STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525421	A. Building B. Wing	11/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindengrove Menomonee Falls	W180 N8071 Town Hall Rd Menomonee Falls, WI 53051

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R3) of 1 resident's representative was notified when there was a need to alter medical treatment.*R3's emergency contact/representative was not notified when R3 had a fall on 6/30/25 and 7/12/25.Findings include:The facility's undated Change of Condition and Provider Notification policy and procedure documents:I. Policy: Upon individual change of condition, proper assessment and provider notification will occur to provide timely delivery of clinical care.II. Procedure:1. Change of Conditiona. Change of Condition is a deviation from an individual's baseline in physical, cognitive, behavioral, or functional status. Clinically important means a deviation that, without intervention, may result in complications or death.3.Notificationb. As applicable, individual representative, managed care organization and hospice will be notified.R3 was admitted to the facility on [DATE] with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side(complete paralysis on one side of body and partial/incomplete weakness on one side following stroke), Atherosclerotic Heart Disease of the Native Coronary Artery(plaque buildup narrows the arteries that supply blood to the heart), Chronic Kidney Disease(progressive damage and loss of function in the kidneys), Chronic Obstructive Pulmonary Disease(lung disease that block airflow and make it difficult to breathe), Epilepsy(disorder in which nerve cell activity in brain is disturbed causing seizures) Anemia(lack of blood), Dysphagia(difficulty swallowing foods) and Depression(mood disorder that causes persistent feelings of sadness and loss of interest). R3's 5-day Minimum Data Set(MDS) completed 8/25/25 documents R3's Brief Interview for Mental Status score to be 11, indicating R3 demonstrates moderately impaired skills for daily decision making.On 11/3/25, at 10:27 AM, Surveyor interviewed R3 and assessed R3 to be alert and oriented to person, place, and time.On 6/30/25, R3 had an unwitnessed fall in the bathroom. Surveyor reviewed R3's electronic medical record(EMR) and the facility's unwitnessed fall investigation.Surveyor noted there is no documentation that R3's wife or emergency contact were contacted and informed of R3's fall and R3's potential change in condition. On 7/12/25, R3 had an unwitnessed fall in the room attempting to close the blinds. Surveyor reviewed R3's electronic medical record(EMR) and the facility's unwitnessed fall investigation.Surveyor noted there is no documentation that R3's wife or emergency contact was contacted and informed of R3's fall and R3's potential change in condition. On 11/3/25, at 1:15 PM, Surveyor interviewed R3 who stated that R3's wife should be notified of all things at the facility.On 11/4/25, at 8:22 AM, Director of Nursing (DON)-B informed Surveyor that R3's wife did not need to be informed of R3's 6/30/25 and 7/12/25 falls because R3 was R3's own person at the time. Surveyor shared that R3's falls was a change of condition and the emergency contact should have been notified of the change of condition. Surveyor shared there is no documentation that R3 stated R3 did not want R3's emergency contact updated on any change of condition. On 11/4/25, at 3:03 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON-B) and Sister Facility Nursing Home Administrator (SFNHA)-C that R3's emergency contact was not contacted when R3 fell on 6/30/25 and 7/12/25.No further information was provided by the facility as to why R3's emergency contact/representative was not contacted when R3 fell on 6/30/25 and 7/12/25 which per the facility's policy and procedure, R3's emergency contact/representative should have been contacted.

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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 - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility did not ensure that allegations of neglect, abuse, and/or misappropriation involving 7 residents (R6, R7, R8, R9,R10, R2 and R1) were reported immediately to the State Survey Agency. *On 8/18/25, R6 initiated a formal grievance to include an allegation of neglect that R6 had not been changed for over 2 hours. On 10/2/25, R6 initiated a formal grievance to include an allegation of neglect of having to wait to be changed until the next shift. The allegation of neglect was not reported to the State Survey Agency. *On 8/12/25, R7's representative initiated a formal grievance to include an allegation of neglect that R7 had to wait a long time to get R7's call light answered. The allegation of neglect was not reported to the State Survey Agency. *On 8/4/25, R8 initiated a formal grievance to include an allegation of neglect of having to wait a long time for call light to be answered multiple times. The allegation of neglect was not reported to the State Survey Agency. *On 9/12/25, R9's representative initiated a formal grievance to include an allegation of neglect that R9 had a bowel movement and was not cleaned up until 11:30 AM. The allegation of neglect was not reported to the State Survey Agency. *On 10/23/25, R10's representative initiated a formal grievance to include an allegation of neglect that R10's call light had been answered but the CNA informed R10 the CNA could not help R10 at that time and R10 had to wait a long time to get assistance. The allegation of neglect was not reported to the State Survey Agency. *On 8/12/25, a formal grievance was initiated to include an allegation of misappropriation involving R1. The allegation of misappropriation was not reported to the State Survey Agency. *On 8/25/25, R2 initiated a formal grievance to include an allegation of neglect that R2 was not changed all night resulting in R2 being soaked in urine so much that R2's brief was disintegrating. The allegation of neglect was not reported to the State Survey Agency. Findings include: The facility's Comprehensive Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Program reviewed 11/8/23 documents: C. Prevention (continued on next page)

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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 - Some	Abuse Policy Requirements: It is the policy of this facility to prevent abuse by providing residents, families and staff information and education on how and to whom to report concerns, incidents and grievances without the fear of reprisal or retribution. The facility will provide feedback regarding complaints and concerns. The facility leadership will assess the needs of the residents in the facility to be able to identify concerns in order to prevent potential abuse. D. Identification Abuse Policy Requirements: It is the policy of this facility that all staff monitor residents and will know how to identify potential signs and symptoms of abuse. Occurrences, patterns and trends that may constitute abuse will be investigated. Procedure: All staff will receive education about how to identify signs and symptoms of abuse. Residents will be monitored for possible signs of abuse. G. Reporting and Response Abuse Policy Requirements: It is the policy of this facility that abuse allegations are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Executive Director of the facility and to other officials(including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility. Procedure: Internal Reporting: a. Employees must always report any abuse or suspicion of abuse immediately to the Executive Director. **Note: Failure to report can make employee just as responsible for the abuse in accordance with State Law. b. The executive Director, will involve key leadership personnel as necessary to assist with reporting, investigation and follow up. External Reporting: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Each covered resident shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located, any reasonable suspicion of a crime against any resident who is a resident of or is receiving care from, the facility, and each covered resident shall report immediately, but not more than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. Initial reporting of allegations: If an incident or allegation is considered reportable, the Executive Director or designee will make an initial(immediate or within 24 hours) report to the State Agency. A follow up investigation will be submitted to the State Agency within 5 working days. When making a report, Misconduct Incident Reporting system will be used. Report the results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State law, including immediate or 24 hour reporting to the State Survey Agency, law enforcement and the follow up report to the State Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. The Executive Director or designee will inform the resident or resident's representative of the report of an incident and that an investigation is being completed. 1) R6 was admitted to the facility on [DATE] with diagnoses of Cerebral Palsy(congenital disorder of movement, muscle tone, or posture), Unspecified Diastolic Congestive Heart Failure(left ventricle stiffens and can't fill properly between heartbeats), Gastro-Esophageal Reflux Disease(stomach contents leak backward from stomach into the esophagus(food pipe), Morbid Obesity(too much body fat), and Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities). R6's Quarterly Minimum Data Set(MDS) completed 8/21/25 documents a R6's Brief Interview for Mental Status(BIMS) score of 13, indicating R6 is cognitively intact. R6's MDS documents: R6 has no mood or behavior issues; R6 has range of motion impairment of both upper and lower extremities on both sides; R6 requires substantial/maximum assistance for eating; R6 is dependent for upper and lower dressing, mobility, and transfers. R6 is always incontinent of bowel and bladder. On 8/18/25, R6 initiated a formal grievance to include an allegation of neglect that R6 had not been changed for over 2 hours. Staff had informed R6 that we are understaff. The box is checked yes that the individual/representative identify the event as abuse, neglect, or misappropriation. On 10/2/25, R6 initiated a formal grievance to include an allegation of neglect of having to wait to be changed until the next shift. R6 reported that it took 4 hours for R6's phone call to be answered. R6 had to use cell phone because R6's call light was not within reach. This was on the NOC shift. R6 needed to be changed. R6 was not changed until after first shift came in. R6 also reported that first shift refused to get R6 up. Surveyor noted that this allegation of potential neglect was not reported to the State Agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) R7 was admitted to the facility on [DATE] with diagnoses of Encephalopathy(group of conditions that cause brain dysfunction), Essential Hypertension(chronic condition of persistently high blood pressure), and Gastro-Esophageal Reflux Disease(stomach contents leak backward from stomach into the esophagus(food pipe). R7's admission Minimum Data Set (MDS) completed 8/15/25 documents R7's Brief Interview for Mental Status(BIMS) score of 12, indicating R7 is moderately cognitively impaired. R7's MDS documents: R7 has no mood or behavior issues; R7 has no range of motion impairment; R7 required set up for eating; R7 required partial/moderate assistance for showers; R7 required partial/moderate assistance for upper dressing and substantial/maximum assistance for lower dressing; R7 was independent for mobility and required partial/moderate assistance for transfers; R7 was frequently incontinent of bladder and always continent of bowel. On 8/12/25, R7's representative initiated a formal grievance to include an allegation of neglect that R7 had to wait a long time to get R7's call light answered. The call light response time was 30-40 minutes. Surveyor noted that this allegation was not reported to the State Agency. 3) R8 was admitted to the facility on [DATE] with diagnoses of Displaced Fracture of Body of Scapula, Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Chronic Kidney Disease(progressive damage and loss of function in the kidneys), Anemia(lack of blood), Atrial Fibrillation(irregular, often rapid heart rate commonly causes poor blood flow), Gastro-Esophageal Reflux Disease(stomach contents leak backward from stomach into the esophagus(food pipe), and Gout(inflammatory arthritis that causes pain and swelling in joints). R8's admission Minimum Data Set (MDS) completed 8/15/25 documents R8's cognitive status was not assessed. R8's MDS documents: R8 has no mood or behavior issues; R8 has range of motion impairment on both sides of upper extremity; R8 required set up for eating; R8 required substantial/maximum assistance for upper and lower dressing; R8 required substantial/maximum for mobility and transfers; R8 was frequently incontinent of bowel and always occasionally incontinent of bladder. On 8/4/25, R8 initiated a formal grievance to include an allegation of neglect of having to wait a long time for call light to be answered multiple times. R8 had to wait 35 minutes during day shift and another 30 minutes on the same day. Surveyor noted that this allegation was not reported to the State Agency. 4) R9 was admitted to the facility on [DATE] with diagnoses of Parkinson's Disease(disorder of the central nervous system that affects movement, often including tremors), Chronic Kidney Disease(progressive damage and loss of function in the kidneys), Depression(mood disorder that causes persistent feelings of sadness and loss of interest), Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities), and Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R9's admission Minimum Data Set (MDS) completed 9/12/25 documents R9 demonstrates modified independence for daily decision making. The MDS documents: R9 has episodes of disorganized thinking and altered level of consciousness; R9's MDS documents R9 has no mood or behavior issues; R9 has no range of motion impairment; R9 required partial/moderate for eating; R9 was dependent for showers; R9 required substantial/maximum assistance for upper dressing and dependent assistance for lower dressing; R9 was substantial/maximum assistance for mobility and dependent assistance for transfers; R9 was frequently incontinent of bladder and bowel. On 9/12/25, R9's representative initiated a formal grievance to include an allegation of neglect that R9 had a bowel movement and was not cleaned up until 11:30 AM. The CNA reported it was busy in the morning and was not able to get R9 up until later in the morning. Surveyor noted that this allegation of potential neglect was not reported to the State Agency. 5) R10 was admitted to the facility on [DATE] with diagnoses of Gout(inflammatory arthritis that causes pain and swelling in joints), Hypothyroidism(underactive thyroid), Gastro-Esophageal Reflux Disease(stomach contents leak backward from stomach into the esophagus(food pipe), Anemia(lack of blood), Peripheral Vascular Disease(circulatory condition in which narrowed blood vessels reduce blood flow to limbs), Chronic Myeloproliferate Disease(group of blood cancers) and Depression(mood disorder that causes persistent feelings of sadness and loss of interest). R10's admission Minimum Data Set(MDS) completed 10/28/25 documents R10's Brief Interview for Mental Status(BIMS) score of 15, indicating R10 is cognitively intact. R10's MDS documents: R10 has no mood or behavior issues; R10 has no range of motion impairment; R10 is independent for eating. R10 requires partial/moderate assistance for showers; R10 required supervision assistance for upper dressing and partial/moderate assistance for lower dressing; R10 required partial/moderate assistance for mobility and transfers; R10 was occasional incontinent of bladder and always continent of bowel. On 10/23/25, R10's representative initiated a formal grievance to include an allegation of neglect that R10's call light had been answered but the CNA informed R10 the CNA could not help R10 at that time and R10 had to wait a long time to get assistance. It was determined that a CNA had clocked out for the shift early, and the next shift did not provide assistance until much later in the shift. On 11/4/25, at 10:17 AM, Surveyor interviewed Life Coach (LC)-AA. LC-AA informed Surveyor that LC-AA is part of the investigation process and part of the resolution when there is a grievance documented. LC-AA interviews other residents if there is a facility reported incident. LC-AA informed Surveyor that LC-AA would initiate a facility reported incident if a resident used the term neglect or abuse or if LC-AA determined off of a risk assessment. Surveyor reviewed the five grievances with LC-AA. Surveyor shared the concern with LC-AA that the five grievances were reflective of allegations of neglect. LC-AA understands the concern. LC-AA stated that LC-AA is still getting comfortable with the role and is not always clear about what is abuse and/or neglect. LC-AA informed Surveyor that LC-AA would go to administration for help. On 11/4/25, at 3:03 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Sister Facility NHA (SFNH)-C that R6, R7, R8, R9, and R10's grievances had allegations of neglect that were no reported to the State Survey Agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No additional information has been provided by the facility as to why R6, R7, R8, R9, and R10's allegations of neglect were not reported to the State Survey Agency. 6.) Surveyor reviewed a grievance filed by R2 on 8/25/25. The resident reported on 8/23/25, she was not changed at all on NOC (night) shift from 10 PM - 6 AM. Staff statement the next morning reported the residents' bed was completely soaked, the brief was falling apart and she had to do a complete bed change. The CNA assigned to R2 that night was terminated. The termination notice documented: Complete and thorough investigation substantiates a lack of quality resident care. Resident was not changed/checked on entire NOC shift. On 11/3/25 at 1:00 PM, Surveyor spoke with Director of Nursing (DON)-B and reviewed the grievance. Surveyor asked if the allegation of neglect contained in the grievance was reported to the state agency. DON-B stated, I don't know, I'll have to ask. No additional information was provided. On 11/4/25 at 1:30 PM, Surveyor spoke with Prior Life Coach-J and reviewed the grievance allegation. Prior Life Coach-J stated, Yes, I remember. I would have given that to the DON because it has an allegation of neglect. Surveyor confirmed, so you feel this was a neglect situation. Prior Life Coach-J stated, Yes, I gave it to the DON because she would have to report it. No additional information was provided. On 11/4/25 at 3:00 PM, during the daily exit meeting, the facility was advised of concern R2's grievance contained an allegation of neglect that should have been reported to the State agency. No additional information was provided. 7.) On 11/3/25, at 3:07 p.m., during the end of the day meeting with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Nurse Clinical Consultant (NCC)-X Surveyor asked for the grievance dated 8/12/25 involving R1. On 11/4/25, at 11:00 a.m., Surveyor reviewed the grievance dated 8/12/25 investigated by Prior Life Coach (PLC)-J. Surveyor noted the individual affected documents [R1's name]. Under describe concern using factual terms documents Writer was call to resident room (anonymous resident) because she was concerned resident from across hall (R1) was giving kitchen staff money. Writer ensured resident (anonymous resident) it will be addressed. On 11/4/25, at 12:30 p.m., Surveyor asked NHA-A if the grievance involving R1 dated 8/12/25 was reported to the State agency for an allegation of misappropriation. NHA-A informed Surveyor as long as she has worked at the facility R1 has made statements about having to pay. NHA-A informed Surveyor it was not reported. Surveyor informed NHA-A the grievance was made by another resident, and the allegation of misappropriation should have been reported to the State agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility did not ensure that allegations of neglect, abuse, and/or misappropriation involving 7 residents (R6, R7, R8, R9, R10, R2 and R1) were not thoroughly investigated. *On 8/18/25, R6 initiated a formal grievance to include an allegation of neglect that R6 had not been changed for over 2 hours. On 10/2/25, R6 initiated a formal grievance to include an allegation of neglect of having to wait to be changed until the next shift. The allegation of neglect was not thoroughly investigated. *On 8/12/25, R7's representative initiated a formal grievance to include an allegation of neglect that R7 had to wait a long time to get R7's call light answered. The allegation of neglect was not thoroughly investigated. *On 8/4/25, R8 initiated a formal grievance to include an allegation of neglect of having to wait a long time for call light to be answered multiple times. The allegation of neglect was not thoroughly investigated. *On 9/12/25, R9's representative initiated a formal grievance to include an allegation of neglect that R9 had a bowel movement and was not cleaned up until 11:30 AM. The allegation of neglect was not thoroughly investigated. *On 10/23/25, R10's representative initiated a formal grievance to include an allegation of neglect that R10's call light had been answered but the CNA informed R10 the CNA could not help R10 at that time and R10 had to wait a long time to get assistance. The allegation of neglect was not thoroughly investigated. *On 8/12/25, a formal grievance was initiated to include an allegation of misappropriation involving R1. The allegation of misappropriation was not thoroughly investigated. *On 8/25/25, R2 initiated a formal grievance to include an allegation of neglect that R2 was not changed all night resulting in R2 being soaked in urine so much that R2's brief was disintegrating. The allegation of neglect was not thoroughly investigated. Findings include: The facility's Comprehensive Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Program reviewed 11/8/23 documents: C. Prevention Abuse Policy Requirements: It is the policy of this facility to prevent abuse by providing residents, families and staff information and education on how and to whom to report concerns, incidents and grievances without the fear of reprisal or retribution. The facility will provide feedback regarding complaints and concerns. The facility leadership will assess the needs of the residents in the facility to be able to identify concerns in order to prevent potential abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Identification Abuse Policy Requirements: It is the policy of this facility that all staff monitor residents and will know how to identify potential signs and symptoms of abuse. Occurrences, patterns and trends that may constitute abuse will be investigated. Procedure: All staff will receive education about how to identify signs and symptoms of abuse. Residents will be monitored for possible signs of abuse. G. Reporting and Response Abuse Policy Requirements: It is the policy of this facility that abuse allegations are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Executive Director of the facility and to other officials(including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility. Procedure: Internal Reporting: a. Employees must always report any abuse or suspicion of abuse immediately to the Executive Director. **Note: Failure to report can make employee just as responsible for the abuse in accordance with State Law. b. The executive Director, will involve key leadership personnel as necessary to assist with reporting, investigation and follow up. External Reporting: Each covered resident shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located, any reasonable suspicion of a crime against any resident who is a resident of or is receiving care from, the facility, and each covered resident shall report immediately, but not more than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Initial reporting of allegations: If an incident or allegation is considered reportable, the Executive Director or designee will make an initial(immediate or within 24 hours) report to the State Agency. A follow up investigation will be submitted to the State Agency within 5 working days. When making a report, Misconduct Incident Reporting system will be used. Report the results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State law, including immediate or 24 hour reporting to the State Survey Agency, law enforcement and the follow up report to the State Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. The Executive Director or designee will inform the resident or resident's representative of the report of an incident and that an investigation is being completed. 1) R6 was admitted to the facility on [DATE] with diagnoses of Cerebral Palsy(congenital disorder of movement, muscle tone, or posture), Unspecified Diastolic Congestive Heart Failure(left ventricle stiffens and can't fill properly between heartbeats), Gastro-Esophageal Reflux Disease(stomach contents leak backward from stomach into the esophagus(food pipe), Morbid Obesity(too much body fat), and Major Depressive Disorder(persistent feelings's of sadness, hopelessness, and a loss of interest or pleasure in activities). R6's Quarterly Minimum Data Set(MDS) completed 8/21/25 documents R6's Brief Interview for Mental Status(BIMS) score of 13, indicating R6 is cognitively intact. R6's MDS documents: R6 has no mood or behavior issues; R6 has range of motion impairment of both upper and lower extremities on both sides; R6 requires substantial/maximum assistance for eating; R6 is dependent for upper and lower dressing, mobility, and transfers; R6 is always incontinent of bowel and bladder. On 8/18/25, R6 initiated a formal grievance to include an allegation of neglect that R6 had not been changed for over 2 hours. Staff had informed R6 that we are understaff. The box is checked yes that the individual/representative identify the event as abuse, neglect, or misappropriation. The allegation of neglect was not thoroughly investigated. The facility did not obtain staff statements and did not interview other residents to determine if there was a pattern of neglect. On 10/2/25, R6 initiated a formal grievance to include an allegation of neglect of having to wait to be changed until the next shift. R6 reported that it took 4 hours for R6's phone call to be answered. R6 had to use cell phone because R6's call light was not within reach. This was on the NOC shift. R6 needed to be changed. R6 was not changed until after first shift came in. R6 also reported that first shift refused to get R6 up. The allegation of neglect was not thoroughly investigated. The facility did not obtain staff statements and did not interview other residents to determine if there was a pattern of neglect. 2) R7 was admitted to the facility on [DATE] with diagnoses of Encephalopathy(group of conditions that cause brain dysfunction), Essential Hypertension(chronic condition of persistently high blood pressure), and Gastro-Esophageal Reflux Disease(stomach contents leak backward from stomach into the esophagus(food pipe). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R7's admission Minimum Data Set(MDS) completed 8/15/25 documents R7's Brief Interview for Mental Status(BIMS) score of 12, indicating R7 is moderately cognitively impaired. R7's MDS documents: R7 has no mood or behavior issues; R7 has no range of motion impairment; R7 required set up for eating; R7 required partial/moderate assistance for showers; R7 required partial/moderate assistance for upper dressing and substantial/maximum assistance for lower dressing; R7 was independent for mobility and required partial/moderate assistance for transfers; R7 was frequently incontinent of bladder and always continent of bowel. On 8/12/25, R7's representative initiated a formal grievance to include an allegation of neglect that R7 had to wait a long time to get R7's call light answered. The call light response time was 30-40 minutes. The allegation of neglect was not thoroughly investigated. The facility did not obtain staff statements and did not interview other residents to determine if there was a pattern of neglect. 3) R8 was admitted to the facility on [DATE] with diagnoses of Displaced Fracture of Body of Scapula, Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Chronic Kidney Disease(progressive damage and loss of function in the kidneys), Anemia(lack of blood), Atrial Fibrillation(irregular, often rapid heart rate commonly causes poor blood flow), Gastro-Esophageal Reflux Disease(stomach contents leak backward from stomach into the esophagus(food pipe), and Gout(inflammatory arthritis that causes pain and swelling in joints). R8's admission Minimum Data Set(MDS) completed 8/15/25 documents R8's cognitive status was not assessed. R8's MDS documents: R8 has no mood or behavior issues; R8 has range of motion impairment on both sides of upper extremity; R8 required set up for eating; R8 required substantial/maximum assistance for upper and lower dressing; R8 required substantial/maximum for mobility and transfers; R8 was frequently incontinent of bowel and always occasionally incontinent of bladder. On 8/4/25, R8 initiated a formal grievance to include an allegation of neglect of having to wait a long time for call light to be answered multiple times. R8 had to wait 35 minutes during day shift and another 30 minutes on the same day. The allegation of neglect was not thoroughly investigated. The facility did not obtain staff statements and did not interview other residents to determine if there was a pattern of neglect. 4) R9 was admitted to the facility on [DATE] with diagnoses of Parkinson's Disease(disorder of the central nervous system that affects movement, often including tremors), Chronic Kidney Disease(progressive damage and loss of function in the kidneys), Depression(mood disorder that causes persistent feelings of sadness and loss of interest), Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities), and Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R9's admission Minimum Data Set(MDS) completed 9/12/25 documents R9 demonstrates modified independence for daily decision making. R9 has episodes of disorganized thinking and altered level of consciousness. R9's MDS documents: R9 has no mood or behavior issues; R9 has no range of motion impairment; R9 required partial/moderate for eating; R9 was dependent for showers; R9 required substantial/maximum assistance for upper dressing and dependent assistance for lower dressing; R9 was substantial/maximum assistance for mobility and dependent assistance for transfers; R9 was frequently incontinent of bladder and bowel. On 9/12/25, R9's representative initiated a formal grievance to include an allegation of neglect that R9 had a bowel movement and was not cleaned up until 11:30 AM. The CNA reported it was busy in the morning and was not able to get R9 up until later in the morning. The allegation of neglect was not thoroughly investigated. The facility did not obtain staff statements and did not interview other residents to determine if there was a pattern of neglect. 5) R10 was admitted to the facility on [DATE] with diagnoses of Gout(inflammatory arthritis that causes pain and swelling in joints), Hypothyroidism(underactive thyroid), Gastro-Esophageal Reflux Disease(stomach contents leak backward from stomach into the esophagus(food pipe), Anemia(lack of blood), Peripheral Vascular Disease(circulatory condition in which narrowed blood vessels reduce blood flow to limbs), Chronic Myeloproliferate Disease(group of blood cancers) and Depression(mood disorder that causes persistent feelings of sadness and loss of interest). R10's admission Minimum Data Set(MDS) completed 10/28/25 documents R10's Brief Interview for Mental Status(BIMS) score of 15, indicating R10 is cognitively intact. R10's MDS documents: R10 has no mood or behavior issues; R10 has no range of motion impairment; R10 is independent for eating; R10 requires partial/moderate assistance for showers; R10 required supervision assistance for upper dressing and partial/moderate assistance for lower dressing; R10 required partial/moderate assistance for mobility and transfers; R10 was occasional incontinent of bladder and always continent of bowel. On 10/23/25, R10's representative initiated a formal grievance to include an allegation of neglect that R10's call light had been answered but the CNA informed R10 the CNA could not help R10 at that time and R10 had to wait a long time to get assistance. It was determined that a CNA had clocked out for the shift early, and the next shift did not provide assistance until much later in the shift. The allegation of neglect was not thoroughly investigated. The facility did not obtain staff statements and did not interview other residents to determine if there was a pattern of neglect. On 11/4/25, at 10:17 AM, Surveyor interviewed Life Coach (LC)-AA. LC-AA informed Surveyor that LC-AA is part of the investigation process and part of the resolution when there is a grievance documented. LC-AA interviews other residents if there is a facility reported incident. LC-AA informed Surveyor that LC-AA would initiate a facility reported incident if a resident used the term neglect or abuse or if LC-AA determined off of a risk assessment. Surveyor reviewed the five grievances with LC-AA. Surveyor shared the concern with LC-AA that the five grievances were reflective of allegations of neglect. LC-AA understands the concern. LC-AA stated that LC-AA is still getting comfortable with the role and is not always clear about what is abuse and/or neglect. LC-AA informed Surveyor that LC-AA would go to administration for help. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/4/25, at 3:03 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Sister Facility NHA (SFNH)-C that R6, R7, R8, R9, and R10's grievances had allegations of neglect that were not thoroughly investigated. The facility did not obtain staff statements and did not interview other residents to determine if there was a pattern of neglect. No additional information was provided by the facility as to why R6, R7, R8, R9, and R10's allegations of neglect were not thoroughly investigated to determine the circumstances of the allegations of neglect. 6.) Surveyor reviewed a grievance filed by R2 on 8/25/25. The resident reported on 8/23/25, she was not changed at all on NOC (night) shift from 10 PM - 6 AM. Staff statement the next morning reported the residents' bed was completely soaked, the brief was falling apart and she had to do a complete bed change. The CNA assigned to R2 that night was terminated. The termination notice documented: Complete and thorough investigation substantiates a lack of quality resident care. Resident was not changed/checked on entire NOC shift. On 11/3/25 at 12:30 PM Surveyor spoke with Director of Nursing (DON)-B and reviewed the grievance. Surveyor asked why the grievance indicated it was resolved on the same date it was filed by R2 (8/25/25). DON-B reported she did not know and would look for more information. Surveyor asked if any other residents assigned to the CNA involved in the allegation of neglect to determine if other residents were affected. DON-B reported she did not know and would look for more information. On 11/4/25 at 1:30 PM, Surveyor spoke with Prior Life Coach-J and reviewed the grievance allegation. Prior Life Coach-J stated, Yes, I remember. I would have given that to the DON because it has an allegation of neglect. Surveyor confirmed, so you feel this was a neglect situation. Prior Life Coach-J advised Surveyor she did not investigate the grievance allegation; she gave it to the DON. Surveyor advised Prior Life Coach-J that the grievance contains her signature as the assigned investigating individual, and the grievance officer reviewing resolution. No explanation was provided as to why she signed the form. Surveyor asked if she interviewed any other residents assigned to the CNA. Prior Life Coach-J stated, No, I didn't do the investigation. I know the CNA was terminated because of this. On 11/4/25 at 3:00 PM, during the daily exit meeting, the facility was advised of concern R2's grievance contained an allegation of neglect that was not thoroughly investigated. No other residents were interviewed to determine if any other residents were affected. No additional information was provided. 7.) On 11/3/25, at 3:07 p.m., during the end of the day meeting with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Nurse Clinical Consultant (NCC)-X Surveyor asked for the grievance dated 8/12/25 involving R1. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/4/25, at 11:00 a.m., Surveyor reviewed the grievance dated 8/12/25 investigated by Prior Life Coach (PLC)-J. Surveyor noted the individual affected documents [R1's name]. Under describe concern using factual terms documents Writer was call to resident room (anonymous resident) because she was concerned resident from across hall (R1) was giving kitchen staff money. Writer ensured resident (anonymous resident) it will be addressed. Investigation Findings documents Resident believes that the oz (ounce) listed on menu are dollar amounts when staff delivers food, she believes she has to pay the bill. Resolution description documents Kitchen staff declines taking any money when offered as they are aware of policy and would not jeopardize their job. Date of resolution documents 8/12/25. On 11/4/25, at 12:19 p.m., Surveyor asked NHA-A if there is any investigation regarding the grievance involving R1 dated 8/12/25. On 11/4/25, at 12:30 p.m., NHA-A informed Surveyor she does not have any staff statements or resident's statements, she looked through the whole book and does not have an investigation. NHA-A informed Surveyor the name of Prior Life Coach (PLC)-J did the investigation, she doesn't work for the facility but works for the corporation. NHA-A informed Surveyor she can provide Surveyor with the phone number if Surveyor would like to speak with PLC-J. Surveyor informed NHA-A Surveyor would be happy to speak with anyone NHA-A would like Surveyor to. On 11/4/25, at 1:17 p.m., Surveyor spoke with PLC-J on the telephone. PLC-J explained a resident, who wanted to be anonymous, called her into the room and was concerned R1 was giving kitchen staff money. PLC-J explained she wrote the grievance, watched breakfast & lunch being served on the unit and saw no money was being exchanged. PLC-J informed Surveyor she spoke to the kitchen staff. Surveyor asked PLC-J who she spoke with. PLC-J replied I don't know, kind of all together in a group or in passing. PLC-J informed Surveyor the kitchen staff know they can't accept funds from residents. Surveyor asked PLC-J if she spoke to other residents to see if they had any concerns regarding having to give money to staff for their meals. PLC-J informed Surveyor she doesn't believe there were other residents in the area, and she just spoke with the two residents, anonymous resident & R1. The facility did not conduct a thorough investigation for an allegation of misappropriation as there is no evidence which dietary staff were interviewed and PLC-J only interviewed anonymous resident & R1 and did not interview other residents.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good grooming for 1 (R4) of 1 resident reviewed for ADL's (Activities of Daily Living).*R4 was to have maintained short fingernails per documented skin intervention. R4 fingernails were observed during the survey process to have extremely long fingernails on all fingers of both hands.Findings Include:The facility's undated policy titled STANDARD ADL (activities of daily living) PROTOCOL documents:- ADLS: Dressing, grooming, eating, toileting, bathing, personal hygiene (oral care, face, hands), mobility, transfers- Problem: Individual requires assistance with Activities of Daily Living (ADLs)- Goal: Individual will preform ADL's at highest functional level with or without staff assist.- CNA (Certified Nursing Assistant):o Trim finger and toenails on bath/shower day and as needed unless diabetico Offer handwashing/sanitizing before meals.R4 was admitted on [DATE] with diagnoses of Hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side (complete and partial loss of movement on right side of the body after ischemic stroke - decreased blood flow to the brain causing lasting physical and mental deficits), Aphasia (inability to understand or speak), Dysphagia (difficulty swallowing), weakness, and need For Assistance with Personal Care.R4's Quarterly Minimum Data Set (MDS) completed 9/12/25 documented R4 has severe cognitive impairment with a Brief Interview Mental Status (BIMS) score of 3. The MDS documents: R4 has unclear speech and is sometimes understood; R4 has impairment on one side upper and lower; R4 eats independently, requires partial to moderate assistance for hygiene, showering, dressing, toileting, and bed mobility; R4 requires set up to supervision assistance for all transfers.R4's comprehensive care plan for R4 documented: The resident has potential impairment to skin integrity r/t (related to) fragile skin, assisted to reposition, incontinence, immobility and history of skin altercation. Scar tissue present to right buttock from prior healed area. Date initiated 6/9/25, revised 8/19/25.o Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Date Initiated 6/9/25. R4's activities of daily living (ADL) self care performance deficit related to Activity intolerance, fatigue, impaired balance-stroke related to hemiplegia care plan initiated 6/9/25 and revised on 6/17/25 documents:o BATHING/SHOWERING: check nail length and trim and clean on bath days and as necessary. Report any changes to the nurse. Initiated on 6/9/25.o Praise all efforts at self care. Resident refuses cares at times. Date initiated 6/9/25, revised on 10/14/25R4's Kardex as of 11/3/25, which instructs Certified Nursing Assistants (CNA) in the care for R4, documented:- Skin Integrity: Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short.On 11/4/25, at 7:35 AM, Surveyor observed R4 sleeping in bed and observed R4's nails to be extremely long and dirty with debris. On 11/4/25, at 3:03 PM, Surveyor shared concerns with Nursing Home Administrator (NHA) -A, Director of Nursing (DON) -B, and Sister Facility NHA-C.The facility did not provide any additional information at this time as to why ADLs were not provided to R4 as R4's fingernails are extremely long and dirty.On 11/4/25, at 3:40 PM, Surveyor observed R4 in bed with extremely long and dirty fingernails. On 11/5/25, at 8:42 AM, Surveyor observed R4 in bed with extremely long and dirty fingernails.No additional information was provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that based on the comprehensive assessment of a resident, residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices for 3 (R1, R2, & R3) of 4 residents. *R1 receives an anticoagulant twice a day. On 10/16/25 R1 sustained an unwitnessed fall hitting her head. R1 sustained a large purplish hematoma on the left side of the R1's forehead and a skin tear on the left hand. While R1 was laying on the floor, Licensed Practical Nurse (LPN)-N obtained vital signs and Nurse Practitioner (NP)-K assessed R1's range of motion. NP-K informed Surveyor after assessing R1's range of motion she left R1's room as multiple staff were coming into the room. NP-K informed Surveyor she planned on returning to R1's room. NP-K did not complete a comprehensive assessment and did not return until sometime after lunch. When NP-K returned sometime after 2:00 p.m., there was bruising on the left side of R1's face. NP-K ordered R1 to be transferred to the hospital. Surveyor also noted there was not a RN (Registered Nurse) assessment completed R1's fall. Surveyor noted R1's neurological check is incomplete as staff did not complete one of the 30-minute checks. According to the ambulance report, a call was received at 2:41 p.m. When the ambulance crew arrived at the unit, the nurse led them to R1's room informing the ambulance crew that R1 had a fall but that she needed to pass medication and would be around the corner. Concierge-BB contacted Licensed Practical Nurse/Nurse Supervisor (LPN/NS)-G to request she speak with the ambulance crew as LPN-N was passing medication. LPN/NS-G was unable to give the ambulance crew a report until she spoke with LPN-N as LPN/NS-G was supervising and was not working the floor. *The facility did not follow R2's physician order dated 9/15/25 to obtain a stool sample to check for C-Diff (Clostridioides difficile). *Neuro (neurological) checks were not completed for R3's unwitnessed falls on 6/30/25 & 7/12/25. Findings include: The facility's policy titled, Change of Condition and Provider Notification and last reviewed 5/8/25 under Policy documents Upon individual change of condition, proper assessment and provider notification will occur to provide timely delivery of clinical care. Under Procedure for 2. Assessment documents a.) Licensed nurse is involved in the assessment process and contribute to the collection of the data base, the planning of interventions and evaluation of individual's response to condition change. b.) a licensed nurse is to complete the initial assessment, and follow-up evaluation as indicated by the complexity and stability of the individual's condition. c.) Change of Condition Assessment shall be reviewed by Registered Nurse. 1.) R1 was admitted to the facility with diagnoses that include chronic respiratory failure with hypoxia (long term condition where the lungs cannot supply enough oxygen to the blood resulting in low blood oxygen levels), dementia (loss of cognitive function that interferes with a person's daily life & activities), atrial fibrillation (irregular and rapid heartbeat), and anxiety disorder (group of mental health conditions characterized by excessive & persistent worry, fear, and nervousness that an interfere with daily life). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's physician orders include an order dated 4/7/25 Eliquis oral tablet 2.5 mg (milligrams) (Apixaban). Give 2. 5 mg by mouth two times a day for anticoagulant. R1's nurses note dated 10/16/25, at 11:03 a.m., written by Licensed Practical Nurse (LPN)-N documents: Writer heard loud screaming from resident's room, someone from PT (physical therapy) stated res. (resident) is on the floor as writer proceeded to resident's room. Writer observed res. On the floor on right side. Resident last observed eating at 1000 (10:00 a.m.) with O2 (oxygen) on. Writer observed res. Without O2 reapplied. Writer made NP (Nurse Practitioner) aware NP came and observed res. On the floor and assessed res. Writer called [Name] res contact person. Staff assisted writer sic (resident) off floor after assessment. Ice pack applied to left side of head, res. With large purplish hematoma, also has purplish bruise area on left hand with skin tear, writer cleaned area and proximate skin and applied steri strips and dry dressing. Neuro check negative, rom (range of motion) wnl (within normal limits) to upper and lower extremities although complaint of pain to coccyx area. R1's nurses note dated 10/16/25, at 14:38 (2:38 p.m.), written by LPN-N documents: NP sending resident out to hospital d/t (due to) previous fall. Resident with hematoma to left side of forehead, also developing a black eye to left eye. Writer called [Name] ambulance, waiting for ambulance to arrive. Writer to update res. Family [Name]. R1's nurses note dated 10/16/25, at 21:54 (9:54 p.m.), written by LPN-N documents: Resident returned from the hospital, test negative, resident in bed resting, offered no c/o (complaint of) pain/discomfort. On 11/3/25, at 11:34 a.m., Surveyor asked LPN-N about R1's bruising on R1's face. LPN-N informed Surveyor she was told that's why Surveyors are here. LPN-N then informed Surveyor she heard yelling; name of Physical Therapy Assistant (PTA)-Y was coming up from the end of the hall where he was treating another resident and said R1 fell. LPN-N stated she was on her way because a resident was yelling. LPN-N informed Surveyor R1 was on the floor in her room. Surveyor asked what time the fall was. LPN-N informed Surveyor she wrote the note at 11:30 a.m. so probably about 11:00 a.m. Surveyor later identified the fall as being at 10:30 a.m. LPN-N informed Surveyor she called the name of Nurse Practitioner (NP)-K. Surveyor asked LPN-N when she called for NP-K. LPN-N replied right away. LPN-N informed Surveyor she and staff got R1 off the floor. Surveyor asked LPN-N when did RN-K come to R1's room. LPN-N replied right away. (continued on next page)

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	525421	A. Building B. Wing	11/11/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/3/25, at 12:25 p.m. Surveyor interviewed NP-K regarding R1's fall on 10/16/25. NP-K informed Surveyor they called her right after R1 fell. Surveyor asked NP-K if she remembers what time they called her. NP-K informed Surveyor she can tell Surveyor it was in the morning because she was in another room down the hall but would be guessing about the time. NP-K informed Surveyor she left the room she was in and went to R1's room. Surveyor asked if R1 was on the floor or in bed. NP-K informed Surveyor R1 was still on the floor and the nurse was getting vital signs. R1 was complaining of she thinks hip or knee pain. NP-K stated I was assessing ROM (range of motion) and then I left the room. NP-K explained multiple people came in to get R1 off the floor. Surveyor asked NP-K before she left R1's room did she give any instructions to the nurse. NP-K replied we talked about dressing her hand. NP-K stated my plan was to come back when she was not on the floor anymore. Surveyor asked NP-K if she returned to R1's room. NP-K replied yes, after lunch. NP-K informed Surveyor R1 had left side bruising, knot on forehead and no other complaints of pain. NP-K informed Surveyor she then gave the order to send R1 out. Surveyor asked NP-K why she decided to send R1 to the hospital. NP-K informed Surveyor R1 had a hematoma on forehead, bruising and on Eliquis. Surveyor informed NP-K she had said she came back to R1's room after lunch and asked NP-K if she remembers what time this was. NP-K stated 2:00 p.m. I'm guessing. Surveyor asked NP-K why she didn't send R1 out in the morning when R1 was on the floor when R1 had an unwitnessed fall, hit her head and was on Eliquis. NP-K replied I'm not sure why I didn't send her out. Surveyor asked NP-K if R1 should have been sent to the hospital right away. NP-K replied probably. On 11/3/25, at 12:42 p.m. Surveyor asked LPN-N if she remembers what time NP-K told her to send R1 to the hospital. LPN-N replied no, and I don't want to give you some bogus answer. Surveyor asked LPN-N if she was here when the ambulance crew arrived. LPN-N replied yes. Surveyor asked if she remembers what time the ambulance crew arrived. LPN-N replied no and explained she remembers calling them and them coming. Surveyor asked LPN-N if she spoke with the ambulance crew. LPN-N replies yes and explained she told them she has some papers to give them, but the secretary (Concierge-BB) is going to print them out. LPN-N informed Surveyor the ambulance crew asked her what happened, and she told them R1 fell and has a hematoma on her head. LPN-N informed Surveyor she was passing medication and told the ambulance crew if they needed her, she was around the corner. On 11/3/25, at 3:26 p.m., Surveyor asked Concierge-BB if she was involved with R1's fall on 10/16/25. Concierge-BB informed Surveyor she printed some paperwork as they were having problems with the printer on the unit. Surveyor asked Concierge-BB what she printed out. Concierge-BB informed Surveyor the face sheet, MAR (medication administration record), medication list, and transfer summary. Surveyor asked Concierge-BB if she had any contact with the ambulance crew. Concierge-BB informed Surveyor when she brought the paperwork into the room, there was a tall man and a shorter female with a bad attitude. Concierge-BB informed Surveyor she was barking at her questions, after questions. Concierge-BB informed Surveyor she told them she's sorry but she's not a nurse and went to get the nurse. Concierge-BB informed Surveyor the name of Licensed Practical Nurse/Nurse Supervisor (LPN/NS)-G was in the hallway. Surveyor asked if LPN/NS-G went in R1's room. Concierge-BB replied I believe so. Surveyor asked Concierge-BB if she spoke with LPN-N. Concierge-BB replied I didn't she was with another resident. Concierge-BB informed Surveyor she believes LPN/NS-G went to get LPN-N. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/3/25, at 3:30 p.m., Surveyor asked LPN/NS-G if she was involved with R1's transfer to the hospital. LPN/NS-G explained Concierge-BB came and got her and asked her to report to the ambulance staff. Concierge-BB told her LPN-N was passing meds. LPN/NS-G informed Surveyor she went in R1's room and the ambulance staff said they wanted report. LPN/NS-G informed Surveyor she told them R1 had a fall and was found in front of the bathroom door. LPN/NS-G informed Surveyor the female ambulance staff was really upset, they had asked for report from the nurse and the nurse was busy passing medication. LPN/NS-G informed Surveyor she gave them report but had to ask LPN-N first because she was the supervisor. Surveyor asked LPN/NS-G what the expectation for the nurse is when the ambulance crew arrive. LPN/NS-G informed Surveyor they always ask for report, need to let them know why we called, vital signs, injuries, stuff like that. Surveyor asked LPN/NS-G if LPN-N should have stopped passing medication and been with the ambulance crew. LPN/NS-G replied she was the nurse so I don't know who else would have been able to do it not the aides. On 11/3/25, at 3:43 p.m., Surveyor asked Registered Nurse/Nurse Supervisor (RN/NS)-O regarding R1's fall on 10/16/25. RN/NS-O informed Surveyor she doesn't know the exact time of the fall and LPN-N called reported she had fallen, had goose egg to her head and they discussed neuro checks, LPN-N to fill out fall risk assessment, and that's all she knows. Surveyor asked if she assessed R1. RN/NS-O replied I just looked at her, they were taking vital signs. Surveyor asked who was taking vital signs. RN/NS-O replied name of LPN-N. Surveyor asked if NP-K was there. RN/NS-O replied not while I was in there, I don't recall them telling me if she was in there previous or after. Surveyor asked RN/NS-O when she was there was R1 still on the floor or in bed. RN/NS-O replied she was already back in bed. On 11/4/25, at 9:51 a.m., Surveyor spoke with Anonymous EMT (emergency medical technician)-P on the telephone. Anonymous EMT-P informed Surveyor they were called for a fall, when they arrived, they were led to the resident's room by a nurse who barely gave them any information as she had to pass medication. Anonymous EMT-P informed Surveyor they did an assessment, the entire side of R1's face was black & blue, really swollen so was R1's hand. Anonymous EMT-P informed Surveyor believes it was the left hand and left side of the face. Anonymous EMT-P informed Surveyor they tried to talk to three different people to find out what time the fall was and if R1 was on blood thinner. Anonymous EMT-P informed Surveyor they received information from another resident who told them R1 had fallen in the morning. Anonymous EMT-P informed Surveyor they weren't getting any information, so they did vital signs, and transferred R1 onto the cot. Anonymous EMT-P informed Surveyor as they were rolling out, they finally were able to speak with a nurse. Anonymous EMT-P informed Surveyor they were told the fall happened at 10:30 a.m. & they were called at 2:00 p.m. Anonymous EMT-P stated Resident is [AGE] years old, on blood thinners, hit her head, one of the biggest emergencies, very dangerous can lead to brain bleed and death. Anonymous EMT-P informed Surveyor they got her to the hospital soon after. On 11/4/25, at 1:04 p.m., Surveyor asked RN/NS-O if she was aware NP-K assessed R1's range of motion after the fall but did not come back until told after lunch to complete the assessment. RN/NS-O informed Surveyor she wasn't aware NP-K didn't come right back and assumed NP-K did. Surveyor informed RN/NS-O Surveyor did not locate a RN assessment. RN/NS-O stated its hindsight but I should of told [Name of LPN-N] to send R1 out. Surveyor reviewed the ambulance report and noted the call was received on 10/16/25 at 14:41 (2:41 p.m.) and the ambulance crew arrived at the patient at 14:58 (2:58 p.m.). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/5/25, at 8:32 a.m., Surveyor asked LPN-N after resident falls when are neuro checks completed. LPN-N provided Surveyor with a blank neurological flow sheet stating she can't remember so she uses the paper. Surveyor noted vitals signs and neuro checks are completed at the time of event, q (every) 30 minutes x (times) 2, q 1 hour x 4, q shift x shift. Surveyor asked LPN-N about R1's neuro checks on 10/16/25 as Surveyor noted a 30-minute neuro check was not completed. LPN-N informed Surveyor they were doing the neuro checks wrong as they were including the time of event as one of the 30-minute neuro checks. LPN-N stated now I know how to do it. No additional information was provided. 2.) R2's Treatment Administration Record (TAR) documented the following physician order: Obtain stool sample to test for C diff (Clostridium Difficile) every shift - 9/15/25. Discontinue order once obtained. Surveyor located no evidence the facility followed up on the above physician order, no stool sample was obtained and sent to lab, and there was no documentation anywhere in R2's medical record regarding the order except for the TAR. On 11/3/25 at 3:30 PM, Surveyor spoke with the infection control nurse Registered Nurse (RN) Supervisor-O. RN Supervisor-O reported she was not aware and was not notified of the order to check for C diff. Surveyor and RN Supervisor-O reviewed R2's medical record and 24 hours boards. There was no documentation the facility followed up on the order to obtain a stool sample to check for C Diff. On 11/4/25 at 10:52 AM, Nursing Home Administrator (NHA)-A was advised of concern the facility did not follow through on the physicians order to check R2's stool for C Diff. No additional information was provided. 3.) The facility's undated Neurological Observation policy and procedure documents: A. Policy: Licensed nurse will monitor and record an individual's neurological status as indicated. B. Procedure: Neurological observation is to be done per the following Neurological Check Schedule, unless otherwise specified by a physician order. 1.At time of event 2.Q 30 minute x2 3. Q 1 hour x4 4. Q shift x3. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3 was admitted to the facility on [DATE] with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side(complete paralysis on one side of body and partial/incomplete weakness on one side following stroke), Atherosclerotic Heart Disease of the Native Coronary Artery(plaque buildup narrows the arteries that supply blood to the heart), Chronic Kidney Disease(progressive damage and loss of function in the kidneys), Chronic Obstructive Pulmonary Disease(lung disease that block airflow and make it difficult to breathe), Epilepsy(disorder in which nerve cell activity in brain is disturbed causing seizures) Anemia(lack of blood), Dysphagia(difficulty swallowing foods) and Depression(mood disorder that causes persistent feelings of sadness and loss of interest). R3's 5-day Minimum Data Set(MDS) completed 8/25/25 documents R3's Brief Interview for Mental Status score to be 11, indicating R3 is moderately cognitively impaired. On 6/30/25, R3 had an unwitnessed fall in the bathroom. Surveyor reviewed R3's electronic medical record(EMR) and the facility's unwitnessed fall investigation. There is no documentation that neurological checks were completed on R3. On 7/12/25, R3 had an unwitnessed fall in the room attempting to close the blinds. Surveyor reviewed R3's electronic medical record(EMR) and the facility's unwitnessed fall investigation. There is no documentation that neurological checks were completed on R3. On 11/4/25, at 8:22 AM, Director of Nursing (DON)-B confirmed to Surveyor that there are no documented neurological checks for both R3's falls on 6/12/25 and 7/12/25. On 11/4/25, at 1:16 PM, Registered Nurse/Supervisor (RN)-O stated that neurological checks should be started and completed for any unwitnessed fall because you don't know if they hit their head. On 11/4/25, at 3:04 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, DON-B, and Sister Facility NHA (SFNHA)-C that neurological checks had not been started and completed for R3's unwitnessed falls on 6/30/25 and 7/12/25. No additional information has been provided by the facility as to why neurological checks were not started and completed for R3's unwitnessed falls on 6/30/25 and 7/12/25.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety 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 the comprehensive assessment of a resident, the facility did not ensure that residents receive care, consistent with professional standards of practice, to prevent pressure injuries and do not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable; and residents receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 2 of 2 (R2 and R4) residents reviewed for pressure injuries. R2 admitted to the facility without pressure injuries and was identified to be at risk for pressure injuries. Care plan interventions to prevent pressure injuries were not implemented. R2 developed a facility acquired unstageable pressure injury and the care plan was not revised. Treatments were not completed as ordered and the wound became infected requiring debridement, antibiotic treatment, and a wound vacuum. The facility's failure to provide interventions and treatment for the prevention of pressure injuries for R2 created a finding of immediate jeopardy that began on 8/25/25. Surveyor notified NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the immediate jeopardy on 11/5/25 at 12:15 PM. The immediate jeopardy was removed on 11/6/25 when the facility completed an IJ removal plan. The deficient practice continues at a scope and severity of a D (potential for harm/isolated) based on the following example of additional noncompliance not at the level of immediate jeopardy: R4 was identified to be at risk for pressure injuries. Care plan intervention for offloading heels was observed not implemented while on survey. Findings include: The facility Policy and Procedure titled Pressure Injury Prevention and Managing Skin Integrity review date 5/8/25 documents: I. Prevention measures are put in place to reduce the occurrence of pressure injuries. 1. Risk Assessment a. Upon admission: Braden Scale will be completed to evaluate individual's risk for developing a pressure injury at admission, and weekly for four weeks for all new admissions. b. Re-evaluation. Braden Scale will be completed upon change of condition and quarterly. c. Based on the individual's Braden Scale Score, pressure reduction interventions will be implemented by nursing and documented in the individual's medical record. 2. Identify Interventions and Care Plan a. Identify interventions (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	i. The care and intervention for any identified skin breakdown or wound is intended to prevent any further advancement of the wound or additional skin breakdown. 1. There will be collaboration with the interdisciplinary (IDT) regarding the presence of breakdown and the intervention plan. b. Care Plan i. In developing a plan of care, the following will be considered: Individual pressure injury history, cognitive changes or impairment of the individual, current state of skin integrity and personal hygiene practices of the individual that impact skin health, any cultural practices that impact the health or integrity of the skin, risk for pressure ulcer development (Braden Scale). 4. Weekly Wound Rounds iii. Update the Care Plan with any new interventions as applicable. 1.) R2 admitted to the facility on [DATE] with diagnoses that included right femur fracture, atrial fibrillation, chronic kidney disease stage 4, type 2 diabetes mellitus, depression, gout, and hypothyroidism. R2's admission Minimum Data Set (MDS) dated [DATE] documented: Functional Limitation in Range of Motion lower extremity (hip, knee, ankle, foot) – impairment on one side. Mobility – the ability to roll from lying on back to left and right side and return to lying on back on the bed – partial/moderate assistance. R2's documented Brief Interview for Mental Status (BIMS) score of 15 indicates R2 is cognitively intact. R2's admission assessment dated [DATE] documented: Skin integrity - right thigh (rear) surgical incision, scattered bruising. Skin color normal, warm, turgor normal. Surveyor noted there were no other skin issues, wounds, or pressure injuries documented. The admission assessment also documented: Incontinent bowel and bladder greater than 1 year. Day/NOC (night) large amount. R2's Braden Scale for Predicting Pressure Ulcer Risk dated 8/8/25 documented a score of 18, indicating that R2 is at risk for the development of pressure injuries. Surveyor questioned the accuracy of R2's Braden assessment as R2 was marked as walks occasionally when in fact R2 was non-ambulatory upon admission. R2 was also marked for friction shear as potential problem/minimal assist, when in fact R2 required moderate assist with bed mobility. Interviews with staff and therapy confirmed the above and Director of Nursing (DON)-B agreed some areas in R2's Braden assessment may have been marked incorrectly. Surveyor also noted that R2 did not have a Braden assessment completed weekly for 4 weeks per the facility's pressure injury policy listed above. Although R2 was identified to be at risk for pressure injuries and needed assist with bed mobility, Surveyor noted that no care plan interventions were implemented to prevent pressure injuries to include offloading or how often she was to be turned and repositioned. In addition, R2 was incontinent of bowel and bladder and there were no care plan interventions related to toileting or how often she was to be checked and/or changed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's care plan documented: The resident has potential/actual impairment to skin integrity of the r/t (related to) fragile skin incontinence – initiated 8/6/25. Interventions: Encourage good nutrition and hydration in order to promote healthier skin. Keep skin clean and dry. Use lotion on dry skin – initiated 8/14/25. The resident has functional bladder incontinence r/t Activity Intolerance, Impaired Mobility initiated 8/6/25. Interventions: Barrier cream as ordered. Clean peri-area with each incontinence episode. Monitor skin for signs of skin breakdown related to incontinence. The resident has limited physical mobility r/t right femoral fracture – initiated 8/6/25. Intervention: The resident is weight bearing as tolerated for transfers only, then toe touch weight bearing with LLE (left lower extremity) when using Sara Steady. The resident has an ADL (Activity of Daily Living) self-care performance deficit r/t Activity Intolerance - initiated 8/8/25. The resident requires left and right mobility bars to turn and reposition in bed as necessary – initiated 8/8/25. Turn and reposition every 2-3 hours, if resident allows. Offload sacral area with pillow, due to pressure ulcer – initiated 8/25/25. The resident is able to transfer and ambulate in room with 1 assist and a 2ww (wheeled walker) – initiated 9/2/25. The resident has actual impairment to skin integrity of the r/t fragile skin incontinence - revision on 8/15/25. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. The resident has actual impairment to skin integrity of the r/t fragile skin incontinence Sacrum unstageable PI (pressure injury) 8/15/25. Revision on 8/27/25. (Surveyor noted there were no new care plan interventions in this section. Offloading, turning, and repositioning were added to the ADL care plan on 8/25/25). On 11/3/25 at 1:55 PM, Surveyor spoke with Certified Nursing Assistant (CNA)-I who reported she took care of R2 from day one. CNA-I reported R2 needed assist to turn in bed, and she had to physically roll her so she could hold onto the grab bar. She remembered R2 complained of pain to her coccyx and her coccyx was really red and maybe had a tiny sore. CNA-I advised Surveyor she told the nurse but could not remember when or which nurse she told. On 8/15/25, Facility Progress notes (entered by DON-B) documented: Resident c/o (complained of) coccyx pain. On assessment noted to have Stage 2 PI (Pressure Injury) 2 cm (centimeters) x 0.2 cm x 0.1cm. Wound bed with white tissue. No drainage or odor. Covering NP (Nurse Practitioner) updated. Surveyor interviewed DON-B and asked her to describe what the wound looked like. DON-B said she was not a wound expert, but remembered the wound was small and had like white tissue, kind of stringy like. Surveyor asked DON-B if she knew what slough looks like, DON-B replied no. DON-B reported she described the wound to the doctor, and she ordered Medi honey with border foam daily. R2's pressure injury was followed by the facility Wound Advance Practice Nurse Practitioner (APNP)-R. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/18/25, Wound APNP-R's wound notes documented: Unstageable pressure injury to the sacrum full-thickness wound measuring 1.5 cm (centimeter) x 1.0 cm by UTD (unable to determine). The base is 100% slough covered with a moderate amount of serosanguineous drainage. Peri wound intact. No signs or symptoms of infection. Plan: Medi honey on bordered foam change daily. Continue pressure redistribution with alternating pressure mattress. Maintain strict turning and repositioning schedule every 2-3 hours. Recommend alternating pressure mattress and offloading boots. Pressure relieving cushion for sitting. Ensure heels are properly offloaded at all times using heel offloading boots. Apply barrier cream to intact skin at risk for breakdown. Assess all pressure points during each care session. Monitor for signs of infection including (erythema, warmth, purulence, drainage or odor) Surveyor noted that although R2 was identified to have a facility acquired unstageable pressure injury, the care plan was not revised to include new interventions or a schedule for offloading, turning and repositioning, toileting, or checking/changing for incontinence. None of Wound APNP-R's recommended interventions were added to R2's care plan. Surveyor did confirm an APM (alternating pressure mattress) was delivered for R2 on 8/20/25. Surveyor reviewed a grievance filed by R2 on 8/25/25. The resident complained that on 8/23/25, she was not changed at all on NOC (night) shift from 10 PM - 6 AM. Staff statement the next morning documented R2's bed was completely soaked, the brief was falling apart and she had to do a complete bed change. The CNA assigned to R2 that night was terminated. The termination notice documented: Complete and thorough investigation substantiates a lack of quality resident care. Resident was not changed/checked on entire NOC shift. Resolution description: Care plan updated to check and change and reposition resident every 2-3 hours. Surveyor noted this care plan intervention was implemented on the ADL care plan as the grievance resolution. On 8/25/25, Wound APNP-R's wound notes documented: Patient is sitting up in her wheelchair, she states that her wound is causing a great deal of discomfort. She reports that it limits her mobility. Unstageable pressure injury to the sacrum, full-thickness wound measuring 2.4 cm x 1.6 cm x 2.0 cm. Tunnel at 12:00 about 2.7 cm, the base is 100% slough covered with a moderate amount of malodorous purulent drainage. Peri wound with erythema and warmth. Status: Evolving-debrided. Plan: Dakin's moist Kerlix cover with border gauze change twice daily. Wound infection. Erythema, pain, odor, purulence. Plan: Culture could not be taken due to necrotic tissue within the wound. Begin Flagyl 500 mg (milligrams) 3 times daily and Doxycycline 100 mg twice daily both x 14 days. Anatomic location of debridement: Coccyx. Necrotic tissue. Type of tissue removed: Subcutaneous tissue. Selective debridement fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm. Percent of wound bed debrided 100%. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/4/25 at 8:00 AM, Surveyor spoke with Wound APNP-R and asked if she was aware that on 8/23/25, R2 was not changed or checked on the entire night shift (8 hours) and in the morning her bed was completely soaked, and the brief was falling apart. Wound APNP-R reported she was not sure if she was specifically made aware but recalled discussion to add to the care plan that R2 be checked and changed at 2 or 3 AM. (Surveyor noted this was not added to R2's care plan). Surveyor asked Wound APNP-R, if R2 was lying in bed, incontinent, and not changed or repositioned for a period of 8 hours, did she think this contributed to the pressure injury decline and infection that was identified 2 days later. Wound APNP-R reported she could not say specifically that the 8/23 occurrence led to the decline and infection of the wound. Wound APNP-R stated, Could it have? Maybe - but wounds get infected even if good incontinence care is provided. On 9/2/25, Wound APNP-R's wound notes documented: Patient is in bed laying on her right side. She states the pain to her wound is improved greatly stating last week she had a hard time sitting but not this week. Unstageable pressure injury to the sacrum full-thickness wound measuring 2.5 cm x 1.6 cm x 2.0 cm. Undermining 11-2:00~1.4 cm. The base is 100% granular with a moderate amount of serous drainage. Peri wound intact. No s/s (signs or symptoms) of infection. Status: improved. Plan: order wound vac and place with black foam. Change 3x/wk (week) and prn (as needed) until wound vac arrives gently pack calcium alginate and cover with border gauze, change daily. Wound infection resolved. On 9/8/25, Wound APNP-R's wound notes documented: Patient is just returned from therapy she transfers to her bed for evaluation. She states her buttocks feels a lot better - states she has no pain to her buttocks. Stage 3 pressure injury to the sacrum full-thickness wound measuring 2.5 cm x 1.6 cm x 1.5 cm. undermining 10-1:00~1.9 cm. The base is 100% granular with a moderate amount of serous drainage. Peri wound intact. No s/s of infection. Status: Improved. Plan: Wound vac change 3x/wk. On 9/15/25, Wound APNP-R's wound notes documented: Patient is just finished working with therapy she lays down in bed on her right side. She denies pain to her wound. She would like to get rid of the wound VAC as soon as possible. Family are looking to take patient home later this week. Stage 3 pressure injury to the sacrum full-thickness wound measuring 2.5 cm x 1.3 cm x 1.1 cm. Undermining 11-1:00~0.9 cm. The base is 100% granular with a moderate amount of serous drainage. Peri wound intact. No s/s of infection. Status: Improved. Plan: Wound vac change 3x/wk. When patient discharges home please discontinue wound VAC and begin Hydrofera Blue to ready followed by bordered foam 3 times a week. Surveyor noted the order to discontinue the wound vac prior to discharge and begin Hydrofera Blue was not transcribed, and therefore not completed. R2's progress notes on 9/20/25 at 1:05 PM documented: Resident discharged to home. Discharge paperwork discussed no concerns noted. Requested wound vac be removed before going home. Remove per request with education in regard to importance of wound vac. Wound cleaned dried with dressing intact. Surveyor noted facility staff removed the wound vac prior to discharge on ly after R2's request and there is no documentation of what type of dressing was placed on the wound prior to discharge. Surveyor review of R2's August 2025 TAR (Treatment Administration Record) documented: Pack wound with Dakin's-soaked gauze, then cover with bordered gauze dressing two times a day for wound care - ordered 8/25/25. Surveyor noted the treatment was not signed out as having been completed on 8/26 AM, 8/27 PM, 8/29 PM, 8/31 PM, and 9/1 PM. On 8/28 PM it was entered as 9 (other/see progress notes). Surveyor located no documentation in R2's progress notes as to why the treatment was not completed as ordered. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/4/25 at 9:00 AM, Surveyor spoke with Registered Nurse (RN) Supervisor-O. She reported she spoke with R2's family often. Surveyor asked if R2's family reported any concerns. RN Supervisor-O stated, Yes, her family reported concerns with the treatment not being done BID (twice daily) and Dakins not used. Surveyor noted on 8/30/25, R2's treatment order on the TAR was rewritten to include instructions dressing date and time written on bandage two times a day for wound care. RN Supervisor-O advised Surveyor the order was rewritten to include date/time on the dressing because of R2's family reporting the treatment was not being done BID. RN Supervisor-O informed Surveyor that when she looked into it, she found out that the nurses did not know where to find the Dakins solution. Surveyor asked how long the nurses were not able to find the Dakins and were not using it. RN Supervisor-O stated, About a week. Surveyor asked what the nurses were using for the treatment if they were not using the (ordered) Dakins solution. RN Supervisor-O stated, I don't know, probably normal saline. Surveyor located no documentation the Physician was notified Dakins solution was not being used as ordered. On 11/4/25 at 10:52 AM, Surveyor advised Nursing Home Administrator (NHA)-A of concerns: R2 admitted to the facility without pressure injuries and was identified to be at risk. No care plan interventions were implemented to prevent pressure injuries, to include offloading, turning and repositioning, toileting and/or checking/changing for incontinence. R2 developed a facility acquired unstageable pressure injury which declined and became infected 2 days after the resident was found to have not been not checked or changed for a period of 8 hours. After the pressure injury was identified, Wound APNP-R's recommended interventions were not implemented, and the care plan was not revised with any new interventions until after the pressure injury declined and became infected. In addition, R2's treatment was not consistently completed as ordered. No additional information was provided. On 11/4/25 at 3:00 PM, during the daily exit meeting with NHA-A, DON-B, and Sister Facility NHA-C, Surveyor advised of the above concerns. On 11/5/25 at 8:35 AM, NHA-A was advised Surveyors would be having a call to discuss R2's pressure injury concern. On 11/5/25 at 12:15 PM, NHA-A, DON-B and Sister Facility NHA-C were advised of the immediate jeopardy. The facility's failure to provide interventions and treatment for the prevention of pressure injuries for R2 created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy that began on 8/25/25. Surveyor notified NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the immediate jeopardy on 11/5/25 at 12:15 PM. The immediate jeopardy was removed on 11/6/25 when the facility completed an IJ removal plan, however, the deficient practice continues at a scope and severity level of D (potential for harm/isolated) based on the example for R4 and as the facility continues to implement the following action plan: - All other residents in the facility are at risk for developing a pressure ulcer, especially those bed ridden or a Braden higher than I0. - A facility-wide skin sweep audit was completed for all in house residents on November 5th and 6th 2025 to identify anyone with existing or potential pressure injuries. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Residents Braden assessments were completed for all in house residents on November 5ht and 6th 2025. - Pressure ulcer prevention interventions were verified for all at-risk residents, including care plan updates if needed. If a new intervention was needed, it was implemented. - Reviewed the Illuminus policy to ensure compliance with CMS and Wisconsin DBS guidance. Policy is appropriate. - Re-educated all nursing staff on: - Wound Nurse, via nurse consultant, on proper process for staging wounds and the required weekly documentation of each wound and a entered intervention. - Pressure injury prevention and skin Integrity. This includes accurate and timely documentation of skin assessments and treatments. - Importance of repositioning, offloading, and movement. - Facility will audit up to 4 residents with wounds a week. Focus on proper staging and documentation. - DON and/or designee with be responsible for these audits. All results will be repo1ied to QAPI committee for future action or adjustment. - Our practice is to follow National Pressure Ulcer Advisory Panel Standards along with the Critical Element Pathway (CEP-for pressure injuries). - Our WCC nurse is credentialed by the wound care educational institute. (WCEI) No additional information was provided. 2.) R4 was admitted on [DATE] with diagnoses of Hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side (complete and partial loss of movement on right side of the body after ischemic stroke – decreased blood flow to the brain causing lasting physical and mental deficits), Aphasia (inability to understand or speak), Dysphagia (difficulty swallowing), weakness, and need For Assistance with Personal Care. R4's Quarterly Minimum Data Set (MDS) completed 9/12/25 documented that R4 has severe cognitive impairment with a Brief Interview Mental Status score (BIMS) score of 3. The MDS also documents: R4 has unclear speech and is sometimes understood; R4 has impairment on one side upper and lower; R4 eats independently, requires partial to moderate assist for hygiene, showering, dressing, toileting, and bed mobility; R4 requires set up to supervision assist for all transfers. R4's Kardex as on 11/3/25, which instructs Certified Nursing Assistants (CNA) in the care for R4, documented: - Skin Integrity (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Resident will at times decline cares; offer to come back, reapproach, different staff, to provide care as allowed. Document declines and reapproach prn (as needed). o Pressure redistributing w/c (wheelchair) cushion o Pressure relieving mattress encourage heel off loading (declines heel boots) air flow mattress with heel pressure reduction. R4's comprehensive care plan for R4 documented: - The resident has potential impairment to skin integrity r/t (related to) fragile skin, assisted to reposition, incontinence, immobility and hx of skin altercation. Scar tissue present to right buttock from prior healed area. Date initiated 6/9/25, revised 8/19/25. o Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Date Initiated 6/9/25. o Resident will at times decline cares; offer to come back, reapproach, different staff, to provide care as allowed. Document declines and reapproaches prn. Date Initiated 11/3/25. o Pressure redistributing w/c (wheelchair) cushion. Date initiated 6/9/25 o Pressure relieving mattress encourage heel off loading as allows (declines heel boots) air flow mattress with heel pressure reduction. Date initiated 6/9/25, revised on 8/19/25. o The resident needs pressure relieving mattress to protect the skin while IN BED. Initiated on 10/8/25, revised on 11/3/25. R4's Braden scale for Predicting Pressure Sore Risk assessment dated [DATE] documents a score of 12, indicating that R4 is at high risk for the development of pressure injuries. R4's Braden scale for Predicting Pressure Sore Risk assessment dated [DATE] documents a score of 14, indicating that R4 is at high risk for the development of pressure injuries. This assessment was added as a late entry at 1:13 PM on 11/3/ 25 By Director of Nursing (DON)-B. On 11/3/25, at 9:49 AM, Surveyor spoke with R4 who is able to communicate with head nods and left-handed gestures. R4 nodded yes to staying in bed the majority of times and nodded no to getting out of bed generally. R4 nodded no to getting out of bed for activities. R4 nodded yes to being able to scoot and reposition self while in bed. When asked if staff helps R4 reposition, R4 shakes his hand side to side and squints eyes. Surveyor asked R4 if R4 refuses the care from staff, R4 nodded yes and grunts. Surveyor asked R4 if R4 likes to be left alone and do things in the room, R4 nodded yes. Surveyor gave R4 the opportunity to write if R4 had anything additional to add. R4 nodded no. Surveyor observed R4's heels were not offloaded to prevent the development of pressure injuries and pressed against the footboard. On 11/3/25, at 10:38 AM, Surveyor observed R4 in Bed. R4's heels were not offloaded to prevent the development of pressure injuries and pressed against the footboard. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/3/25, at 11:33 AM, Surveyor observed R4 in Bed. R4's heels were not offloaded to prevent the development of pressure injuries and pressed against the footboard. On 11/3/25, at 12:24 PM, Surveyor observed R4 in Bed. R4's heels were not offloaded to prevent the development of pressure injuries and pressed against the footboard. On 11/3/25, at 1:26 PM, Surveyor observed R4 in Bed. R4's heels were not offloaded to prevent the development of pressure injuries and pressed against the footboard. On 11/3/25, at 1:36 PM, Surveyor interviewed Certified Nursing Assistant (CNA) -E who stated they have worked at this facility for 3 years and the hallway R4 is on is where they normally work. CNA-E stated R4 needs help with everything except eating. CNA-E stated R4 can adjust self in bed. CNA-E states R4 refuses repositioning and other cares like getting washed up and changing clothes. CNA-E stated CNAs are to tell the nurse of the refusal and then the nurse is supposed to chart the refusal because CNAs cannot make notes in the electronic medical record (EMR). On 11/3/25, at 3:17 PM, Surveyor interviewed CNA-L who has worked at the facility since December 2024 and floats around to all units, but has provided care for R4 frequently. CNA-L states R4 stays in bed mostly and refuses repositioning and will remove pillows, but can adjust self in bed. CNA-L stated when residents refuse CNAs are to inform the nurse so the nurse can document the refusal and help reapproach. CNA-L informed surveyor CNA-L reports the refusals to the nurses but does not think the refusals get documented. Surveyor noted that there are no documented refusals for pillows under R4's feet or that R4 refused repositioning. Surveyor also noted that R4 does not have a care plan in place for when R4 refuses cares until 11/3/25, when the survey started. On 11/4/25, at 7:35 AM, Surveyor observed R4 sleeping in bed on R4's back, R4's heels not offloaded to prevent the development of pressure injuries and pressed against the footboard. On 11/4/25, at 8:52 AM, Surveyor observed R4 laying on R4's back and R4's heels are not offloaded to prevent the development of pressure injuries and pressed against the footboard. On 11/4/25, at 9:56 AM, Surveyor observed R4 in bed and R4's heels are not offloaded to prevent the development of pressure injuries and pressed against the footboard. On 11/4/25, at 10:58 AM, Surveyor observed R4 in bed and R4's heels not offloaded to prevent the development of pressure injuries and pressed against the footboard. On 11/4/25, at 11:02 AM, Surveyor interviewed CNA-E who stated the Kardex is used to indicate what cares each resident are ordered to receive. CNA-E stated they view the Kardex 'all the time'. When asked when the last time CNA-E viewed R4's Kardex CNA-E stated 'it's been awhile' and that R4 has been the same since R4 came here so there isn't a need to look at the Kardex and the interdisciplinary team is very good at updating the staff verbally and passing new information off in report. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/4/25, at 11:18 AM, Surveyor overheard a conversation between Licensed Practical Nurse/Nurse Supervisor (LPN/NS)-G and CNA-E. CNA-E walked up to LPN/NS-G and asked if LPN/NS-G removed the pillows from under R4. LPN/NS-G stated LPN/NS-G did not remove the pillows and only removed the straws. CNA-E stated all morning when CNA-E goes into the room, the pillows from under R4 are removed. LPN/NS-G told CNA-E to tell the nurse so that the nurse can document R4's refusal to be repositioned and have pillows placed. On 11/4/25, at 12:40 PM, Surveyor observed R4 in bed eating lunch, R4's heels are not offloaded to prevent the development of pressure injuries. On 11/4/25, at 12:44 PM, Surveyor interviewed DON-B on expectations on the CNAs rounding on the units and expectations on refusing. DON-B expects CNAs to do rounding as soon as the CNAs walk in, to loom into the rooms and observe the residents and the room and both should be 'presentable'. DON-B defined presentable as in room not dirty, garbage taken out, residents comfortable and clean, check to see if the residents need anything and call light in reach. DON-B stated when residents refuse cares that the CNAs should notify the nurse, and the nurse is expected to document and reapproach and document the outcome. On 11/4/25, at 1:39 PM, Surveyor observed R4 in bed and R4's heels are not offloaded to prevent the development of pressure injuries. On 11/4/25, at 3:03 PM, Surveyor shared R4 has been observed with heels not offloaded as documented on R4's Kardex and care plan with Nursing home administrator (NHA) -A, DON -B, and Sister Facility NHA-C. No additional information was provided as to why R4 has not had R4's heels offloaded to prevent the development of pressure injuries. On 11/4/25, at 3:40 PM, Surveyor noted R4 in bed and R4's heels were not offloaded to prevent the development of pressure injuries. On 11/5/25, at 8:21 AM, Surveyor reviewed R4's progress notes and did not see any refusal documentation from 11/4/25 for refusing repositioning and pillows. On 11/5/25, at 8:42 AM, Surveyor observed R4 in bed and R4's heels were not offloaded to prevent the development of pressure injuries. No additional information was provided.

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F 0689 Level of Harm - 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 supervision and safety to prevent an accident from occurring for 3 of 3 Residents (R1, R3, and R4) reviewed for accidents. *R3 had 10 unwitnessed falls, 3 were not thoroughly investigated for a root cause. On 7/19/25, R3 had an unwitnessed fall in which R3 sustained a left hip fracture. *R1's fall on 10/16/25 was not thoroughly investigated for a root cause. R1's fall interventions of brushing teeth after lunch, toileting schedule, call light in reach, and transferring using a gait belt were observed not to be implemented. *R4's call light was observed to not be within reach and received straws which R4 should not have due to an aspiration risk during the survey process. Findings Include: The facility's undated Falls policy and procedure documents: Policy: Prevention measures are put in place to reduce the occurrence of falls and risk of injury from falls. Procedure: 1.Fall Risk: a. Licensed nurse will complete an electronic Fall Assessment upon admission. b. A licensed nurse will complete a Fall Assessment quarterly, or with change in condition. c. A licensed nurse will determine the individuals' risk for falls and individualized care needs. If the individual is at risk for falls, then create a falls care plan. 3.Administrative Review a. The Interdisciplinary Team (IDT) will review fall incident report and utilize root cause analysis to make further recommendations. 1.) R3 was admitted to the facility on [DATE] with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side (complete paralysis on one side of body and partial/incomplete weakness on one side following stroke), Atherosclerotic Heart Disease of the Native Coronary Artery (plaque buildup narrows the arteries that supply blood to the heart), Chronic Kidney Disease (progressive damage and loss of function in the kidneys), Chronic Obstructive Pulmonary Disease (lung disease that block airflow and make it difficult to breathe), Epilepsy (disorder in which nerve cell activity in brain is disturbed causing seizures) Anemia (lack of blood), Dysphagia (difficulty swallowing foods) and Depression (mood disorder that causes persistent feelings of sadness and loss of interest). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's 5-day Minimum Data Set (MDS) completed 8/25/25 documents R3's Brief Interview for Mental Status (BIMS) score to be 11, indicating R3 is moderately cognitively impaired. R3's MDS documents: R3 has no mood or behavior issues; R3 is setup for eating; R3 requires partial/moderate assistance for lower dressing, mobility, and transfers; R3 requires supervision for upper dressing; R3 is frequently incontinent of bladder and always continent of bowel. R3's Fall Care Area Assessment (CAA) dated 8/6/25 does not document any pertinent information. R3's fall assessment dated [DATE] documents a score of 10, indicating that R3 is at high risk for falls. R3's fall assessment dated [DATE] documents a score of 11, indicating that R3 is at high risk for falls. R3's fall assessment dated [DATE] documents a score of 18, indicating that R3 is at high risk for falls. R3's fall assessment dated [DATE] documents a score of 13, indicating that R3 is at high risk for falls. R3's fall assessment dated [DATE] documents a score of 17, indicating that R3 is at high risk for falls. R3's fall assessment dated [DATE] documents a score of 15, indicating that R3 is at high risk for falls. R3's Kardex as of 11/3/25 documents: Fall 9/1/25 Non-slip socks on while in bed if R3 allows Fall 8/12/25 Ensure room temperature is adjusted to R3's preference Fall 7/19/25 Staff to check on R3 every 30 minutes while in room Fall 7/17/25 Remind spouse to let staff know if R3 is ambulating unassisted while she is visiting with R3 Fall 7/12/25 Staff to offer to close R3's blinds as desired at HS Fall 6/30/24 Urinal at bedside Fall 6/24/25 R3 to be in common area when in wheelchair if permitted Fall 6/19/25 Call don't fall sign Fall mat at bedside while R3 in bed PT/OT evaluate and treat as ordered or as needed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3 needs a safe environment Transfer Status: assist of 1 with 2 wheeled walker Toilet Use: R3 is 1 assist with 2 wheeled walker or bathroom grab bar for toileting Be sure R3's call light is within reach and encourage R3 to use it for assistance as needed. R3 needs prompt response to all requests for assistance. Ensure that R3 is wearing appropriate footwear, non-skid when ambulating, transferring, or mobilizing in wheelchair. R3's comprehensive care plan documents R3 is high risk for falls due to deconditioning, gait/balance problems. Initiated 6/19/25 Revised 8/6/25 Be sure R3's call light is within reach and encourage R3 to use it for assistance as needed. R3 needs prompt response to all requests for assistance. 6/19/25 Ensure that R3 is wearing appropriate footwear, non-skid when ambulating, transferring, or mobilizing in wheelchair. 6/20/25 R3 needs a safe environment 6/20/25 Fall 9/1/25 Non-slip socks on while in bed if R3 allows 10/22/25 Fall 8/12/25 Ensure room temperature is adjusted to R3's preference 8/19/25 Fall 7/19/25 Staff to check on R3 every 30 minutes while in room [ROOM NUMBER]/21/25 Fall 7/17/25 Remind spouse to let staff know if R3 is ambulating unassisted while she is visiting with R3 7/27/25 Fall 7/12/25 Staff to offer to close R3's blinds as desired at HS 7/17/25 Fall 6/30/24 Urinal at bedside 6/30/25 Fall 6/24/25 R3 to be in common area when in wheelchair if permitted 6/24/25 Fall 6/19/25 Call don't fall sign 6/20/25 Surveyor noted that on 3/21/25 R3's Fall Assessment documented R3 is high risk for falls but a care plan was not implemented until 6/19/25 with the first fall. A continence evaluation completed 10/18/25 does not document a specific bowel/bladder program implemented for R3. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed the facility investigations of R4's 10 falls: 6/19/25- R3 had an unwitnessed fall at 9:45 PM in the bathroom and R3 stated R3 was trying to use the bathroom. The investigation documents 1 person got R3 up off the floor of the bathroom. 6/24/25- R3 had an unwitnessed fall at 4:15 PM. R3 stated R3 was trying to go to the bathroom and lost balance. 6/30/25- R3 had an unwitnessed fall at 2:35 PM. R3 was found sitting on the floor of the bathroom. R3 stated R3 was trying to get on the toilet. R3's emergency contact was not updated. Neurological checks were not completed. 7/4/25-R3 had an unwitnessed fall at 9:45 AM. R3 was observed on the floor of the bathroom. R3 stated R3 was attempting to toilet self. The facility did not obtain any staff statements. The intervention of a bedside commode was initiated, however, R3 refused the bedside commode, and no new intervention was implemented. 7/12/25-R3 had an unwitnessed fall at 8:00 PM. R3 fell trying to close the blinds. R3's emergency contact was not updated, neurological checks were not completed, and the facility did not obtain statements from staff. 7/17/25- R3 had an unwitnessed fall 5:00 PM. R3 was trying to get to the bathroom. 7/19/25- R3 had an unwitnessed fall at 1:45 PM. R3 was trying to get to the bathroom. A facility reported incident was completed and submitted to the State Survey Agency. The summary of the fall stated that R3 was found in R3's room on the floor with blood coming from R3's head. The summary stated R3 was continent of bowel and bladder at the time of the occurrence. R3 was last seen in bed between 1:15 and 1:30 PM. When last observed, R3 had R3's call light within reach. R3's call light was activated when staff entered the room. The sign was up to call for help and R3's walker was at bedside. The summary documents R3 had a hematoma sized 2x1 inch on the left side of R3's head. R3 complained of hip pain. Neuro-checks were initiated. Physician gave order to send R3 out to the hospital for further evaluation. The summary documents that the room was clean and with no clutter and R3 had socks (does not document if non-skid) on at the time. The facility assessment documented left trochanter (hip) fracture. R3's family arrived to the facility and confirmed that the hospital had informed family R3 had broke R3's hip. Based on documentation in the summary of R3's fall the following interventions were in place: -call light within reach -the call don't fall sign was posted The intervention from 6/30/25 to have a urinal at bedside is not documented as being in place at the time of the fall on 7/19/25 Surveyor had observations during the survey process of the urinal not in place. The summary does not indicate if non-skid footwear initiated on 6/20/25 was in place at the time of the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted that the commode listed in the fall summary was not in place and removed on 7/7/25 because R3 refused the commode, but no other intervention was put into place when R3 refused. Surveyor noted R3 had five previous unwitnessed falls due to R3 attempting to ambulate to the bathroom prior to the 7/19/25 unwitnessed fall. Surveyor noted the hospital Discharge summary dated [DATE], documented R3 suffered a subcapital left femoral neck fracture-closed. Surveyor noted R3 was re-admitted from the hospital on 7/28/25 after sustaining a left hip fracture due to attempting to ambulate to the bathroom. Five days later, on 8/2/25, R3 had another unwitnessed fall attempting to ambulate to the bathroom. Upon return, the intervention initiated on 7/21/25 as a result of the fracture was to check on R3 every 30 minutes. The fall incident report completed on 8/2/25 does not document 30 minute checks being completed. 8/12/25- R3 had an unwitnessed fall at 2:00 PM. R3 was cold and trying to get a blanket. 9/1/25- R3 had an unwitnessed fall at 2:55 PM. R3 slid out of recliner and R3 stated R3 was trying to get to the bathroom. Surveyor noted the facility did not obtain staff statements for the 7/4/25 and 7/12/25 unwitnessed falls. Surveyor noted all of R3's falls except for two were the result of R3 attempting to ambulate to get to the bathroom. The facility did not complete a thorough investigation of the falls to establish a root cause analysis. The facility did not complete a bowel and bladder assessment to establish a toileting pattern, and the facility did not establish a pattern based on the times of the falls. Not establishing a root cause analysis of R3's falls resulted in R3 falling and resulting in a left hip fracture. On 11/3/25, at 10:27 AM, Surveyor observed R3 sitting in R3's recliner with call light within reach. R3 is aware that R3 is to get assistance when needing to get to the bathroom. On 11/4/25, at 7:25 AM, Surveyor observed R3 in bed, call light is within reach, and there is a mat next to the bed on the left side. The bed is pushed against the wall. Overbed table is next to the bed. Surveyor noted there is no urinal next to the bed as documented on R3's Kardex and care plan. On 11/4/25, at 9:10 AM, Surveyor observed R3 in bed eating breakfast and head of bed is elevated. There is no mat next to the bed and no urinal at bedside as documented on R3's Kardex and care plan. R3 stated that R3 had to get changed in the middle of the night. R3 confirmed R3 had no urinal last night and would use the urinal if the urinal was within reach. Surveyor observed no urinal in R3's room or bathroom. On 11/4/25, at 9:36 AM, Certified Nursing Assistant (CNA)-M confirmed R3's mat is down on the floor next to bed and CNA-M located the mat leaning up against the wall by the wardrobe. CNA-M confirmed the mat is supposed to be on the floor next to the bed when R3 is in bed. On 11/4/25, at 12:55 PM, Surveyor observed R3 in bed eating lunch. R3 states R3 got up later in the morning and then returned to bed. Surveyor observed the mat not down on the floor next to R3's bed and no urinal within reach of R3. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/4/25, at 1:16 PM, Surveyor interviewed Registered Nurse Supervisor (RN)-O in regard to R3's falls. RN-O has been new to the supervisor role since September. RN-O explained RN-O is supposed to be a part of a resident's fall investigation, but since RN-O is new to the role, RN-O is still learning the process. RN-O stated the expectation is that the CNAs do rounds at the beginning of their shift and make sure fall interventions are in place. RN-O has not been a part of establishing a root cause analysis for R3's 10 falls. RN-O stated that R3 can be impulsive and wants to be independent. RN-O stated the facility does not do a bowel/bladder patterning to in order to avoid falls. On 11/4/25, at 3:03 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Sister Facility (NHA)-C that R3 has had 10 falls with one resulting in a left hip fracture. Surveyor shared the serious concern that R3's fall investigations were not thoroughly investigated including not establishing a root cause analysis. Surveyor shared that all falls, but two, were because R3 was attempting to ambulate to the bathroom. Surveyor shared that the facility did not establish a bowel/bladder pattern along with time of day of the falls. Surveyor also shared that the mat and urinal at bedside interventions were observed during the survey process to not be in place. No additional information was provided. 2.) R1 was admitted with diagnoses that include chronic respiratory failure with hypoxia (long term condition where the lungs cannot supply enough oxygen to the blood resulting in low blood oxygen levels), dementia (loss of cognitive function that interferes with a person's daily life & activities), atrial fibrillation (irregular and rapid heartbeat), and anxiety disorder (group of mental health conditions characterized by excessive & persistent worry, fear, and nervousness that an interfere with daily life). R1's at risk for falls care plan initiated 6/24/24 & revised 6/25/25 documents the following interventions: *Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Initiated & revised on 6/24/24. *Ensure that the resident is wearing appropriate footwear (shoes/socks with non-skid soles) when ambulating, transferring or mobilizing in w/c (wheelchair). Initiated & revised 6/24/24. *PT/OT (physical therapy/occupational therapy) evaluate and trat as ordered or PRN (as needed) Initiated & revised 6/24/24. *The resident needs a safe environment with: (even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, handrails on walls, personal items within reach). Initiated & revised 6/24/24. *Fall 12-20-24-dycem to w/c (wheelchair) initiated 12/20/24. *4/5/25-fall-staff to assist resident with brushing teeth after lunch if permitted. Initiated 4/7/25. *4/5/25-fall-staff to offer toileting q (every) 2 to 3 hours and prn. Initiated 4/5/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*5/25/25-fall-staff to ensure resident not attempting to feed others when dining room. Initiated 5/25/25. *Fall-5/31/25-staff to ensure bed is made to resident's preference. Initiated 5/31/25. *10/16/25: Reacher at bedside to help with sorting dirty clothes from the laundry hamper if needed. Initiated 10/27/25. R1's fall CAA (care area assessment) dated 6/25/25 documents under the analysis of findings section: At risk for fall – dementia -arthritic pain assisted to safely transition surfaces meds (medication) taken have risk potential. For care plan considerations under describe impact of this problem/need on the resident and your rationale for care plan decision documents At risk for fall – new environment dementia – foot pain. Assisted to safely transition surfaces. Continue to care plan – Falls place at risk for serious injury and potential of hospital return. R1's quarterly MDS (minimum data set) with an assessment reference date of 9/19/25 documents a BIMS (brief interview mental status) score of 6 which indicates severe cognitive impairment. R1 is assessed as having no behavior including refusal of care. R1 is assessed as being independent for eating, partial/moderate assistance for toileting hygiene, chair/bed to chair transfer, & toilet transfer and substantial/maximal assistance for roll left and right. R1 is assessed as being frequently incontinent of urine and occasionally. R1 is assessed as not having any falls since prior assessment period. R1's nurses note dated 10/16/25, at 11:03 a.m., written by Licensed Practical Nurse (LPN)-N documents: Writer heard loud screaming from resident's room, someone from PT (physical therapy) stated res. (resident) is on the floor as writer proceeded to resident's room. Writer observed res. On the floor on right side. Resident last observed eating at 1000 (10:00 a.m.) with O2 (oxygen) on. Writer observed res. Without O2 reapplied. Writer made NP (Nurse Practitioner) aware NP came and observed res. On the floor and assessed res. Writer called [Name] res contact person. Staff assisted writer sic (resident) off floor after assessment. Ice pack applied to left side of head, res. With large purplish hematoma, also has purplish bruise area on left hand with skin tear, writer cleaned area and proximated skin and applied steri strips and dry dressing. Neuro check negative, rom (range of motion) wnl (within normal limits) to upper and lower extremities although complaint of pain to coccyx area. R1's nurses note dated 10/16/25, at 14:38 (2:38 p.m.), written by LPN-N documents: NP sending resident out to hospital d/t (due to) previous fall. Resident with hematoma to left side of forehead, also developing a black eye to left eye. Writer called [Name] ambulance, waiting for ambulance to arrive. Writer to update res. Family [Name]. R1's nurses note dated 10/16/25, at 21:54 (9:54 p.m.), written by LPN-N documents: Resident returned from the hospital, test negative, resident in bed resting, offered no c/o (complaint of) pain/discomfort. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's nurses note dated 10/17/25, at 15:18 (3:18 p.m.), written by LPN-N documents: F/u (follow up) fall: B/P (blood pressure) 112/63, T (temperature) 98.2, P (pulse) 78, R (respirations) 20, spO2 (peripheral oxygen saturation) 92%. Resident is alert and oriented, neuro check negative, rom wnl to both upper and lower extremities, res (resident) cont, (continue) with hematoma to left forehead and left hand. Resident denies pain/discomfort. Resident with dark purple bruises through out face, writer fed res. for breakfast this morning, but refused lunch, will cont. to monitor. On 11/3/25, at 3:07 p.m., during the end of the day meeting with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Nurse Clinical Consultant (NCC)-X Surveyor asked for the facility's investigation for R1's fall on 10/16/25. On 11/4/25, Surveyor reviewed the facility's investigation for R1's fall on 10/16/25. The information provided to Surveyor is an incident report completed by LPN-N, fall risk evaluation dated 10/19/25, fall questions/statement completed by CNA-I and neurochecks. Surveyor noted R1's incident report dated 10/16/25 under incident description for nursing description is the same documentation as LPN-N's nurses note dated 10/16/25 at 11:03 a.m. Under resident description documents Resident sated she was trying to sort out clothes. Under notes dated 10/16/25 documents Resident was found lying on the right side without oxygen in place, last seen eating at 1000 (10:00 a.m.) with oxygen on. NP was notified, assessed the resident, and informed [Name] contact person. Staff assisted resident off the floor after assessment. Ice pack applied to left side of head for large hematoma; left hand noted with bruising and skin tear? Area cleansed, approximated, and dressed with stei-strips and dry dressing. Neuro check negative, ROM (range of motion) within normal limits, resident reported pain to coccyx. Skin intact. Root cause identified as self-transfer trying to sort out clothing; reacher provided to assist with retrieving clothing. CNA-I's fall questions/statement dated 10/16/25 for time of fall 10:30 a.m. documents for question when was the resident last seen document 1000 (10:00 a.m.). For question what was the resident doing prior to fall documents in bed. For the question what was the resident wearing on their feet at the time of the fall documents nothing. For the question were previous fall interventions in place at the time of the current fall documents yes. Surveyor noted R1's fall interventions were not in place as there is a fall intervention for R1 to wear appropriate footwear (shoes/socks with non-skid soles) when ambulating, transferring or mobilizing in w/c. Surveyor noted there were no other staff statements obtained including LPN-N and Physical Therapy Assistant (PTA)-Y. On 11/5/25, at 9:10 a.m., Surveyor asked PTA-Y if he could explain to Surveyor what occurred on the morning of 10/16/25 when R1 was found on the floor. PTA-Y explained he was ambulating another resident in the hallway, as they were ambulating past R1's room he looked in and saw R1 sitting comfortably in the wheelchair as R1's door was wide open. PTA-Y explained he had the resident he was ambulating rest at the end of the hallway and then started ambulating back down the hall. When they were walking back, he heard a resident calling out help me help but he didn't recognize the voice, and the voice didn't sound like R1. PTA-Y informed Surveyor when they got to R1's door he looked in and saw R1 laying on the floor. PTA-Y informed Surveyor he had the resident he was ambulating with sit in their wheelchair and told this resident to rest. PTA-Y informed Surveyor he went into R1's room, R1 was still yelling out, asked R1 if she was having pain but R1 didn't answer him. PTA-Y informed Surveyor he pulled both nurse call lights. PTA-Y asked R1 if she was comfortable which R1 replied yes and left R1's room to look for a nurse. PTA-Y informed Surveyor the nurse was in the hallway, believes it was LPN-N and informed the nurse R1 was on the floor. PTA-Y informed Surveyor R1's wheelchair was behind her, and it seemed to him R1 tried to get up. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/5/25, at 9:29 a.m., Surveyor informed DON-B R1's fall on 10/16/25 was not thoroughly investigated and prior fall interventions were not in place. Surveyor informed DON-B there is only one staff statement from CNA-I. DON-B informed Surveyor they usually staff the unit with one CNA & one nurse. Surveyor informed DON-B there is not a statement LPN-N as to when she last saw R1, what was R1 doing etc. and there is no statement or interview with physical therapy. DON-B informed Surveyor she was not aware physical therapy was on the unit. Surveyor informed DON-B Surveyor spoke with PTA-Y as LPN-N's nurses note on 10/16/25 documents PT was on the unit. Surveyor informed DON-B PTA-Y was the first staff to find R1. Surveyor also informed DON-B R1's fall interventions were not in place as CNA-I's fall statements documents R1 didn't have anything on her feet and according to the plan of care R1 should wear shoes or gripper socks. R1's Visual/Bedside Kardex Report, which is the Certified Nursing Assistant care plan, as of 11/3/25 under the safety section documents *10/16/25: Reacher at bedside to help with sorting dirty clothes from the laundry hamper if needed. *4/5/25-fall-staff to assist resident with brushing teeth after lunch if permitted. *4/5/25-fall-staff to offer toileting q (every) 2 to 3 hours and prn. *Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. *Ensure that the resident is wearing appropriate footwear (shoes/socks with non-skid soles) when ambulating, transferring or mobilizing in w/c. *PT/OT evaluate and treat as ordered or PRN. *The resident needs a safe environment with: (even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, handrails on walls, personal. Surveyor noted there is no further documentation after the word personal. Under section toileting includes*TOILETING SCHEDULE: Assist with toileting every 2-3 hours and as needed. Under section Safety documents: *fall-12-20-24 dycem to w/c. *fall-5/25/25-staff to ensure resident not attempting to feed others when dining room. *fall-5/31/25-staff to ensure bed is made to resident's preference. *Monitor/document/report PRN adverse reactions of ANTICOAGULANT therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB (shortness of breath), loss of appetite, sudden changes in mental status, significant or changes in v/s (vital signs). Under the section Transfer documents *Transfer Status: assist of 2 with gait belt and 2ww (wheeled walker). *TRANSFER: The resident requires partial assistance by 1 staff and gait belt to move between surfaces as necessary. On 11/3/25, at 9:18 a.m., Surveyor observed R1 sitting in a wheelchair in R1's room with oxygen via nasal cannula. On 11/3/25, at 10:00 a.m., Surveyor observed Certified Nursing Assistant (CNA)-I stating to R1 I'm going to fill up tank and then will bring you out. I'll be back. CNA-I then left R1's room with the small portable oxygen tank. On 11/3/25, at 10:07 a.m. Surveyor observed CNA-I enter R1's room with the small oxygen tank and then Licensed Practical Nurse (LPN)-N entered R1's room. R1's nasal cannula oxygen tubing was connected to the small tank, R1 was wheeled out of her room and wheeled to the two chairs outside the nurses station to listen to music. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/3/25, at 10:18 a.m., Life Enrichment Director (LED)-Z asked R1 if she wants to come upstairs. R1 stated I hope I'm not making a mistake, LED-Z asked R1 about her glasses, wheeled R1 to her room to look for R1's glasses and then LED-Z wheeled R1 back down the hall, to the elevator and up to the 2nd floor for an exercise activity. On 11/3/25, at 11:04 a.m. Surveyor observed R1 sitting in a wheelchair in the sunroom on the 2nd floor participating in an exercise activity. On 11/3/25, at 11:30 a.m., Surveyor observed R1 sitting in a wheelchair by the two chair across from the nurse's station. Surveyor observed R1 continued to be sitting in a wheelchair by the two chair across from the nurse's station until at 12:01 p.m. when Certified Nursing Assistant (CNA)-I asked R1 if she was ready to eat. CNA-I then wheeled R1 to the dining room stating to R1 will get you some coffee and ice to cool it down. On 11/3/25, at 12:33 p.m., Surveyor observed R1 continues to be sitting in a wheelchair at a table in the dining room. Surveyor observed R1 has not been served lunch but has a cup of coffee and a glass of juice. On 11/3/25, at 12:55 p.m., Surveyor observed R1 continues to be sitting in a wheelchair at a table in the dining room with her lunch plate in front of R1. On 11/3/25, at 1:11 p.m., Surveyor observed R1 propelling herself in the wheelchair out of the dining room, down the hall, to the area where the two chairs with the CD player is. Surveyor observed R1 continued to sit in a wheelchair in the area by the two chairs with the CD player. R1 continued to sit in her wheelchair by the two chairs opposite the nurse's station. On 11/3/25, at 1:58 p.m. Surveyor asked CNA-I about when R1 is toileted. CNA-I informed Surveyor she thinks she asked R1 when she brought R1 her oxygen. Surveyor informed CNA-I she brought R1's oxygen around 10:00 a.m. CNA-I informed Surveyor when she got R1 up she took R1 to the bathroom. Surveyor asked CNA-I if she toileted R1 after she got R1 up. CNA-I replied no I didn't take her to the bathroom. Surveyor asked CNA-I how often R1 should be toileted. CNA-I replied suppose to take her every two hours. Surveyor asked CNA-I if she will toilet R1 before she leaves. On 11/3/25, at 2:02 p.m., Surveyor observed CNA-I wheel R1 to her room and into the bathroom. CNA-I placed a gait belt around R1, told R1 to wait a minute and placed gloves on stating to R1 you usually tell us. CNA-I moved R1's wheelchair closer to the grab bar on the wall. CNA-I assisted R1 to stand by holding on to the back of R1's pants. Surveyor noted although the gait belt was on R1, CNA-I did not use the gait belt to lift R1 off the chair. CNA-I lowered R1's product & pants and assisted R1 with sitting on the toilet. CNA-I removed her gloves, informed R1 she would step out to give her privacy, washed her hands, informed R1 to let her know when she is ready. R1 stating I'm done. Surveyor noted R1 urinated in the toilet. CNA-I placed gloves on, removed the incontinence product and place a new product on R1. CNA-I assisted R1 to stand by using the gait belt, wiped R1's peri area with toilet paper, and pulled up R1's incontinence product & pants. CNA-I used the gait belt to assist R1 with sitting in the wheelchair. CNA-I told R1 she was going to have her wash her hands, CNA-I removed her gloves & washed her hands, wheeled R1 to the sink and R1 washed her hands. CNA-I asked R1 if she wanted to come back out and listen to Elvis. CNA-I wheeled R1 out of the bathroom, removed the gait belt from R1, washed her hands, and wheeled R1 out of the room. (continued on next page)

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Lindengrove Menomonee Falls	W180 N8071 Town Hall Rd Menomonee Falls, WI 53051

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/3/25, at 2:13 p.m., Surveyor asked CNA-I when R1 brushes her teeth. CNA-I replied in the morning. If she refuses nothing can be done. CNA-I then stated after lunch. Surveyor informed CNA-I she did not offer to brush R1's teeth or have R1 brush her teeth. Surveyor noted R1's fall interventions were not implemented as R1 was not toileted every two to three hours, CNA-I did not offer to brush or have R1 brush her teeth and did not use the gait belt when transferring R1 onto the toilet. On 11/4/25, at 7:06 a.m., Surveyor observed R1 sitting in a wheelchair in her room with an over bed table in front of R1 and a reacher on the over bed table. Surveyor observed R1's call light is not in reach and is hanging on the headboard of R1's bed. On 11/4/25, at 7:36 a.m., Surveyor observed R1 continues to be sitting in a wheelchair in R1's room. R1 has her head down and appears to be sleeping. Surveyor observed R1's call light continues not to be in reach and is hanging on the headboard of R1's bed. On 11/4/25, at 8:36 a.m., Surveyor observed R1's continues to be sitting in a wheelchair in R1's room. Surveyor observed R1's call light continues to be hanging on the headboard of R1's bed and is not in reach. On 11/4/25, at 8:48 a.m., Surveyor observed Licensed Practical Nurse (LPN)-N deliver R1's breakfast tray to R1 who is sitting in a wheelchair in R1's room. Surveyor observed after LPN-N left R1's room, the call light continues to be hanging on the headboard of R1's bed and is not in reach. On 11/4/25, at 9:26 a.m., Surveyor observed R1 sitting in a wheelchair in R1's roo

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	525421	A. Building B. Wing	11/11/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility did not provide the necessary respiratory care and services for 1 (R1) of 2 residents receiving oxygen therapy.R1did not receive oxygen via nasal cannula per physician orders. On 10/16/25, the ambulance crew observed R1's oxygen tubing was disconnected at the connector and R1's oxygen level was 80%. The facility's intervention to prevent this from occurring in the future was to not use extension tubing. On 11/4/25, R1's oxygen tubing was observed to have extension tubing.Findings include:The facility's policy titled, Safe Use of Oxygen and last reviewed 11/8/23 under policy documents Entity will provide individuals who are in need of oxygen safe storage, use, and transportation in regulated health care settings.The facility's, Standard Respiratory Protocol not dated under the sections Registered Nurse (RN), Certified Nursing Assistant (CNA) & (Med Tech) MAA all include Apply oxygen as ordered.R1's diagnoses include chronic respiratory failure with hypoxia (long term condition where the lungs cannot supply enough oxygen to the blood resulting in low blood oxygen levels), COPD (chronic obstructive pulmonary disease) (group of lunch diseases that cause ongoing breathing problems) and dependence on supplemental oxygen.R1's quarterly MDS (minimum data set) with an assessment reference date of 9/19/25 has a BIMS (brief interview mental status) score of 6 which indicates severe cognitive impairment. Oxygen is checked yes for while a resident.R1's physician orders dated 6/24/24 documents Oxygen at 2 liters per NC (nasal cannula) to keep O2 (oxygen) sats (saturation) > (greater) or = (equal to) 95% every shift for hypoxia. Wean off when possible.Resident has SOB (shortness of breath)/Emphysema/COPD care plan initiated 6/24/24 & revised 3/26/25 documents the following interventions:*Give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness. Initiated & revised 6/24/24.*Monitor for difficulty breathing (dyspnea) on exertion. Remind resident not to push beyond endurance. Initiated & revised 6/24/24.*Monitor for s/sx (signs/symptoms) of acute respiratory insufficiency: anxiety, confusion, restlessness, SOB at rest cyanosis, somnolence. Initiated & revised 6/24/24.*Monitor/document/report PRN (as needed) any s/sx of respiratory infection: fever, chills, increase in sputum (document the amount, color, and consistency), chest pain, increased difficulty breathing (dyspnea), increased coughing and wheezing. Initiated & revised 6/24/24.*O2 (oxygen) per MD (medical doctor) orders. Initiated 3/26/25.*OT (occupational therapy) consult for energy conservation recommendations. Initiated & revised 6/24/24.Resident has oxygen therapy care plan initiated 9/30/24 & revised 12/24/24 documents: Intervention of Monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, increased heart rate (tachycardia), restlessness, diaphoresis (sweating), headaches, lethargy, confusion, atelectasis (partial or complete collapse of the lung tissue), hemoptysis (coughing up blood), cough, pleuritic pain (sharp stabbing pain in the chest), accessory muscle usage, skin color. Initiated 9/30/24.R1's incident report dated 10/16/25 for incident description under nursing description documents patient's oxygen tubing was detached at the connector, patient oxygen level 80%. Under resident description documents Resident unable to give description. Under immediate action taken documents Changed oxygen tubing to 1 long single tubing, instead of 2 tubes connected together to make it longer. Under notes dated 10/17/25 documents IDT (interdisciplinary team) met and discussed the resident incident involving hypoxia. The resident's oxygen was found disconnected between two nasal cannula (NC) tubes while the resident was lying in bed, with an O (oxygen) saturation of 80%. The resident is confused at baseline with no change in mentation noted and remains alert and oriented to self, place, and situation. Root Cause: Resident likely tossed in bed, pulling and disconnecting the oxygen tubing. The oxygen concentrator remained connected, so no alarm was triggered. Interventions: NC will now be connected directly to the oxygen concentrator without the use of extension tubing to prevent recurrence. Surveyor noted neither R1's oxygen therapy or SOB/Emphysema/COPD care plans were revised to include this intervention.On 11/3/25, at 9:18 a.m., Surveyor observed R1 sitting in a wheelchair in R1's room with oxygen via nasal cannula. Surveyor observed the oxygen concentrator is set at 3.5 liters. Surveyor noted R1's physician orders are for 2 liters.On 11/3/25, at 10:00 a.m., Surveyor observed Certified Nursing Assistant (CNA)-I stating to R1 I'm going to fill up tank and then will bring you out. I'll be back. CNA-I then left R1's room with the small portable oxygen tank. On 11/3/25, at 10:07 a.m., Surveyor observed CNA-I enter R1's room with the small oxygen tank and then Licensed Practical Nurse (LPN)-N entered R1's room. R1's nasal cannula oxygen tubing was connected to the small tank and R1 was wheeled out of her room. R1's small oxygen tank was set at 2 liters and observations of R1 until 3:50 p.m. revealed R1 continued to receive oxygen via the small tank.On 11/4/25, at 7:06 a.m., Surveyor observed R1 sitting in wheelchair in R1's room

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not provide routine and emergency drugs and biologicals to its residents (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (R2) of 4 residents reviewed.R2's Mirtazapine was not given as ordered.Findings include:R2 admitted to the facility on [DATE] with diagnoses that included right femur fracture, atrial fibrillation, chronic kidney disease stage 4, type 2 diabetes mellitus, hypothyroidism and depression. R2's Brief Interview for Mental Status score was 15, indicating no cognitive impairment.The facility policy titled Medication administration - general guidelines dated May 2018 documents:Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions.11) If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g. other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted, or medication removed from the night box/emergency kit.R2's Medication Administration Record (MAR) documented an order for Mirtazapine 15 mg (milligrams) give 1.5 tablet by mouth at bedtime for depression - start date 8/6/25.On 9/9, 9/10 and 9/13/25 the medication was documented as 9 (other/see progress notes). There was no documentation in the progress notes as to why the medication was not given.Surveyor review of the facility Omni inventory of available medications indicated Mirtazapine 15 mg tablet available in contingency.On 11/4/25 at 8:20 AM, Surveyor spoke with Pharmacy-S regarding R2's Mirtazapine. Pharmacy-S reported they received the script on 8/6/25 and sent 45 tablets (a month supply) to get through 9/3/25. She reported they received another script on 9/15/25 and sent another 45 tablets, and 38 tablets were returned when the resident discharged . Pharmacy-S reported she was not sure what the facility did from 9/4-9/15/25, as she is unable to view the contingency removal, but Pharmacy Manager-T would be available this afternoon.On 11/4/25 at 3:45 PM, Surveyor spoke with Pharmacy Manager-T. He confirmed a 30-day supply of Mirtazapine was sent for R2 on 8/6/25 which was enough to get through 9/3/25 and another 30-day supply was sent on 9/15/25. Pharmacy Manager-T reported the medication does not require a prescription, the facility only needs to remove the reorder label and fax the pharmacy for refill. Pharmacy Manager-T reviewed the Omnicel contingency for any medications removed for R2. Pharmacy Manager-T advised Surveyor no doses of Mirtazapine were removed for R2 from 9/5/25 to 9/15/25. R2's MAR indicated at least 3 doses of Mirtazapine were not given (9/9, 9/10 and 9/13/25). Although the MAR had check marks indicating the medication was given for the other dates between 9/5 and 9/14/25, Pharmacy confirmed no Mirtazapine was sent to the facility and the medication was not removed from contingency. On 11/4/25 at 10:52 AM, Nursing Home Administrator (NHA)-A was advised of concern regarding R2's Mirtazapine not given as ordered. No additional information was provided.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on interview and record review, the facility did not ensure 5 of 5 direct care staff chosen at random received Quality Assurance and Performance Improvement (QAPI) training with the potential to affect all 43 residents in the facility.Certified nursing assistant (CNA)-CC, CNA-DD, CNA-EE, CNA-FF, and CNA-GG did not receive QAPI training as a new hire.Findings include:On 11/11/2025, Surveyor requested from nursing home administrator (NHA)-A the documentation of training for CNA-CC, CNA-DD, CNA-EE, CNA-FF, and CNA-GG. NHA-A stated the facility used Relias, an online computer-based training program, for staff education.Surveyor reviewed the provided training transcripts for CNA-CC, CNA-DD, CNA-EE, CNA-FF, and CNA-GG. CNA-CC, CNA-DD, CNA-EE, CNA-FF, and CNA-GG did not have documentation of receiving QAPI training.Surveyor reviewed the Facility Assessment, last review/ approval date of 3/27/2025, which documents, Staff Education, Training, and Competencies: Each job description identifies the required education and credentials for the job. Staff education and credentials are verified prior to hiring. Each staff member has knowledge competency in the following:- Resident Rights- Abuse, Neglect, Misappropriation- Fire Basics- HIPPA Compliance- Lockout-Tagout Basics- Infection Control- Corporate Compliance and Ethics- IT Policies- Personnel Handbook- Trauma Informed Care- Dementia Management and Behavioral Health .Competencies are verified upon orientation, at least annually and as needed. The facility provides education and training in various ways. The staff training and education program is designed to ensure knowledge competency for all staff. Education is provided through the on-line learning system Relias . The training program is reviewed and revised each time the Facility Assessment is reviewed and /or revised. Surveyor noted QAPI training was not included in the topics in the training plan.On 11/11/2025, at 1:07pm, Surveyor interviewed nursing home administrator (NHA)-A and asked how it is ensured that staff have completed all required trainings. NHA-A stated corporate employee-HH will email NHA-A staff that have education to be completed. Surveyor shared concern CNA-CC, CNA-DD, CNA-EE, CNA-FF, and CNA-GG did not have documentation of receiving QAPI training. NHA-A shared a phone number for corporate employee-HH as NHA-A does not have knowledge of the Relias education staff has to complete.On 11/11/2025, at 1:15pm, Surveyor interviewed corporate employee-HH via phone who stated was unable to talk at the time due to driving to an appointment. Corporate employee-HH requested an email be sent by Surveyor with specific questions and requests to corporate employee-HH and corporate employee-II.On 11/11/2025, at 1:25pm, Surveyor sent an email to corporate employee-HH and corporate employee-II requesting QAPI education completed by CNA-CC, CNA-DD, CNA-EE, CNA-FF, and CNA-GG.On 11/11/2025, at 1:16pm, Surveyor shared concern with nurse clinical consultant (NCC)-X CNA-CC, CNA-DD, CNA-EE, CNA-FF, and CNA-GG did not have QAPI training documented and waiting on reply back from corporate employee-HH or corporate employee-II. NCC-X stated staff was working on locating requesting documents.On 11/11/2025, at 2:21pm, Surveyor received an email from corporate employee documenting, . Every year a team sits down to review the training plan for the following year. Last year it was identified that we have a gap in QAPI training for our staff. We proactively assigned this to our staff for the 2025 calendar year. I will say that [Facility name] incorporates the input of our front line staff and asks that they actively participate in QAPI related initiatives. The QAPI training module is assigned to all staff in quarter (Q)4 of 2025.On 11/11/2025, at 2:30pm, Surveyor shared concern with NHA-A and NCC-X CNA-CC, CNA-DD, CNA-EE, CNA-FF, and CNA-GG did not receive QAPI training upon hire. NHA-A and NCC-X did not have further concerns or questions.