B reported there was documentation of R5's suicidal thoughts and this was addressed and documented when R5 was monitored for 7 days starting 12/21/25. Surveyor asked DON B what the procedure was for when residents verbalize thoughts of suicide. DON B stated they would assess resident for a plan, do a search of the room, and offer counseling.On 2/17/2026 at 2:20 PM, Surveyor interviewed DON B. Surveyor asked DON B about R5's care plan not addressing R5's change in mental status/increased depression. DON B stated it was addressed in R5's treatment administration record when R5's behaviors were monitored for 7 days. DON B stated it was a one-time episode of what was believed situational thoughts of suicide. Surveyor pointed out the increased PHQ-9 score had also indicated R5's change in mental status. R5's care plan does not address his change in condition and does not provide interventions for staff to monitor his behaviors or awareness of R5's thoughts of suicide.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure 1 (R32) of 1 resident reviewed receiving physical therapy received the care necessary to meet professional standards.Facility did not obtain a Cam boot for R32's transfers as ordered from Orthopedic Surgeon I.Findings include:R32 was admitted to the facility on [DATE] with diagnoses including in part, atrial fibrillation, nonrheumatic aortic insufficiency, hypertensive heart disease, peripheral vascular disease, unilateral osteoarthritis left ankle and foot, hypertension, weakness, and presence of right artificial hip joint.R32's Minimum Data Set (MDS) assessment, dated 12/13/25, identified R32 required substantial maximal assistance for bed mobility, taking on and off footwear, rolling left to right, sitting to lying, chair to bed, toileting, and for transfers.Surveyor reviewed R32's ortho notes, which stated in part, .-On 02/10/26, Left tibia/fibula fractureMay remove temp splint and transition to tall Cam walking boot. May remove boot for skin hygiene and showers and ankle ROM. Weight bearing as tolerated for transfers in boot, 25% weight bearing for distance in boot. Ankle and knee range of motion.Skin care-wounds from first splint with inadequate padding.Follow up in 5 weeks. Next appointment 03/17/26. On 02/16/2026 at 3:29 PM, Surveyor interviewed R32 and asked how R32 injured her foot. R32 reported to Surveyor that she had a transfer in bathroom with physical therapy (PT) on 12/29/25 where R32 felt and heard a pop with burning sensation. Later that day provider came to visit R32 who stated it is in fact broken and sent to emergency room (ER). R32 reported that she came back with a cast on from the ER due to a displaced fracture of left fibula. R32 stated to Surveyor, I feel like facility has not been taking care of my leg as it's growing crooked and never gets looked at. R32 reported that the post op shoe on R32's foot is hurting all the time during transfers, and even when sitting in wheelchair.On 02/17/2026 at 6:38 AM, Surveyor observed R32 in wheelchair self-propelling around in R32's room. Surveyor observed a post op shoe and posterior splint on left foot.On 02/17/26 at 2:31 PM, Surveyor interviewed Director of Nursing (DON) B and asked if DON B knew that R32 was still wearing post op shoe instead of the Cam boot that was recommended by Orthopedic Surgeon I on 02/10/26. DON B asked Surveyor where Surveyor sees the recommendations. Surveyor showed DON B the recommendation orders from Orthopedic Surgeon I from a scanned document in R32's medical record scanned on 02/11/26. DON B reported that somehow R32's ortho orders did not make it into the medical record and expectation would be that the nurse on duty transcribes orders into medical record once new orders are known. Surveyor asked if resident has the Cam boot on now, and DON B reported that DON B was unsure but didn't think so. Surveyor asked DON B to go with Surveyor to peek at R32's left foot. On 02/17/26 at 2:35 PM, Surveyor entered R32's room with DON B. DON B confirmed that R32 still had post op boot and posterior splint instead of the Cam boot recommended back on 02/10/26.On 02/18/26 at 8:45 AM, Surveyor called Orthopedic Surgeon I to interview about post op shoe and Cam boot orders. Surveyor left message for return call.On 02/18/26 at 9:32 AM, Surveyor interviewed Orthopedic Surgeon I and asked if Orthopedic Surgeon I could walk Surveyor through consultation visits Orthopedic Surgeon I had with R32 over the last couple months. Orthopedic Surgeon I reported that R32's initial consultation visit was on 01/13/26 where R32 arrived from a cast placed by the ER weeks prior. R32 was noted to have substantial eschar from the initial cast placed from the ER for the initial fracture and splint. Then R32 was seen recently on 02/10/26 and fracture looked good, so recommendations were to put temporary posterior splint on with post op shoe but change to a Cam boot once facility receives Cam boot. Orthopedic Surgeon I reported that when Orthopedic Surgeon I went to apply Cam boot in the clinic visit, insurance stated Cam boot won't be covered and that the facility had to order it through DME services to have it covered. Surveyor asked if Orthopedic Surgeon I is aware that R32 is still being transferred via EZ-Stand with post op shoe and temporary posterior splint. Orthopedic Surgeon I stated that the posterior splint and post op shoe was to be used temporarily, and R32 absolutely needs to be in a Cam boot as soon as possible to provide (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stability while transferring from standing to sitting position.On 02/18/26 at 1:21 PM, Surveyor interviewed Physical Therapy Assistant (PTA) J and asked if R32 has a Cam boot on. PTA J reported to Surveyor that R32 does not have a Cam boot on and that R32 is wearing her post op shoe. Surveyor asked if PTA J was aware that R32 should be transferring with a Cam boot versus the temporary splint with post op shoe. PTA J reported that PTA J did not know that but maybe Physical Therapy (PT) L did. Surveyor requested PTA J to have PT L call Surveyor once PT L was available to talk.On 02/19/26 at 8:07 AM, Surveyor interviewed PT L and asked about R32's Cam boot. PT L reported that PT L received the orthopedic's orders on Wednesday February 11th, 2026. Surveyor asked if Cam boot was ordered for R32. PT L stated, I received CAM boot orders last week on Wednesday February 11th, but Cam boot wasn't ordered until this week on Tuesday February 17th, 2026. Surveyor asked PT L why the Cam boot was ordered a week later after seeing the orders prior. PT L reported that ordering the Cam boot is a shared responsibility between nursing and PT as nursing does all the ordering from special companies, but usually a resident will come back from an orthopedic clinic visit with Cam boot on and R32 did not come back with it on.At 8:16 AM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked if the Cam boot was ordered for R32. NHA A reported that the Cam boot was ordered on Tuesday 02/17/26. Surveyor asked where did NHA A order Cam boot from. NHA A reported that sometimes we order stuff off Amazon. Surveyor asked for verification of invoice or receipt for ordering R32's Cam boot. NHA A reported she would email it to Surveyor soon. On 02/19/26 at 9:27 AM, Surveyor received an email confirmation that NHA A ordered R32's Cam boot. NHA A was on phone with Surveyor and explained that R32's Cam boot was ordered now but should have been ordered when the Orthopedic Surgeon I's recommendations came through back on 02/10/26.

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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 residents were safe in their environment to prevent the risk of falling. This occurred for 1 of 1 resident (R) reviewed for falls, (R16). The facility staff did not ensure R16 had dycem pad while R16 was sitting in recliner as care planned.Findings include: R16 was admitted to the facility on [DATE] with diagnoses including in part, type 2 diabetes mellitus with hyperglycemia, hypertensive kidney disease stage 1-4, Alzheimer's disease, benign neoplasm of cerebral meninges, nonrheumatic aortic stenosis, dementia, personal history of MRSA, and muscle weakness. R16's Minimum Data Set (MDS) assessment, dated 11/06/25, identified R16 had Brief Interview for Mental Status (BIMS) of 10/15 that identified R16 with moderate cognitive impairment. R16's fall risk care plan stated, R16 is at risk for falls r/t disease process, dementia initiated on 09/26/2023: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, initiated on 09/27/2023. Dycem in recliner, initiated on11/22/2025. Encourage to participate in activities that promote exercise, physical activity for strengthening and improved mobility, initiated on 09/27/2023. Surveyor reviewed R16's progress notes, state in part, -On 11/22/25 fall note: Late Entry: CNA alerted writer to resident room, stating resident was on the floor. Writer approached resident room and observed resident lying on the floor in front of recliner with head up, recliner in full upright position. Res was immediately assessed for injury and vitals were obtained. Vitals WNL, no apparent injuries noted. Res LOC intact and responses were appropriate.Action: Res was lifted with 2-assist and hoyer-lift from floor into bed. Res stated to writer that he went to adjust his chair and the chair started lifting and didn't stop- and before he knew it he was on the floor. Res denies hitting head but stated that he was unsure.Response: DON notified. POA notified via telephone and thanked for the update, stated she would call him tomorrow. Theoria on-call NP notified. Intervention of dycem to recliner when resident up out of bed. Encourage resident to ask for assistance with adjusting chair if needed. Observations: On 02/17/26 at 10:12 AM, Surveyor observed Certified Nurse Assistant (CNA) D and CNA G transfer R16 to recliner from bed with Hoyer lift. R16 was placed in recliner with no dycem in place on recliner seat. CNA D and CNA G exited R16's room. Surveyor did not observe any staff place the dycem pad in R16's recliner as ordered to prevent potential falls. On 02/18/2026 at 12:15 PM, Surveyor interviewed CNA G and asked if CNA G had placed dycem pad on recliner before transferring R16 to recliner from bed yesterday to prevent potential falls from occurring. CNA G reported to Surveyor that CNA G was unsure if dycem was in R16's recliner and did not place it in recliner when transferred R16 to recliner yesterday on 02/17/26. On 02/18/26 at 12:38 PM, Surveyor interviewed Director of Nursing (DON) B and asked DON B's expectation for R16 to have dycem in recliner when out of bed in recliner. DON B reported that staff should be making sure dycem is in recliner whenever R16 is in the recliner. Surveyor reported to DON B that Surveyor observed R16 placed in recliner without dycem underneath. DON B reported that staff should have verified dycem was in recliner before R16 was placed in recliner.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable disease and infection, for 2 out of 13 residents (R) (R2 and R4) reviewed. R2 and R4 have indwelling medical devices and were not on Enhanced Barrier Precautions (EBP). Licensed Practical Nurse (LPN) H did not perform hand hygiene during water flush for R4's peg tube. Findings include: The facility's policy titled, Infection Prevention and Control Manual Enhanced Barrier Precautions (EBP)reads in part, .The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of Multidrug-Resistant Organisms (MDROs) to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids. High-contact resident care activities include Dressing, bathing/showering, transferring, providing hygiene, changing linins, changing briefs or assisting with toileting .3. Enhanced Barrier Precautions are to be implemented in addition to Standard Precautions . when facility identifies any resident with .c. Any indwelling medical device, for example . iii. Feeding tubes . State Operations Manual, Implementation of Transmission-Based Precautions reads in part, .When a resident is placed on transmission-based precautions, facility staff should implement the following: Clearly identify the type of precautions and the appropriate PPE to be used. Place signage that includes instructions for use of specific PPE in a conspicuous location outside the resident's room (e.g., on the door or on the wall next to the doorway), wing, or facility wide. Additionally, either the CDC category of transmission-based precautions (e.g., contact, droplet, or airborne) or instructions to see the nurse before entering should be included in signage. Ensure that signage also complies with residents' rights to confidentiality and privacy. Example 1 R2 was admitted on [DATE] with diagnosis that include hemiplegic and hemiparesis following a cerebral infarction affecting right side, aphasia, dysphagia, and gastrostomy. Most recent Minimum Data Set (MDS) completed on 11/21/25 indicated R2 was not able to complete a Brief Interview for Mental Status (BIMS) assessment. R2 is dependent on cares and has a feeding tube. On 02/17/25 at 7:30 AM, Surveyor observed that R2 did not have EBP signage on or near her door, nor did she have personal protective equipment at or near her door. On 02/17/26 at 7:36 AM, Surveyor observed Certified Nurse Assistant (CNA) E providing personal cares for R2. CNA E provided R2 with incontinence cares, a partial bed bath, and dressed R2. CNA E and Director of Nursing (DON) B then transferred R2 using a Hoyer lift. Both CNA E and DON B used hand hygiene, gloves and wore a mask during R2's cares and transfer. Neither CNA E nor DON B wore a gown. On 2/17/26 at 10 AM, Surveyor interviewed CNA E, who reported R2 does have a Percutaneous (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525712	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care and Rehab - Cumberland	1100 7th Ave Cumberland, WI 54829

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Endoscopic Gastrostomy (PEG) tube placed. CNA E is unsure why R2 is not on EBP. On 2/17/26 at 10:01 AM, Surveyor interviewed LPN F, who reported she also is unsure why R2 is not on EBP. LPN F reported she attempted to do R2's catheter flush this morning, and R2 refused. LPN F stated she did not wear a gown because R2 is not on EBP. On 2/17/2026 at 10:46 AM, Surveyor interviewed DON B, who stated R2 does not require EBP because area around R2's PEG tube site is healed, even though PEG tube remains in place. On 2/17/2026 at 2:32 PM, DON B reported after further investigation R2 is now on EBP for her indwelling PEG tube. Example 2 R4 was admitted to facility on 08/11/25. Surveyor reviewed R4's physician orders -Clean PEG tube insertion site and change PEG tube dressing daily. -Enteral Feed two times a day 16oz Jevity 1.5 BID via gravity -Enteral Feed four times a day for hydration 50 mL Free water flush Observations: On 02/16/26 at 2:10 PM, Surveyor did not observe an EBP sign outside R4's room. Surveyor did not observe a PPE cart anywhere in R4's room or outside R4's door. On 02/17/26 at 11:03 AM, Surveyor observed LPN H enter R4's room without sanitizing hands. Surveyor did not observe LPN H don Personal Protective Equipment (PPE) before entering and gathering R4's PEG tube supplies. LPN H placed tube feeding supplies on contaminated bedside table. Surveyor did not observe LPN H clean bedside table or re-sanitize hands. On 02/17/26 at 11:06 AM, Surveyor observed Infection Control (IC) Registered Nurse (RN) C come to R4's door and called for LPN H. LPN H walked to door and IC RN C reported to LPN H that R4 should be on EBP. IC RN C placed EBP sign on wall outside R4's door and placed a PPE cart inside R4's door. LPN H reported to IC RN C that once LPN H was done with PEG tube supplies LPN H would don PPE. IC RN C walked away from R4's door and LPN H finished placing R4's supplies on bedside table. LPN H walked over to R4's door and donned gown. LPN H reached into LPN H's pocket and pulled a pair of contaminated gloves out of pocket. While LPN H grabbed pair of gloves out of LPN H's scrub pockets, Surveyor could hear keys making noises in LPN H's scrub pocket. LPN H donned contaminated gloves, then grabbed contaminated garbage can, moving to side of bed, and then began drawing up gastric residual from R4's PEG tube with contaminated gloves. LPN H grabbed R4's PEG tube and began flushing water into R4's PEG tube. Surveyor observed LPN H take old dressing off and then grabbed clean dressing with contaminated gloves. LPN H reported that LPN H realized the new dressing had some kind of grime on it from R4's PEG tube from old dressing and LPN H touching the clean dressing with contaminated gloves. So, LPN H quickly threw the clean dressing in the garbage and grabbed another new dressing for R4's PEG tube site with contaminated gloves. LPN H applied (continued on next page)

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	525712	A. Building B. Wing	02/18/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	new dressing to R4's PEG site with contaminated gloves. Surveyor observed LPN H doff contaminated gloves, placed PEG tube supplies on sink in R4's bathroom and exited R4's room. Surveyor did not observe LPN H sanitize hands in between glove changes nor exiting R4's room. On 02/17/26 at 12:00 PM, Surveyor interviewed LPN H and asked about process for utilizing EBP and hand hygiene between glove changes. LPN H reported should have used sanitizer and did not. On 02/17/26 at 12:20 PM, Surveyor interviewed IC RN C for expectation of hand hygiene during tube feeding, sanitizing hands between glove changes, and wearing EBP. Surveyor also stated to IC RN C that LPN H had gloves stored in LPN H's scrub pocket. IC RN C reported to Surveyor that staff are not to store gloves in scrub pockets when delivering cares. IC RN C reported that LPN H should have used hand hygiene such as sanitizing hands in between glove changes. IC RN C reported that IC RN C will be educating LPN H. IC RN C reported to Surveyor that IC RN C knows that the EBP signage and use was unclear so residents receiving tube feeding will now always be on EBP measures.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not establish an Infection Prevention and Control Program (IPCP) which must include, at a minimum, an antibiotic stewardship program with a system to monitor antibiotic use. This had the potential to affect 1 of 5 residents (R7) reviewed for unnecessary medications.Hospice placed R7 on Cephalexin 500mg oral to be given two times a day for a UTI, which was not diagnosed with a urinalysis (U/A) and a culture and sensitivity (C & S). Facility did not ensure the antibiotic stewardship program was followed and that the criteria used to identify infection, McGeer's, was followed.Findings:Facility policy titled, Antibiotic Stewardship Policy, copy with permission dated 2023 stated in part: .Procedure: .2. The Nurse will utilize the (insert facility identified/approved standardized criteria tools: i.e. Loeb Minimum Criteria, McGeer Constitutional Criteria, AHRQ-UTI SBAR, etc.) infection criteria protocol to assess/evaluate resident to determine if it is necessary to treat with antibiotics or if adjustments in therapy need to be made.3. Notify physician/practitioner of resident change of condition and evaluation information. The nurse will communicate to physician/practitioner the facility infection criteria protocol to treat the respective infection .5. If indicated, based upon (identified) criteria, an antibiotic is ordered, the physician/practitioner must identify the diagnosis/indication for use, the appropriate antibiotic, proper dose, duration and route.a. in the event that the prescribing practitioner orders an antibiotic without identification of infection criteria, the practitioner will be requested to identify rational for ordered antibiotic. The Medical Director may be contacted for further directions .10. The infection Preventionist will track antibiotic use and monitor adherence to evidence-based criteria, and compile reports related to monitoring antibiotic usage and resistance date.R7 was admitted to the facility on [DATE] with diagnoses of Urinary Tract Infection (UTI). There was an order in R7's Electronic Health Record (EHR) for Cephalexin 500 milligrams (mg) to be given two times a day for a UTI starting on 02/13/26 and ending on 02/18/26.On 02/17/26 at 7:17 AM, Surveyor was screening R7 and asked R7 about the antibiotic. R7 replied, Well, I think hospice services put me on this antibiotic for 5 days to see if it helps, but I don't know why? Normally I would expect them to do some sort of lab work before just putting me on an antibiotic.On 02/17/26 at 7:46 AM, Surveyor asked Director of Nursing (DON) B for a copy of any lab work that would justify R7 being on the antibiotic.On 02/17/26 at 8:45 AM, DON B provided Surveyor with a ?Comment to the Provider' dated 02/13/26 that stated in part: Also was hesitant. Hospice treat with no Urinalysis (UA)/Urine Culture (UC). Spoke with hospice regarding this and on McGeer's criteria. He stated he would relay message to provider .On 02/17/26 at 8:55 AM, Surveyor interviewed Infection Control (IC) C about this antibiotic being ordered for R7. IC C replied, This resident had urgency and hesitancy. When I spoke to hospice, they indicated that the provider wanted the antibiotic started right away to treat for comfort without any lab work.On 02/17/26 at 10:00 AM, Surveyor interviewed IC C about whether or not this antibiotic would meet the facility's antibiotic stewardship policy and protocol. IC C replied, This antibiotic does not meet McGeer's criteria by the resident's symptoms alone, and this resident has a history of urgency prior to coming. [R7] just has to go to the bathroom all of the time.