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	0019111	A. BUILDING: _____ B. WING _____	C 09/10/2025

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N 000	Initial Comments On 08/27/2025, with additional information gathered through 09/10/2025, Surveyors conducted a complaint investigation at Bayview Senior Care LLC. The complaint was substantiated. Four deficiencies were identified. Census: 47	N 000		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not assess Resident 1 and Resident 2 when there was a change in needs, abilities or condition. Resident 1 was last assessed on 07/24/2024. Resident 1 had a change in needs, abilities, and condition regarding effective verbal skills, combativeness/resistance with cares, skin integrity, ambulating, transferring, positioning, dressing needs, toileting needs, and dietary needs and has not been assessed since.	N 381		

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

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N 381	Continued From page 1 Resident 2 was last assessed on 01/27/2025. Resident 2 had a change in his/her needs and abilities regarding combativeness/resistance with cares, skin integrity, dressing needs, toileting needs, and dietary needs and has not been assessed since. Resident 2's individual service plan (ISP) was not updated to reflect changes. Findings include: The provider was licensed on 09/15/2022 following a change of ownership (CHOW). Resident 2 had resided at the facility prior to the CHOW. On 08/07/2025, the department received complaint information alleging resident care needs were not being met. On 08/27/2025, Surveyors conducted a complaint investigation. RESIDENT 1 On 09/03/2025, Surveyors reviewed Resident 1's record which noted s/he admitted to the facility on 06/01/2024 with diagnoses of vascular dementia, foot drop in both feet, hypertension and neuropathy. On 08/29/2025, Surveyor reviewed Resident 1's assessment provided by Regional Director (RD) A and noted Resident 1's most recent assessment and last assessment was on 07/24/2024. His/her last ISP review was 08/27/2025. Resident 1 has had a change in condition since his/her last assessment as evidenced by the following noted in provider observation notes written by hospice, physician order, interviews, and Surveyor	N 381		

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N 381	Continued From page 2 observations. Toileting Assessment - 07/24/2024 - Toileting - Independent - "Independent, no assistance required." Observation Notes - 04/19/2025 (Resident Assistant M) "[Resident 1] was unable to help with standing, needed to call for extra assistance for help standing to change [Resident 1] ... Once [Resident 1] was changed, [s/he] was transferred into [his/her] wheelchair." Observation notes - 08/04/2025 Hospice Registered Nurse I (RN I) "Writer attempted catheter placement today, which [Resident 1] tolerated well, but writer was unsuccessful. Another Unity nurse came and attempted with a smaller [type] catheter and was also unsuccessful." Hospice Record - 08/18/2025 - Hospice Registered Nurse Q (RN Q) "Foley catheter inserted with no difficulty." Hospice Record - 08/26/2025 (RN I) "Writer applies stat-lock and secures the foley catheter." Interview - On 09/09/2025, at approximately 2:36 PM, Surveyor interviewed RN I who advised Resident 1 is doing better with the catheter inserted and no longer pulls on it. No assessment was completed for changes in Resident 1's toileting needs, need for a catheter and placement of catheter. Skin Integrity/Wounds	N 381		

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N 381	Continued From page 3 Assessment - 07/24/2024- Current Skin Status - No entry on assessment Observation notes - 08/04/2025 (RN I) "[His/her] gluteal fold is red but still blanching. Please make sure that you are applying a thick layer of zinc each time you change [him/her]." Observation notes - 08/04/2025 (RN I) "Assessment revealed an open area to gluteal fold to which writer applied a dressing to. Please note that there are more dressings in the cabinet above the toilet in [Resident 1's] bathroom. [S/he] has blancheable [sic] redness to both of [his/her] hips and insides of both of [his/her] knees. [S/he] also is red to [his/her] groin folds and under side of [his/her] [genitals] which also seemed to be painful." Observation notes - 08/25/2025 (RN I) "[Resident 1] is experiencing significant pain each time writer barely touches the skin in the groin area. Writer provides teaching with facility staff on checking on [Resident 1] as frequently as they were prior to catheter insertion and to make sure area is clean and dry prior to applying antifungal powder and zinc to buttocks around dressing." Hospice Record - 08/28/2025 (RN I) "Pressure ulcer to coccyx is resolved, but skin to coccyx and groin area is still red and raw." Hospice Record - 09/02/2025 (RN I) "Skin to coccyx is pink, but no open areas present. Groing [sic] is still red, but not as painful to touch when writer touches the area. Writer provides teaching about keeping the skin dry and making sure that the brief is in [his/her] skin fold to act as a moisture barrier."	N 381		

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N 381	Continued From page 4 Interview - On 09/09/2025, at approximately 2:36 PM, Surveyor interviewed RN I, s/he described wounds on Resident 1's buttocks as " ....skin looks like it's been through a meat grinder, they are very bad. The areas in [his/her] skin folds have gotten better, they are light pink in color." Interview - On 08/28/2025 at approx. 2:15 PM, Surveyor interviewed POAHC G, s/he expressed concerns for Resident 1's unhealed wounds for the past few months since losing the ability to self-transfer and ambulate. No assessment was completed for changes in Resident 1's skin integrity and wound care. Ambulating, Transferring and Positioning Assessment - 07/24/2024- Positioning - Independent - "No assistance required with positioning needs. Mobility & Walking - Independent - "Can walk and ambulate independently. Transferring - Independent - Can independently transfer from bed to walker/cane/wheelchair and around the home." Observation notes - 04/19/2025 (Resident Assistant M) "[Resident 1] was unable to help with standing, needed to call for extra assistance for help standing to change the [Resident 1] .... Once [Resident 1] was changed, [s/he] was transferred into [his/her] wheelchair." Observation notes - 07/02/2025 (Director of Nursing C) "Fall Risk [sic] [Resident 1] had 6 falls this review [sic] [Resident 1] transfers with staff assist and varies with the need of equipment to be used [Resident 1] uses a Broda Chair [sic] and Hospital [sic] Bed [sic] for positioning [sic] [Resident 1] is on medications that increase fall	N 381		

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N 381	Continued From page 5 risk. [Resident 1] often will not be accepting of redirection or assist from staff and become agitated and aggressive." Observation notes - 06/29/2025 (Resident Assistant P) "Writer contacted [RN I] to order a Hoyer sling for [Resident 1]. Its [sic] getting unsafe to transfer [Resident 1] with a sit to stand." Hospice Record - 07/24/2025 (RN I) "Interventions and signs of decline: [Resident 1] is transferred with an EZ stand to a broda [sic] chair. [S/he] has had a couple of falls since last [Interdisciplinary Team] including one out of [his/her] bed, landing on a fall mat and one where [s/he] slipped out of [his/her] broda [sic] chair for a total of 3 fal!s [sic] so far this month. Facility uses a tab alarm to alert them to any attempts to get up." Observation notes - 07/28/2025 (RN I) " .... Tab alarm, Hoyer sling, butt support sling and seat cushion ordered." " ... During the first visit in the morning [Resident 1] was very agitated and restless. [S/he] yelled at writer several times and tried stabbing [him/herself] in the leg with [his/her] spoon. PRN requested and given during visit. [S/he] didn't allow much of an assessment during the first visit as [s/he] punched writer's hands away when attempting to auscultate lungs/heart. Kicked at writer when attempting to check edema. 2nd visit following slip to foot rest [sic] of his broda [sic] chair. Writer assisted staff with sitting [him/her] on the floor, laying [him/her] down and getting [him/her] up with the hoyer [sic] lift and into bed." No assessment was completed for Resident 1's changes in repositioning, transferring, and mobility needs.	N 381		

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N 381	Continued From page 6 Eating & Diet Assessment - 07/24/2024 - Eating-Independent - "Current Diet - General ... Independent with all eating .... Overall appetite is good." Observation notes - 06/11/2025 (Resident Assistant P) "Resident is having some difficulty with chewing his food." Physician's order received for a mechanical soft diet for Resident 1. Observation notes - 06/29/2025 (Resident Assistant P) "Change in condition. A: [Resident 1] has not ate since since [sic] Friday. Writer has tried to get [Resident 1] to eat but [s/he] has no interest [s/he] just keeps falling asleep." Observation notes - 06/30/2025 (RN I) "[Resident 1] was sleeping when writer entered the room, but [s/he] roused to verbal stimulation. Physical assessment is per baseline for [him/her] though [s/he] has lost 1 cm in [his/her] arm circumference in the last couple of weeks which indicates further weight loss and muscle wasting." Observation notes - 07/11/2025 (Assistant Director B) "Hospice requested [Resident 1] trail [sic] a pureed diet for a week .... as long as [s/he] is eating it, if not go back to Mechanical Soft diet." Hospice Record - 07/24/2025 (RN I) Interventions and signs of decline: "John is transferred with an EZ stand to a broda [sic] chair. He has had a couple of falls since last [Interdisciplinary Team] including one out of his bed, landing on a fall mat and one where he slipped out of his broda [sic] chair for a total of 3 falls so far this month. Facility uses a tab alarm to alert them to any attempts to get up. Weight obtained for a notable 30 lb	N 381		

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N 381	Continued From page 7 [pound] weight loss since May 1st. Facial and temporal wasting present. Mostly nonsensical verbalization when he does communicate." Hospice Record - 09/02/2025 (RN I) " .... [Resident 1] didn't eat anything yesterday or this morning for breakfast. Facility staff report that [s/he] had a sip of [his/her] shake but nothing else for lunch ..." Interview - On 08/28/2025 at approx. 2:15 PM, Surveyor interviewed Power of Attorney Healthcare G (POAHC-G), s/he expressed concern for Resident 1's health, explaining staff need to assist and encourage him/her to eat. POAHC-G fears staff may not be doing this consistently and without them physically assisting him/her and verbally cueing, s/he doesn't eat. Observation - On 08/27/2025 at approximately 12:05 PM, Surveyor observed the noon meal. Surveyor observed Resident 1 being fed a pureed meal by Attendant F. While being fed, Resident 1 would cough and clear his/her throat after every bite. Attendant F would hand Resident 1 his/her water to drink, but not assist him/her to drink it. Resident 1 would stare at the cup and attempt to bring the straw to his/her mouth, but after some time, would say no. Attendant F would then put the cup down on the table. No assessment was completed for Resident 1's changes in special diet, abilities to eat and drink independently, and risk for choking. Interpersonal Relationships Assessment - 07/24/2024 - Interpersonal - Independent - "None, resident displays healthy one on one interaction with other residents and	N 381		

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N 381	Continued From page 8 staff." Observation notes - 03/26/2025 (Resident Assistant L) "[Resident 1] became verbally aggressive towards everyone. Yelling, Slamming [sic] walker into the ground in an intimidation method. Stating 'I am going to kill someone!'" Observation notes - 03/30/2025 (Resident Assistant M) "Writer tried redirecting [Resident 1] to their room to get changed, but [Resident 1] was combative. .... [Resident 1] started to push their chest against writer and hit writer in the arm with the newspaper they were holding." Observation notes - 04/03/2025 (Resident Assistant N) "Writer witnessed [Resident 1] hit another resident 3 times in the chest" Interview - On 08/28/2025 at approx. 2:15 PM, Surveyor interviewed (POAHC-G), s/he described Resident 1 always in bed when s/he visits, s/he is concerned there is not enough staff to transfer Resident 1 to his/her Broda chair to spend time with Resident 3 or other people at the facility. Interview - On 09/09/2025, at approximately 2:36 PM, Surveyor interviewed RN I who stated Resident 1had an increase in behaviors associated with the type of dementia s/he had. RN I stated dosage increases and additional medications prescribed to decrease negative behaviors has caused Resident 1 to be drowsy and sleep more, limiting contact with others. Interview - On 08/28/2025 at approximately 4:02 PM, Surveyor interviewed Social Worker H (SW H) who stated during the past 5 weeks Resident 1 is in his/her bed most of the time. SW H described providing Resident 1 with a fidget board if s/he is sitting in Broda chair, otherwise	N 381		

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N 381	Continued From page 9 Resident 1's communication is very limited and avoids close contact because of his/her behaviors. No assessment was completed for Resident 1's communication needs and abilities, and interpersonal relationships. RESIDENT 2 On 08/27/2025, Surveyor reviewed Resident 2's record and noted s/he was admitted to the facility on 0/21/2021, prior to the provider CHOW. S/he had diagnoses of chronic kidney disease, frailty syndrome, failure to thrive, dementia, depression, chronic pain in his/her low back and neck, irritable bowel syndrome, history of falls with fracture, and osteoarthritis. On 08/29/2025, Surveyor reviewed Resident 2's assessments provided by Regional Director (RD) A and noted Resident 2's most recent assessment and last assessment was on 01/27/2025. His/her last ISP review was 02/23/2025. Resident 2 has had a change in condition since his/her last assessment and care review as evidenced by the following noted in provider observation notes written by hospice, physician order, interviews, and Surveyor observations. Acceptance to Care 01/27/2025 Assessment & 08/28/2025 most recent/ongoing ISP - Destructive/Abuse - "Displays no destructive/abusive behaviors." Aggressive/Combative - "None, resident displays no aggressive, combative behaviors ...Accepting of cares provided by staff."	N 381		

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ISP - Communication Skills - "A&O [alert and oriented] to self Accepting [sic] of assist provided by staff may be unable to communicate needs to staff at times Able/ to understand and follow simple directions."

Observation notes - 08/20/2025 (Hospice) " ...was agitated during writer's visit, cuing and swinging at writing during cares and assessment."

Interviews - On 08/27/2025 at approximately 10:52 AM, Surveyor interviewed Attendant F who indicated Resident 2 was sometimes in a mood and resists assistance from staff.

On 08/28/2025 at approximately 3:15 PM, Surveyor interviewed Family Member J who stated "from what [facility staff] tell me [getting Resident 2 up] depends on [his/her] mood, if [s/he's] cranky" and combative.

No assessment was completed for Resident 2's change in behaviors and acceptance of care.

Skin Integrity/Wounds

Assessment - "Current Skin Status ...Resident's skin is currently intact. Resident is at risk for skin breakdown related to falls, left lower extremity edema, occasional incontinence. Wound/Skin Care [left blank]."

ISP - "Dressing change to _____[blank space] as prescribed by physician (add orders for wound care)."
Physician order (written to physician from Hospice Nurse [RN] I) - 02/03/2025 "Just providing an update for you. [Resident 2] has developed 4 pressure sores to [his/her] buttocks that opened pretty quickly as [his/her] skin was

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red but still intact as of Friday, 1/31 when [hospice] showered [him/her] last. [His/her] appetite has been pretty poor ...I did start wound care per [hospice] guidelines.."

Observation notes - 07/10/2025 "Wound care to coccyx area. Please continue to keep this area clean, dry, and covered at all times."

07/24/2025 "Please continue to keep coccyx clean and covered with optifoam for protection. Reposition frequently and/or offload with pillows as well. Edema 2+ to lower extremities."

08/08/2025 "Optifoam in place on coccyx area ...Optifoam 4x4 in place to shoulder wound as well."

08/19/2025 "Staff had noticed new blisters to [Resident 2's] back and hip during cares this am [morning] ...New fluid blisters noted to right low back and hip. Blisters are intact and peri [perineal] wound area clean, dry, and intact. Blisters covered with optifoam for comfort/protection.

No assessment was completed for Resident 2's change in skin integrity and wound care needs.

Dressing

Assessment & ISP - Dressing - as needed assistance ..."will call if assistance is needed"

Observation & Interview - On 08/27/2025 at approximately 10:58 AM, Surveyor observed staff go to Resident 2's room to assist him/her. Upon being brought into the dining room, Surveyor inquired with Caregiver E what cares Resident 2 required and s/he said [Resident 2] was full assist

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with changing and dressing. Surveyor inquired whether s/he pressed his/her call light and Caregiver E said no.

No assessment was completed for Resident 2's change in dressing needs.

Toileting

Assessment & ISP - Toileting - "Incontinent__of bowels- has a history of irritable bowel and frequently has loose stools ...To have staff initiate and assist with toileting schedule on an ongoing basis. Staff will cue as needed and assist when required. Follow their toileting schedule ...Assist with toileting needs." 12x every day

Interviews - At approximately 11:11 AM, Surveyors interviewed LPN D who stated Resident 2 required full assistance with all cares. Surveyor inquired whether Resident 2 was taken to the toilet at all and LPN D stated "no, [s/he] is incontinent."

On 09/03/2025 at approximately 10:30 AM, Surveyors interviewed Director of Nursing C who verified Resident 2 was incontinent of bowel and transferred with a hoyer lift, so they did not take him/her to the bathroom and toilet him/her.

No assessment was completed for Resident 1's change in toileting needs and abilities.

Eating & Diet

Assessment & ISP - Eating - "Current Diet General Assist as needed with eating ...Resident needs consistent assistance with all dietary needs ...Supplements/Shakes, etc."

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N 381	Continued From page 13 Physician Order - 05/09/2025 signed physician order for pureed diet with continued thin liquids. Observation - On 08/27/2025 at approximately 12:05 PM, Surveyor observed Caregiver E feeding Resident 2 pureed carrots, mashed potatoes, and gravy. Observation notes - 06/26/2025 "[Resident 2] is dependent for all cares. Facility staff feeds; pureed diet." Assessment & ISP - Physical Disabilities - "None, resident displays no physical disabilities." No assessment was completed for Resident 1's changes in special diet, feeding needs, and risk for choking. On 09/03/2025 at approximately 10:15 AM, Surveyors interviewed RD A and DON C who verified Resident 1 and Resident 2 have had changes in care needs and decline in condition. Cross Reference N0448 83.41(2)(a) Nutrition: Diet Y3244 50.09(1)(L) Care	N 381		
N 448	83.41(2)(a) Nutrition: diet. Diets. 1. The CBRF shall provide each resident with palatable food that meets the recommended dietary allowance based on current dietary guidelines for Americans and any special dietary needs of each resident. 2. The CBRF shall provide a therapeutic diet as ordered by a resident ' s physician.	N 448		

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This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not follow Resident 2's special dietary needs as ordered by his/her physician.
Resident 2 was identified as requiring his/her food to be pureed. Resident 2 was served a cup of popcorn.

According to the International Dysphagia Diet Standardization Initiative (IDDSI), a pureed diet is characterized as: "usually eaten with a spoon, do not require chewing, have a smooth texture with no lumps, hold shape on a spoon, fall off a spoon in a single spoonful when tilted, are not sticky, liquid must not separate from solids ...Pureed Food may be used if you are not able to bite or chew food or if your tongue control is reduced. Pureed foods only need the tongue to be able to move forward and back to bring he food to the back of the mouth for swallowing. It's important that puree foods are not too sticky because this can cause the food to stick to the cheeks, teeth, roof of the mouth or in the throat ...For safety, AVOID these food textures that pose a choking risk for adults who need level 4 pureed food: mixed thin and thick textures, hard or dry food, tough or fibrous foods, chewy, crispy, crunchy food ...popcorn ...sharp or spiky, crumbly bits, pips, seeds, etc."
https://www.iddsi.org/images/Publications-Resources/PatientHandouts/English/Adults/4_pureed_adults_consumer_handout_30jan2019.pdf.
Retrieved 09/08/2025.

Findings include:

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N 448	Continued From page 15 On 08/07/2025, the department received complaint information alleging concerns with food service. On 08/27/2025, Surveyors conducted a complaint investigation. At approximately 12:05 PM, Surveyor observed Resident 2 being served and fed a pureed meal. On 08/27/2025 at approximately 1:45 PM, Surveyor observed residents watching a matinee in the theater room and observed Attendant F handing out popcorn. Surveyor observed Attendant F hand Resident 2 a cup of popcorn in which Resident 2 started eating. Surveyor inquired with Attendant F if s/he was giving popcorn to all residents and s/he said "yes, if they want it." On 09/02/2025 at approximately 11:33 AM, Surveyor interviewed Family Member J who reported observing provider staff giving Resident 2 puffs in the most recent past despite his/her need for pureed foods. On 08/27/2025, Surveyor reviewed Resident 2's record and noted s/he was admitted to the facility on 01/21/2021 with diagnoses of frailty syndrome, failure to thrive, gastroesophageal reflux disease, and chronic kidney disease. Surveyor reviewed Resident 2's most recent individual service plan (ISP) with review date 02/03/2025 and noted: "EATING - FULL ASSISTANCE...Current Diet General Assist as needed with eating. Keep tumbler in room filled with cold water and encourage to drink fluids between meals. Overall appetite is fair to poor Report changes in meal intakes or weights.... SPECIAL DIETARY NEEDS...Monitor and assist	N 448		

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with resident's special dietary needs...Resident needs consistent assistance with all dietary needs. Nutritional Supplements/Shakes...Maintain diet parameters and provide nutritious food choices within diet parameters."
Surveyor note: Resident 2's ISP was not updated to reflect Resident 2's orders for a special diet of pureed food.

On 08/28/2025, Surveyor reviewed Resident 2's physician orders and noted a signed order: Hospice Nurse (RN) I wrote "[Resident 2] is pocketing what little solid food [s/he] is eating. Facility and family would like to try a pureed diet. Can we have an order for a pureed diet with continued thin liquids? YES/NO...[handwritten] Agree w/ above [signature] [Physician K] 5/9/2025."

On 08/27/2025 at approximately 12:00 PM, Surveyor observed the facility kitchen with Assistant Administrator B and noted postings on the wall listing resident special diets. Surveyor and Assistant Administrator B noted Resident 2 was not listed on the posting as having a special diet - pureed. Surveyor and Assistant Administrator B also noted Resident 1 was also not listed as being on a pureed diet. Assistant Administrator B stated, "I should get you the most recent copy."

On 09/03/2025 at approximately 10:00 AM, Surveyors interviewed Regional Director A and Director of Nursing C who verified Resident 1 and Resident 2 were on pureed diets. Regional Director A acknowledged the concern and risk of Resident 2 eating popcorn contrary to his/her physician ordered special diet.

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N 448	Continued From page 17 Cross Reference N0381 83.35(1)(a) Pre-Admission And Ongoing Assessments N0452 83.41(3)(b) Food Safety Y3244 50.09(1)(L) Care	N 448		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not distribute and serve food under sanitary conditions for the prevention of food borne illnesses. The provider did not hold hot foods at 140 degrees Fahrenheit or above for 15 of 47 residents who ate in a side dining room or in their room of the enhanced care wing. Surveyor observed food temperatures of 97.6 degrees Fahrenheit, 96.8 degrees Fahrenheit,	N 452		

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N 452	Continued From page 18 and 96 degrees Fahrenheit. According to USDA Food Safety and Inspection Service, "The "Danger Zone" (40 °F-140 °F) Bacteria grow most rapidly in the range of temperatures between 40 ° and 140 °F, doubling in number in as little as 20 minutes. This range of temperatures is often called the "Danger Zone." That's why the Meat and Poultry Hotline advises consumers to never leave food out of refrigeration over 2 hours. If the temperature is above 90 °F, food should not be left out more than 1 hour. If you are traveling with cold food, bring a cooler packed with plenty of ice, frozen gel packs or another cold source. If you are cooking, use a hot campfire or portable stove. It is difficult to keep foods hot without a heat source when traveling, so it's best to cook foods before leaving home, cool them, and transport them cold ... Reheating Foods should be reheated thoroughly to an internal temperature of 165 °F or until hot and steaming. In the microwave oven, cover food and rotate so it heats evenly. Follow manufacturer's instructions for stand time for more thorough heating. In the absence of manufacturer's instructions, at least a two minute stand time should be allowed." https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/how-temperatures-affect-food. Retrieved 09/08/2025. Findings include: On 08/07/2025, the department received complaint information alleging concerns with food service. On 08/27/2025, Surveyors conducted a complaint investigation.	N 452		

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At approximately 11:55 AM, Surveyor observed the food service for lunch in the side dining room, on the enhanced care wing. Surveyor observed 14 residents across 4 separate tables.
Surveyor observed a plastic cart that held a large, insulated beverage dispenser, plate covers, a wash bin, and a large, insulated food delivery bag. Within the insulated food delivery bag was 15 plates of mashed potatoes with gravy and meatballs and carrots with covers. Surveyor observed Caregiver E and Attendant F serving residents. Surveyor noted Attendant F warmed at least 3 dishes of general diet meals in the microwave prior to serving them to the residents.

At approximately 12:05 PM, Surveyor asked Resident 5 how his/her food was. S/he said, "it's cold, but don't tell anyone, I don't really want anything." Surveyor noted Attendant F was standing near Resident 5 and Surveyor, and overheard Resident 5 say this. Surveyor noted Attendant F nor Caregiver E followed up with Resident 5 about his/her lunch.
Surveyor observed 2 plates of pureed mashed potatoes and gravy and puree carrots, and 1 plate of mechanical soft diet potatoes and gravy and mashed carrots. Surveyor checked the temperatures of the mashed potatoes on the 2 pureed plates and noted 96.8 degrees Fahrenheit. Surveyor checked the temperature of the pureed carrots on the plates and noted 96 degrees Fahrenheit. Surveyor checked the temperature of the mechanical soft meal plate and noted 97.6 degrees Fahrenheit. Attendant F indicated the 2 plates that were pureed were Resident 1 and Resident 2's and the mechanical soft meal plate was for Resident 4 who was fed in his/her room. After all general meals were served to residents, Attendant F microwaved Resident 2's pureed meal and then Resident 1's

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pureed meal. Surveyor observed Attendant F sit down and begin feeding Resident 1 and Caregiver E fed Resident 2. Resident 6 requested for his/her plate to be warmed up, so Attendant F took his/her plate to the microwave and heated it up.
At approximately 12:06 PM, Surveyor asked Caregiver E whether meal plates needed to be warmed up often and s/he said "not always, just if lunch is running late." Surveyor inquired whether lunch was running late that day and Caregiver E said no.

At approximately 12:25 PM, Surveyor observed Attendant F put Resident 4's plate in the microwave, heat it up and bring it to Resident 4's room to assist him/her to eat.
Surveyor note: At approximately 12:05 PM, Resident 4's food was 97.6 degrees Fahrenheit. Surveyor observed the plate with a cover sat in the unzipped, open food delivery bag from 12:05 PM until 12:25 PM before it was heated in the microwave and served to Resident 4.

On 09/02/2025, Surveyor reviewed provider's "Dining Room Standards" and noted "Meals will be served from the warming kitchen, ensuring our residents receive their meals at the right temperatures."

On 09/03/2025 at approximately 10:30 AM, Surveyors interviewed Regional Director A and Director of Nursing C who acknowledged the food served to residents on the enhanced care wing was not maintained and served at a temperature of 140 degrees Fahrenheit or warmer. Regional Director A stated "I've done everything I can think of to keep the food warm...I think we will have them eat in the main dining room again."

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N 452	Continued From page 21 Cross Reference N0448 83.41(3)(b) Nutrition: Diet Y3244 50.09(1)(L) Care	N 452		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 2 of 2 residents reviewed (Resident 1 and Resident 2) received adequate and appropriate care within the capacity of the facility. Resident 1 was completely dependent on staff for bathing, dressing, nail care, toileting, changing of incontinence products, catheter care, repositioning, wound care, transfers, mobility, eating and drinking, laundry, and housekeeping.	Y3244		

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Resident 1 required 2-staff assistance for all transfers with a Hoyer lift and utilized a Broda chair. Resident 1 was on a pureed diet. Resident 1 had an approximate 39-pound weight loss from March 2025 to August 2025.
Resident 2 was completely dependent on staff for bathing, dressing, toileting, changing of incontinence products, catheter care, repositioning, wound care, medication administration, transfers, mobility, eating, laundry, and housekeeping. Resident 2 required 2-staff assistance for all transfers with a Hoyer lift and utilized a Broda chair. Resident 2 was on a pureed diet. Resident 2 had an approximate 20-pound weight loss from March 2025 to August 2025.
Resident 1 and Resident 2 were put at risk and experienced negative outcomes related to morning cares, autonomy, meal service, repositioning, toileting, catheter placement and care, reoccurring skin impairment, safety checks, and housekeeping.

Findings include:

The provider is a licensed CNA (non-ambulatory) CBRF who may serve up to 70 residents who may have physical disabilities, be terminally ill, advanced age, and/or have Alzheimer's dementia.

On 08/07/2025, the department received complaint information alleging residents who required full assistance were neglected.

On 08/27/2025, Surveyors conducted a complaint investigation. At the time of survey, 47 residents were residing at the facility. Surveyors observed the following staff positions working: 2 caregivers (1 caregiver, 1 LPN), 1 attendant, activity

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coordinator, activity aide, housekeeper, housekeeper trainee, administrative coordinator, health coordinator, and assistant director, regional director, and 4 kitchen staff.

Four residents were identified by LPN D as requiring 2 staff for assistance including Resident 1 and Resident 2.

RESIDENT 1
On 08/27/2025, Surveyor reviewed Resident 1's record and noted Resident 1 was admitted to the facility on 06/01/2024 with diagnoses of vascular dementia with behavior disturbance, foot drop in both feet, hypertension and neuropathy. Resident 1 had an activated Power of Attorney for Healthcare (POAHC) and required assistance making his/her needs known.

On 09/04/2025, Surveyor reviewed Resident 1's hospice notes and noted additional diagnoses of senile degeneration of brain, debility, weight loss, recurrent falls, attention deficit disorder, anxiety, Barret's esophagus, diverticulosis, obstructive sleep apnea, and atrial fibrillation.

Surveyor reviewed Resident 1's most updated individual service plan (ISP) with print date 08/27/2025, and noted s/he required assistance with all activities of daily living (ADL's) - bathing, dressing, transferring with a Hoyer lift, mobility with a Broda chair, toileting, incontinence care, eating, drinking, repositioning, and housekeeping.

Morning Cares
On 08/27/2025 at approximately 10:17 AM, Surveyors entered Resident 1's room and immediately noted strong feces- like odor. Surveyors observed Resident 1 to be sitting in a semi-Fowler's position without support behind

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his/her back in his/her bed. Resident 1 appeared to be attempting to get up. The comforter was half off the bed next to him/her and there was no top sheet. Surveyors observed him/her to have a t-shirt, tabbed brief, and one sock on. Resident 1 had a visibly dry mouth. Resident 1's tabbed brief was semi-secured, making a large bowel movement in the brief visible. Surveyors noted feces along Resident 1's upper, inner thighs, and lower abdomen above his/her brief. Resident 1 was observed to have a urethral catheter, and the urethral tubing had smeared feces around it next to the urethral entrance and spanning to the urine drainage port. Surveyors observed Resident 1 to have long fingernails that appeared to have feces under each nail. Resident 1 presented uncomfortable to Surveyors' observation. Surveyor asked Resident 1 how long s/he had been sitting up like that and Resident 1 said "some time." The bedding was disheveled, and s/he had a disposable incontinence pad crumpled next to him/her and the fabric incontinence pad crumpled below his/her lower back. Surveyor asked Resident 1 how s/he slept, s/he said, "never sleep good." Surveyor asked Resident 1 if s/he wanted to get up, s/he said "yeah." Surveyor noted Resident 1's catheter drainage bag did not have any urine output in the bag or the drainage tubing. Surveyors noted dark yellow to brown dregs to the bottom of the drainage bag not amounting to any cubic centimeters as labeled on the bag.

Surveyor went to the hallway to find a staff to assist Resident 1 while other Surveyor stayed with Resident 1. Surveyor observed Licensed Practical Nurse (LPN) D sitting in the nurse's station down the hall and around the corner from Resident 1's room. Surveyor observed Caregiver E was assisting a resident in the dining room.

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Surveyor notified LPN D that Resident 1 needed assistance. LPN D hesitantly said, "Yes, we were just about to take care of [him/her]."

At approximately 10:20 AM, LPN D, Caregiver E, and Surveyor entered Resident 1's room and LPN D presented alarmed. S/he said to the other Surveyor "we were just by [him/her]. We were attentive." Surveyor inquired when staff last checked on Resident 1 and s/he said when s/he gave Resident 1 his/her medications a little while ago. Surveyor asked whether Resident 1 had been sitting like s/he was at that time and LPN D said no, s/he was laying down with a blanket over him/her. Surveyor asked whether Resident 1 received breakfast and LPN D said s/he should have; Attendant D would've fed him/her.

Surveyor reviewed Resident 1's August 2025 Medication Administration Record (MAR) with time stamps of charting of medication administration and noted Resident 1's medications were charted as being administered at 8:24 AM.

Surveyor reviewed Resident 1's August 2025 Task Administration Record (TAR) and noted his/her catheter bag was documented as being emptied at 6:00 AM.

At approximately 11:12 AM, Surveyors observed LPN D taking Resident 1's bedsheets off his/her bed and putting them in the laundry basket. LPN D stated Attendant D will grab those and wash them. Surveyor inquired whether there was any feces on the bedsheets since Resident 1 seemed to have a bowel movement, LPN D said it was dirty. Surveyors observed LPN D put the soiled bedsheets into the laundry basket making it heap over. LPN D said Attendant F would probably get

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the laundry. Surveyors inquired when the usual time Resident 1 was gotten up in the mornings and s/he said, "we get [him/her] up when we can." Surveyor inquired how many residents do staff need to get up in the morning. LPN D said s/he thought it was 6 on that hallway. LPN D stated all other residents were already assisted and indicated Resident 1 and Resident 2 were the only 2-assist residents on this hall. LPN D stated Resident 1 did have feces under his/her nails and s/he cleaned them really good and would be cutting his/her nails that morning. Surveyor inquired when his/her nails were usually trimmed, s/he said nails should be cut on shower days.

Surveyor inquired when Resident 1's shower day last was, LPN D said s/he would have to look, as hospice bathed him/her.
Surveyor note: Surveyor reviewed Resident 1's August 2025 TAR and noted Resident 1 was last showered on Monday 08/18/25 at 1:00 PM by Resident Assistant N (RA N).

On 08/28/2025 at approximately 2:15 PM, Surveyor interviewed POAHC G, s/he expressed concern for Resident 1's health and overall wellbeing. POAHC G stated Resident 1 was always in his/her bed when s/he visited on the weekend. POAHC G stated there were only 2 caregivers for the building and Resident 1 needs 2 caregivers to transfer him/her out of bed and assist him/her with personal cares.

Surveyor reviewed Resident 1's hospice notes: 08/21/2025 " ...routine visit made. [Resident 1] is sound asleep in bed upon arrival. Staff report [s/he] has been sleeping more. [S/he] used to resist cares, but now [s/he] will say 'no no' sometimes, but will let them wash and change [him/her] without difficulty most times."

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Meal Service
Surveyor reviewed Resident 1's pre-admission assessment dated 04/26/2024 and noted Director of Nursing B wrote "likes ice cream...not a fan of veggies."

Surveyor reviewed Resident 1's ISP and noted it did not reflect disliking vegetables and liking ice cream.

Surveyor reviewed Resident 1's MAR and noted s/he had an order for a mighty shake three times daily.
At approximately 11:14 AM, Surveyor interviewed Attendant F. S/he asked whether Resident 1 ate breakfast that day and s/he said s/he believed so. Surveyor asked who fed them and Attendant F indicated s/he had. Surveyor asked what s/he fed Resident 1 and Attendant F hesitated and said, "umm eggs ...and I think a hashbrown thing ...[s/he] gets [his/her] food mixed up and soft." Attendant F said it depended on the day, but s/he "usually" ate well. Surveyor inquired how much Resident 1 ate that morning for breakfast and s/he said, "I'm pretty sure [s/he] ate 100%."

Surveyor reviewed Resident 1's food and fluid intake and noted on 08/27/2025 breakfast documentation showed Resident 1 ate at 9:42 AM - 25% of meal consumed, 6 ounces of fluid by 1 staff, and was signed out by Attendant O.

On 08/27/2025, At approximately 12:05 PM, Surveyor observed the noon meal. Vegetables were the main course - mashed potatoes with gravy and pureed carrots. Resident 1 dosed off to sleep and Attendant F would try to wake him/her and ask if s/he wanted to eat without response from Resident 1, so Attendant F

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stopped feeding him/her. Resident 1 ate less than 25% of food with frequent breaks during the approximate 10 minutes the meal was offered to him/her. Resident 1 did not have anything to drink as s/he was unable to bring the cup of water and straw to his/her mouth when it was put in his/her hand. Surveyor observed Caregiver E and Attendant F put Resident 1's cup in his/her hand, but neither of them brought the straw to his/her mouth, so s/he visibly could not drink and did not drink. Resident 1 did not receive a mighty shake at lunchtime. At approximately 12:15 PM, Surveyor noted the tables were being cleared by Caregiver E and Attendant F. Surveyor observed a few residents finish their dessert which appeared to be a lemon cheesecake type pie which had a crust with a custard-like consistency with whipped cream on top. Resident 1 was not offered and did not receive a dessert. Surveyor asked Caregiver E whether Resident 1 would be getting a dessert, s/he said, "I wasn't told they would and don't see anything for them [Resident 1 and Resident 2]." Surveyor inquired whether Resident 1 regularly received desserts and Caregiver E said it depended on the day, but not always.

Resident 1's lunch documentation in his/her TAR showed Resident 1 ate at 12:56 PM - 25% of meal consumed, 8 ounces of fluid by 1 staff, and signed out by Attendant O.

On 08/28/2025 at approximately 2:15 PM, Surveyor interviewed POAHC G who explained Resident 1 needed full assistance for eating and drinking. S/he voiced concern of staff's availability to feed him/her on days they were not staffed well, such as on weekends. S/he said if staff don't feed Resident 1, s/he isn't able to eat and drink at all.

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Y3244	Continued From page 29 On 08/27/2025 at 12:00 PM, Assistant Director B and Surveyor observed a "Resident Allergies/Dislikes List," special diets, and "Mighty Shakes" typed and handwritten laminated sign on the refrigerator in the kitchen. Resident 1 was not listed on the sign for his/her special diet, dislike of vegetables and his/her order for mighty shakes. Assistant Director B acknowledged the sign did not have Resident 1 listed on it. Weights Surveyor reviewed Resident 1's Vital History from provider and noted the following weights: 03/28/2025 - 203 pounds (lbs.) 04/03/2025 - 200 lbs. 04/24/2025 - 193 lbs. 08/19/2025 - 164 lbs. Surveyor note: Resident 1 had a 39-pound weight loss from March to August 2025. On 09/05/2025, Surveyor reviewed Resident 1's hospice notes. 07/11/2025 hospice visit - "[POAHC G] wants [Resident 1] to be comfortable. Interventions and signs of decline: ...Weight obtained for a notable 30 lb [pound] weight loss since May 1st. Facial and temporal wasting present ...PPS [palliative performance scale] increased as [s/he] had hardly been eating at last [visit], but regained some appetite with change to pureed diet ...Current Wt [weight]: 170 lb. Wt 1 month ago: 200 lbs on May 1st Wt 3 months ago: 193 lb Wt on admit [to hospice]: 224 lb." On 08/27/2025 at approximately 1:00 PM, Surveyors interviewed Assistant Director B. Surveyor inquired whether there was concern about Resident 1's weight loss as Resident 1 was	Y3244		

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down 30 pounds from May to July 2025 and now was down another 6 pounds from 07/11/2025 to 08/19/2025. Assistant Director B acknowledged awareness of Resident 1's weight loss and said "I went to a training and this decline in weight is normal for people with vascular dementia."

Surveyor note: According to the National Library of Medicine, "Weight loss is a clinical condition that increases the morbidity and mortality risk in elderly people... The diagnosis of weight loss in an elderly population is important to prevent or treat the underlying causes because it may emerge at the beginning or during the course of any disease. Hence, is weight loss in frail elderly people related to [vascular dementia], a contributory factor for [vascular dementia] or a consequence of [vascular dementia]? Little is known about the relationship between weight loss-related brain structural changes and [vascular dementia]. However, the association between cerebral infarcts [infarctions; stroke] and weight loss is well established." Source: https://pmc.ncbi.nlm.nih.gov/articles/PMC5588206/

Safety Checks
Surveyor reviewed Resident 1's ISP dated 08/27/2025 and noted "Safety Checks - Staff to check on [Resident 1] every 30 minutes."

Surveyor reviewed Resident 1's August 2025 TAR and noted "30 MINUTE SAFETY CHECKS Staff to check on residents safety every 30 minutes." Surveyor noted staff documented Resident 1 as being checked on at the following times for 5:00 AM - 1:30 PM (note - 30 minute checks): 5:12 AM, 5:35 AM, 10:22 AM (6:00 AM), 12:34 PM (6:30 AM), 8:53 AM (7:00 AM), 8:54 AM (7:30 AM), 8:59 AM, 9:46 AM, 9:47 AM, 9:48 AM, 10:04

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AM, 11:00 AM, 11:01 AM, 12:52 PM, 12:53 PM, 12:57 PM, 1:51 PM, 1:51 PM.

On 08/28/2025 at approximately 2:15 PM, Surveyor interviewed POAHC G who explained unless s/he requested a caregiver to come to Resident 1's room when s/he visited, they did not check on Resident 1 for many hours. POAHC G does not believe staff are checking on Resident 1 every 30 minutes on the weekend or during the week, especially if Resident 1 was in his/her room. Upon discussion with POAHC G about Surveyors' observation upon entering Resident 1's room on 08/27/2025, POAHC G indicated Resident 1 was often in the same position as Surveyor described. Surveyor note: Surveyor reported how Surveyors observed Resident 1 upon arrival at the facility on 08/27/2025 as written above. POAHC G said s/he was concerned about Resident 1's safety as s/he does have falls and was not able to make his/her needs known.

Toileting/Catheterization
Surveyor reviewed Resident 1's July & August 2025 TAR and noted the following orders related to toileting:
"TOILET CHECK - SCHEDULED Follow their toileting schedule and assist in monitoring and assisting._____Continent/Incontinent of bladder____Wears incontinent pads at all times Report changes in urinary habits. Assist with toileting needs." Every 2 hours

Surveyor note: Task was listed and signed out on July 2025 TAR, was removed from August 2025 TAR and readded on 08/18/2025 when his/her catheter was placed. No documentation was noted when toileting schedule was not listed as a task from 08/01/2025-08/18/2025. Staff did not

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document toileting/catheter checks/ 08/18/2025-08/26/2025.

"STAFF BM [bowel movement] MONITORING Document bowel movements daily. Continent/Incontinent_____of bowels Report changes in bowel habits Usually has a bowel movement_____" (underlined areas were left blank; unspecified specific to Resident 1)
Surveyor reviewed Resident 1's hospice Plan of Care Update for 07/25/2025, "Wounds: Resolved."
Surveyor reviewed Resident 1's hospice notes for Hospice RN Q's visit on 08/04/2025, "Due to skin concerns, a 16 Fr regular catheter [w]as attempted and not able to get past [through] ...Writer attempted to insert [an alternative] catheter, but was unsuccessful. [Resident 1] tensed up and would grimace and groan. Blood noted when catheter removed. Area was cleansed and antifungal powder applied."

On 08/05/2025, Hospice RN I visit notes stated "Writer is unsuccessful at catheter placement ...Writer notes blood at the tip of the catheter and [genitals] and teaching provided to facility staff that this will likely be normal for a day or two. Another [hospice] nurse will come to attempt placement."

08/18/2025 "Foley [catheter] inserted with no difficulty."

On 08/28/2025 at approximately 2:15 PM, Surveyor interviewed POAHC G. POAHC G stated, s/he felt like the catheter was placed so staff did not have to toilet and check on Resident 1.

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Y3244	Continued From page 33 On 08/28/2025 at 3:49 PM, Surveyor reviewed written correspondence between Hospice RN I and POAHC G: On 07/31/2025, Hospice RN I wrote to POAHC G "[Staff] at the facility reached out to me after I saw [Resident 1] today and asked about maybe trying a catheter with [Resident 1]. I am hesitant because I am afraid that [Resident 1] will pull it out when [s/he] is agitated but then at the same time, maybe [s/he] would[not] be as agitated if [s/he] wasn't wet so often. I told [him/her] I would reach out to you and see what your thoughts on it were." POAHC G "Don't catheters increase risk of infection with [incontinence]?" Hospice RN I "Catheters in and of the themselves definitely increase the risk of infection ..." 08/26/2025 POAHC G "Are we sure the catheter is the right solution? It doesn't sound like it's improving [Resident 1's] skin health with needing the pants on, and the blood in the uterine is definitely not an improvement ...I feel like the staff there are just looking for ways to provide less care throughout the day. I'm not sure I'm happy with the way this is going." Hospice RN I "I agree ... I'm not sure either ...my thought is we give it a couple weeks and if we don't see improvement then we pull it?" POAHC G "One more week. Let's make the decision after your visit next Monday. If thee blood in he urine and/or the redness in [his/her] groin aren't improved, we pull it." 08/28/2025 Hospice RN I "[His/her] butt is looking better but I still put a patch on it ... [his/her] groin, [genitals] area though was not good ...super red and painful ...I talked to [Assistant Director B] and [s/he] is going to have [Director of Nursing (DON) C] add an intervention for them to make sure that [his/her] skin is dry ...I think maybe [s/he] is dong	Y3244		

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some sweating because they are keeping pants on [him/her] to keep [him/her] from pulling on [his/her] catheter ...[s/he] had almost straight blood in [his/her] catheter bag today and [Assistant Director B] said it has been like that off/on since it was placed so I'm thinking it is getting pulled on and the blood thinner then makes it bleed more ...I'm ordering a thing that stick to [his/her] leg that hopefully will keep it from getting pulled on as much ...we will see ..."

08/28/2025 Hospice RN I "So [Resident 1] has been having straight liquid diarrhea since yesterday ...[His/her] butt is red and raw but the open pressure sore that was there is gone now. [His/her] groin is still very red and raw also, but they have been leaving [his/her] pants off and they said [s/he] did have [his/her] hands wrapped around he catheter tubing this morning when they went in to get [him/her] up ...but the diarrhea that [s/he's] having is also making that worse because it is everywhere. The catheter bag still had a lot of blood in it so it is still getting pulled on. The sticky catheter holding thing that I put on ...was already off so I'm not sure what happened to that." POAHC G "I think we need to pull the catheter. I'm not happy with the discomfort and agitation it seems to be causing [him/her], and the risk to [him/her] between the anti coagulants [sic] and infection.

Skin Integrity
Surveyor reviewed Resident 1' s July and August 2025 TAR and noted "POSITIONING - FULL ASSIST Has a Hospital Bed with assist rail and Broad Chair Give total assistance to resident with positioning. Assist with repositioning resident to comfort in bed, wheelchair/device, standing or in other facility/home furniture." - Every 2 Hours

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Surveyor reviewed Resident 1's hospice notes and noted on 07/27/2025, "Collaborated with facility [staff]. [S/he] reports using the hoyer [sic] lift to transfer [him/her] this morning and it worked better than the sit to stand. It is not the first time [Resident 1] has slid out of [his/her] broda [sic] chair. [S/he] often scoots down in it, and appears [his/her] bottom is sore. [S/he] is not able to say whether or not it is, but [s/he] grimaced and said 'ow' when scooting [him/herself] back in [his/her] chair ... boosted [Resident 1] up in [his/her] w/c [wheelchair] and pushed back down a little more to take pressure off [his/her] bottom ...Writer instructed staff to reposition [Resident 1] often in [his/her] w/c, especially if [s/he] is sliding [him/herself] around to get comfortable. Also, lay [him/her] in bed in the afternoon to take pressure off buttocks. Writer will collaborate with primary nurse regarding safety in Broda chair and any other interventions that would prevent this."

07/28/2025 "Writer is able to assess skin to buttocks which is red in gluteal fold but still blanching."

08/07/2025 "[Staff] continue to apply antifungal powder and zing cream to [Resident 1's] groin. Writer brought [him/her] to [his/her] room to assess skin, and there is still some redness to the groin, but is improving."

08/11/2025 "Writer requests assistance from facility staff with repositioning to assess skin to gluteal fold which now has an open area ...[s/he] yells out in pain, grabbing [his/her] left leg with transferring and continues to exclaim 'owe, owe' while trying to shift in the seat ..."

08/11/2025 Wound Assessments:
"Site: Coccyx ...Primary Wound type: Pressure

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inj[ury] ...Wound Orientation: Folds ...Wound Length (cm)[centimeters]: 2.1 cm Wound Width (cm): 1 cm Wound Depth (cm)" 0/1 cm ...Well-defined edges ...Bleeding; Red ...Pressure Injury Stage: 2."
"Issues: decubitus ulcer Skin temperature: warm ...Skin turgor: decreased ...Redness bilaterally to hips which are blanching - new open are to gluteal fold, cleaned and applied a bordered dressing to gluteal fold wound. Redness to groin folds and scrotal sack. Writer reinforces with facility staff to reposition [Resident 1] when [s/he] is in bed at a minimum of every 4 hours and to apply barrier cream and zing to hips and bony prominences of but not covered by the dressing."

"Braden (pressure ulcer risk) Scale - Sensory Perception: 2 - Very Limited Moisture: 2 - Often Moist Activity: 2 - Chairfast Mobility: 3 - Slightly Limited Nutrition: 2 - Probably Inadequate Fiction & Shear: 1 - Problem; Score: 12."

On 08/28/2025 at approximately 2:15 PM, Surveyor interviewed POAHC G, s/he stated ever since Resident 1 cannot self-transfer or ambulate s/he had been visiting more often because every visit Resident 1 was always in his/her bed wearing a soiled brief and wet bedding. POAHC G explained Resident 1 had reoccurring open sores because of being left in a soiled brief for extended periods of time and not being repositioned or transferred out of bed and his/her Broda chair.

Housekeeping
At 10:17 AM, Surveyors looked around Resident 1's room and observed the following:
In Resident 1's bedroom, there was a small recliner with at least 3 unfolded blankets.
The dresser had 2 shirts on top of it, a gait belt, a

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saltshaker, and 3 dresser drawers sticking out open and 1 with clothes sticking out of it. A sock and straw were on the ground in front of the dresser.
On a table in front of the window, a chair cushion was positioned on the table against the window, a bucket of snacks, a bag of cookies, a box of crackers, and empty water jug.
Resident 1's hospital bed had a thick layer of dust along the entire frame and a piece of clothing or bedsheets were under the bed.
Resident 1's nightstand had a nail stick, nail clippers, toilet paper roll, wipes, 2 towels, a freezer bag of miscellaneous items, a lanyard, a pen, Chapstick, tooth-etes, and other items. The drawer of the nightstand was cracked open with paper sticking out of it and the shelf of the nightstand had multiple remotes and various newspapers and paper piled up.
Resident 1's carpeting had debris and needed to be vacuumed. His/her closet had 2 items of clothing bundled up and, on the floor, 5 pairs of pants hanging and at least 6 hangers without anything on them.
The shelf in the closet had a pile of mismatched bedsheets, a shirt, blanket, and another piece of clothing unfolded and piled together.
Resident 1's bathroom - counter around the sink was covered with 3 bottles of mouthwash, hand soap pump, 2 hand towels, the toilet paper roll holder, a roll of toilet paper, 2 open boxes of gloves, 3 tubes of Chapstick, 3 bottles of cleansing soap, 1 spray bottle of peri wash, a commode bucket with Resident 1's watch, a miscellaneous cord, Lysol wipes, a piece of paper, an accounting/receipt book, and a wash basin with at least 4 tubes of diaper rash cream.
Below the sink counter was an open box of wound care supplies and an open box of open bags of incontinence briefs and pads.

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Y3244	Continued From page 38 Surveyor reviewed Resident 1's ISP dated 08/27/2025 identified Resident 1 required assistance with all housekeeping and laundry needs .... "gather dirty/soiled clothes/linen and wash/dry/fold and put away properly .... maintain a clean and orderly space ...check [Resident 1's] bathroom for any episodes of incontinence and clean ..." Surveyor reviewed Hospice record dated 08/25/2025 signed by Hospice CNA P, who noted "Assist with Dressing ... [Resident 1] needs full hands-on assistance with getting dressed. [Resident 1's] clothing is in [his/her] closet and drawers in [his/her] room, please choose for [him/her]. Frequently [s/he] doesn't have clean clothes in [his/her] closet or drawers. Sometimes [s/he] has clean clothes on [his/her] chairs in [his/her] room or on the bathroom counter in [his/her] bathroom. Sometimes you have to request that facility staff find [him/her] clothing." "Condition of home: Notable Smell of Urine." On 09/09/2025, at approximately 2:36 PM, Surveyor interviewed Hospice RN I who stated "[Resident 1's] room is always pretty bad, always a mess." RESIDENT 2 On 08/27/2025, Surveyor reviewed Resident 2's record and noted s/he was admitted to the facility on 01/21/2021 with diagnoses of depression, stage 3 kidney disease, chronic SI joint pain, osteoarthrosis, irritable bowel syndrome with diarrhea, arthritis, lymphedema of left leg, and dementia. Resident 2 had an activated POAHC and was limited in making his/her needs known. Surveyor reviewed Resident 2's most recent	Y3244		

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reviewed ISP dated 02/07/2025 and his/her most recent "current ongoing care plan" with print date 08/28/2025. S/he was receiving hospice services with diagnoses of frailty syndrome and failure to thrive, was immobile, and was completely dependent on staff for all personal care needs. Resident 2 was able to make limited needs known with assistance. S/he often spoke nonsensical. S/he was unable to recall the need or the ability to press his/her call button for assistance and was dependent on staff to check on him/her. S/he required assistance from 2 staff for transferring with a Hoyer lift into his/her Broda chair. Resident 2 had a foley catheter and reoccurring pressure injuries, which were overseen by hospice.

Morning Cares
On 08/28/2025, Surveyor reviewed Resident 2's August 2025 TAR and noted "SLEEP QUALITY AT NIGHT Document quality of sleep each night. Normal bedtime varies - wakes around 6:30 AM."

On 08/27/2025 at approximately 10:35 AM, Surveyor observed Resident 3 walk into [later identified as] Resident 2's room, look around, go into his/her bathroom, and walk back out to the dining room. Surveyor noted from the dining room being able to see a person laying in the bed. Resident 3 went into the room again and looked in onto the bed and then walked out back to the dining room. At approximately 10:36 AM, Surveyor entered Resident 2's room and observed Resident 2 laying on his/her right side facing towards the wall away from the door, awake. Resident 2 was observed to have his/her legs bent and to be short and frail in stature, laying in the fetal position. S/he had short sleeve pajama top and no pants on and was covered in a single thin quilt and no top sheet. On Resident

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2's pillow, Surveyor observed a wet, dime size yellow spot appearing to be emesis next to his/her mouth. Surveyor greeted Resident 2 who stated s/he was happy to see Surveyor and was open to conversing. Resident 2 said "I'm thirsty." Surveyor observed there were no beverages or beverage containers in Resident 2's room. Surveyor asked Resident 2 if s/he ate any breakfast or food yet, and s/he said "no, that sounds good."
Surveyor note: Resident 2's current ongoing ISP with print date 08/28/2025 listed "Keep tumbler in room filled with cold water and encourage to drink fluids between meals."

At approximately 10:52 AM, Surveyor interviewed Attendant F in the dining room. Attendant F stated "it was normal" for Resident 2 to not be assisted up first thing in the morning, but the caregivers will get him/her up and feed them lunch. Attendant F paused and then said, "or we'll feed them [Resident 1 & Resident 2] in bed." S/he said it depended on what mood Resident 2 was in. At approximately 10:54 AM, Surveyor observed Caregiver E go into Resident 2's room and grab the Hoyer lift from his/her room. Caregiver E stated "[S/he's] next. We just had to get the Hoyer for [Resident 1] from [Resident 2's] room."

At approximately 10:58 AM, Surveyor observed Caregiver E and Administrative Coordinator M go to Resident 2's room with the Hoyer lift. When done, they brought Resident 2 to the dining room for lunch. Surveyor inquired whether Resident 2 did not want to get up this morning and Caregiver E said they were "just about to get [him/her] up." Surveyor asked Caregiver E whether Resident 2 was in a mood that s/he did not want to get up earlier and Caregiver E said no and indicated

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Resident 2 was in good spirits. Surveyor asked whether Resident 2 was taken to the bathroom and Caregiver E said Resident 2 does not use the toilet anymore since they used a Hoyer lift to transfer him/her.

Surveyor reviewed hospice notes and noted on 07/01/2025, "Goal: [Resident 2's] family wants [him/her] to continue to get up for meals as much as possible."

On 08/28/2025 at approximately 3:15 PM, Surveyor interviewed Family Member J. Family Member J stated s/he visited Resident 2 fairly often, and of the last 3 visits, Resident 2 was not out of bed late morning/midday 2 of the 3 visits. S/he indicated him/her not being up was concerning as it was lunch time and s/he questioned whether s/he was fed breakfast and if anyone had checked on him/her. S/he said "from what they [staff] tell me, it depends on [Resident 2's] mood and if s/he is cranky ...they say they changed [him/her] so are just going to leave [him/her] in bed." Family Member J said s/he had not seen Resident 2 personally refuse or be cranky to get up, but what s/he was told was that s/he can pinch or swat at staff. Surveyor inquired whether s/he knew if staff made other attempts to get Resident 2 up if s/he did not want to get up right away and Family Member J said s/he was unsure.

Surveyor note: Resident 2's current ongoing ISP was silent to behaviors related to resisting care, pinching or swatting at staff, as well as any approaches and interventions. "Displays no destructive/abusive behaviors ...Other Behavior: Not Applicable ...resident displays positive interaction with others, independently and without incident ...resident displays no

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aggressive/combative behaviors ...Accepting of cares provided by staff." "A&O [alert and oriented] to self Accepting of assist provided by staff may be unable to communicate needs to staff at times. Able/ [sic] to understand and follow simple directions."

Meal Service
On 08/28/2025, Surveyor reviewed Resident 2's August 2025 TAR and noted "EATING - FULL ASSISTANCE Current Diet General Assist as needed with eating ...Overall appetite is fair to poor. Report changes in meal intakes or weights." Surveyor noted, Resident 2's food intake was not signed off on or documented from 08/01/2025-08/25/2025.
"SPECIAL DIETARY NEEDS Resident is now on a pureed diet. Monitor and assist with resident's special dietary needs." Surveyor note: Resident 2's physician ordered diet was not updated in Resident 2's ISP.

On 08/27/2025 at approximately 12:15 PM, Surveyor noted the tables were being cleared by Caregiver E and Attendant F. Surveyor observed a few residents finish their dessert which appeared to be a lemon cheesecake type pie which had a crust with a custard-like consistency with whipped cream on top. Resident 2 was not offered and did not receive a dessert. Surveyor asked Caregiver E whether Resident 2 would be getting a dessert and s/he said "I wasn't told they [residents on pureed diet] would and don't see anything for them."

On 08/28/2025 at approximately 3:15 PM, Surveyor interviewed Family Member J. Family Member J indicated Resident 2 required staff to feed him/her as "if you don't feed [Resident 2], [s/he] forgets how to and won't eat." S/he

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questioned the quality and options of food, as the last time s/he was there, Resident 2 was getting pureed fish, and s/he felt Resident 2 may eat better if there were better options for individuals who require pureed consistency. S/he said Resident 2 really had a sweet tooth and would never turn down a dessert.

On 09/03/2025 at approximately 10:00 AM, Surveyors interviewed Director A and DON C and requested records of Resident 2's food and fluid intake. At 12:03 PM, Surveyor received written correspondence from Director A that said "The consumption monitor was not linked to [Resident 2's] care plan, [DON C] did fix that now - going forward."

Weights
Surveyor reviewed Resident 2's documented weights from the provider:
03/18/2025 121 pounds (lbs)
04/15/2025 116.5 lbs
05/06/2025 113.5 lbs
05/23/2025 110.5 lbs
06/06/2025 107 lbs
07/08/2025 101.6 lbs
Surveyor note: Resident 2 had an approximate 20 pound weight loss from March to July 2025.

On 08/27/2025 at approximately 1:00 PM, Surveyors interviewed Assistant Director B. Surveyor inquired whether there was concern of Resident 2's weight loss and Assistant Director B said "not at all, [s/he] is a really good eater," and indicated that hospice checked his/her weight. S/he said s/he was not aware of the weight loss.

Surveyor reviewed Resident 2's hospice notes:
07/10/2025 "[Resident 2] is approximately 6 lbs [pounds] down (7/8) from 6/24 visit."

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Y3244	Continued From page 44 07/17/2025 "[Resident 2] is cachexic [wasting syndrome] ...Writer notes improved appetite this week compared to last week, but overall weight loss noted and facial wasting appears more pronounced." 09/03/2025 "Appetite: fair ...Diet type: puree Supplements: eating 50-75% of meals; staff assists." Safety Checks Surveyor reviewed Resident 2's current ongoing ISP and noted "Check on resident's safety every 30 minutes. 30 minute safety checks 48x Every Day." "Resident is at risk for falls related to prior fall history, use of assistive device, pain issues, arthritis." "Resident is at risk for pain ...Pain History & Management ongoing monitoring." On 08/27/2025, Surveyor reviewed observation notes provided by DON C from 03/09/2025, who wrote "Resident is at moderate risk for falls due to [his/her] diagnosis of arthritis, chronic pain, and HTN [hypertension] and medications that increase Risk. Is dependent on staff for transfers with use of Hoyer and Broda Chair [sic] Resident has Call Don't Fall Reminder and is on frequent Checks and alarms." On 08/27/2025 at 10:35 AM, Surveyor observed Resident 2 to have bruising on his/her left hand, 2 bruises on his/her left forehead, 1 bruise on his/her left eyebrow, and purpling around Resident 2's eyes. Surveyor asked whether Resident 2 had been up that day yet and s/he said no. Resident 2 stated "can you get me up?" Surveyor asked Resident 2 whether s/he ate yet that day and Resident 2 said no. Surveyor asked if s/he was hungry and Resident 2 stated "yeah"	Y3244		

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and opened and closed his/her mouth until saliva was visible in his/her mouth. Surveyor noted Resident 2's mouth was very dry. Resident 2 began to rub his/her forehead and said "I need to take some pills" and indicated s/he had a headache.

On 08/28/2025, Surveyor reviewed Resident 2's incident report from 08/16/2025 which identified Resident 2 had a semi-unwitnessed fall out of his/her Broda chair in the common area. Staff looked over at residents watching TV and s/he did not see Resident 2 in his/her chair, so another staff went to check on him/her. Resident 2 was seen leaning/ falling forward to the ground out of his/her Broda chair and landing on his/her left side and face. It was not documented when Resident 2 was last checked on prior to the fall.

On 08/28/2025 at approximately 3:15 PM, Surveyor interviewed Family Member J. S/he reported having concerns about the provider not having enough caregivers to meet Resident 2's needs. Family Member J indicated s/he could sit with Resident 2 for over an hour and not see any staff member walk past his/her room or check in on Resident 2.

Toileting & Catheter Care
Surveyor reviewed Resident 2's August 2025 MAR and TAR and noted the following related to Resident 2 being checked and toileting care as s/he was fully dependent on staff for toileting and incontinence care.

MAR & TAR - "STAFF BM MONITORING Document bowel movements daily. Incontinent _____ [sic] of bowels - has a History [sic] of irritable bowel and frequently has lose [loose] stools." 1:45 AM, 5:45 AM, 6:00 AM, 1:45 PM,

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Y3244	Continued From page 46 2:00 PM, 9:45 PM TAR - "TOILET CHECK - SCHEDULED To have staff initiate and assist with toileting schedule on an ongoing basis. Staff will cue as needed and assist when required. Follow their toileting schedule and assist in monitoring and assisting. HAS FOLEY CATHETER ____ [sic] Wears incontinent pads at all times ...Assist with toileting needs." - every 2 hours Surveyor note: Surveyors were in the vicinity of Resident 2 and Resident 2's room from approximately 10:35 AM to approximately 1:30 PM. Resident 2 was assisted out of bed at and was brought to the table for lunch in his/her broda chair, was brought to the sitting area by the TV after lunch, and then was brought to the movie room at approximately 1:00 PM. Resident 2 was observed to not be toileted and checked for incontinence for the entirety of Surveyors' visit. TAR - "CATHETER CARES Empty drainage bag every shift. Cleanse around the catheter insertion site every shift." Surveyor reviewed Resident 2's hospice notes. "Starting 07/02/2024 Goal: Patient catheter will be managed" "Facility staff want a ...catheter in order to minimize repositioning needed in bed..." 07/10/2025 "Issues: bladder incontinence ...Reason for catheter: bedbound, bladder incontinence, skin integrity, comfort." Surveyor note: Resident 2 was immobile, not bedbound. On 08/28/2025 at approximately 3:15 PM, Surveyor interviewed Family Member J who said Resident 2's catheter was placed following a fall	Y3244		

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with fracture back in Summer 2024. S/he indicated that s/he was under the impression that it was placed as a means to prevent skin breakdown. Family Member J stated Resident 2 had not fully returned to baseline since.

Wounds
Surveyor reviewed Resident 2's ongoing ISP and noted "Give total assistance to resident with positioning. Assist with repositioning resident to comfort in bed, wheelchair/device, standing or in other facility /home furniture. Resident has a Hospital Bed with Repositioning [sic all] bars. 12x Every Day And As Needed. To maintain comfort ability [sic] and ease in all forms of positions."
"Dressing change to _____[sic] as prescribed by physician (add orders for wound care) ...Skin Care Management 3x Every Day And As Needed ...To be free from infection to the wound by next review."
Surveyor reviewed Resident 2's August 2025 MAR and noted an order for "NYSTATIN 100,000u/GM powder Apply to Groin Area 2 Times a Day Until Redness/rawness Clears [sic all]" As needed.
Surveyor reviewed Resident 2's August 2025 TAR and noted:
"POSITIONING - FULL ASSIST" 6 days/times were left blank without initial to identify whether or not Resident 2 was repositioned. On 08/27/2025, during Surveyors' visit, Resident 2's TAR was documented that s/he was repositioned contrary to the 2-hour task times at: 10:11 AM (6:00 AM), 1:40 PM (8:00 AM), 1:36 PM (10:00 AM), 1:38 PM (12:00 PM), 3:43 PM (2:00 PM).
"ELEVATE LEGS ISP ADDENDUM: Elevate legs; Encourage [Resident 2] to elevate [his/her] feet every afternoon by sitting in [his/her] recliner in [his/her] room or may sit in the community rooms recliner ..."

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Y3244	Continued From page 48 "SKIN CARE MANAGEMENT Bruise to LEFT head ..." Surveyor note: Resident 2's MAR and TAR were silent to monitoring and management of his/her skin integrity and wounds, outside of his/her injury from the fall. Surveyor note: Surveyors observed Resident 2 from approximately 10:35 AM to approximately 1:30 PM. Surveyors observed Resident 2 to only be repositioned once and it was from his/her bed to his/her Broda chair at approximately 11:00 AM. On 09/02/2025, Surveyor reviewed Resident 2's 03/01/2025-08/27/2025 observation notes completed by provider staff and hospice, and noted the following related to pressure injuries/ wound care. 03/25/2025 6:30 PM "A blister on [his/her] right hip, a red area on the inside of [his/her] left butt cheek." 03/27/2025 12:15 PM "[Hospice] visit today. Physical assessment baseline. [His/her] dressing were both intact with no shadow drainage, so I did not remove. Increased nursing visits to 2 x wk [week] to manage wound care. Continue to reposition every 2 hours while [s/he] is in bed to minimize pressure to [his/her] bony prominences." 05/08/2025 "Wounds continue to coccyx, If dressing to coccyx comes off, please apply a new one or call [hospice] to come out and apply a new one." 06/19/2025 "Wound care to coccyx which is healing. Dressing placed."	Y3244		

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Y3244	Continued From page 49 06/26/2025 11:45 AM "[Resident 2] was laying on [his/her] right side. [Resident 2] reported being cold. Write observed that room window was open and asked if [Resident 2] would like it closed. [S/he] responded, 'yes'. [sic] Writer closed window. During dressing change it was noted that [Resident 2] had large soft brown BM [bowel movement] and that there was not a dress on [his/her] sacrum. Writer called for facility staff ... for assistant [sic] to change and measure cluster wound ...[Resident 2] continues to having [sic] +2 pitting edema to BLE [bilateral - both lower extremities] feet and contracture of bilateral lower extremities noted [sic]." 07/24/2025 5:45 PM "Reposition frequently and/or offload with pillows as well. Edema 2+ to lower extremities." 08/08/2025 7:00 PM "Please continue to reposition frequently when in bed and off load when in Broda chair with pillows on both feet/buttocks area. Opti foam in place to coccyx area ... Opti foam in place to shoulder wound as well." 07/31/2025 "Open areas to coccyx are closed, but still not blanching. Thick layer of CALMOSEPTINE applied. Please use this to coccyx instead of the zinc. Do not wipe off unless visibly soiled. It is a very thick cream and will hopefully help protect skin better than the zinc." 08/19/2025 3:15 PM "New fluid filled blisters noted to right lower back and hip." On 09/03/2025, Surveyor reviewed hospice notes and noted the following related to reoccurring wounds and the condition of his/her wounds at the time of survey.	Y3244		

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	0019111	A. BUILDING: _____ B. WING _____	C 09/10/2025

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Y3244	Continued From page 50 07/01/2025 "Pressure wound to buttocks with Optifoam coccyx dressing in place and Optifoam dressing to right hip for blister. Avoid these areas when cleaning if dressing is still intact. If dressing is not intact, update [hospice] ... Issue: decubitus ulcer/ pressure, dry skin, edema Wound care provided per care plan to clustered pressure wounds. Excoriated moist red area with a few small open areas approximately 0.5 cm in diameter. Wound Width (cm) [centimeters] 3 cm Total Wound Surface Area 16.485 cm ... Treatments Off Loading Medicated Ointment/Powder/Cream Used: Barrier Cream (Zinc, Petroleum) Dressing Type Barrier Film ...Foam Border." 07/03/2025 "Writer reinforces teaching regarding keeping area [on coccyx] clean, dry, and covered at all times." 07/10/2025 "Open area to coccyx noted in inside the stage 1 area." 07/17/2025 "Skin appears grayish to the face today ....Physical assessment per baseline ...with exception of area to coccyx opened up again ... [Resident 2] [has] contractures bilaterally [both] to lower extremities. [S/he] already has an air mattress." 08/13/2025 "Wound care provided to left shoulder wound and coccyx area ...facility staff joins for visit and writer reinforces the importance of position changes and keeping dressing in place to aid in skin healing as well. The coccyx dressing was not in place on arrival ..." 09/03/2025 "Optifoam placed to hip blister for	Y3244		

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additional protection...Writer reinforces teaching regarding the importance of position changes, frequent checks for BM [bowel movement], and keeping an optifoam in place to ensure skin integrity continue to be maintained at this time."
"Active Wound 06/19/25 Pressure Injury Coccyx ...Days 77 ...Peri-Wound Assessment Fragile; Pink..Well-defined edges ... Drainage Amount Scant ...Drainage Description Serous ...Non-staged Wound Description Full thickness ...
Skin Issue Wound 3 08/19/25 Traumatic Lateral; Lower; Right Back ...Day 16 ...Secondary Wound Blister ..."

On 09/09/2025, at approximately 2:36 PM, Surveyor interviewed Hospice RN I who stated s/he had never seen Resident 2 sitting in a recliner and/or having his/her legs elevated in the past months. S/he said Resident 2's legs were extremely contracted and s/he was in significant pain when they were moved and attempted to stretch out.

On 08/28/2025 at approximately 3:15 PM, Surveyor interviewed Family Member J who stated hospice tells him/her that they're constantly stressing to staff that Resident 2 needs to be repositioned in and out of bed. S/he said s/he was always on his/her right side in bed or sitting on his/her butt in his/her Broda chair.

Housekeeping
Surveyor reviewed Resident 2's ongoing ISP and noted "Housekeeping/Chores" Requires assistance with housekeeping needs ...to maintain a clean and orderly living space ...Requires assistance with laundry tasks ...To produce clean clothes/linen for resident in an orderly efficient manner."

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Y3244	Continued From page 52 On 08/27/2025 at approximately 10:43 AM, Surveyor observed Resident 2's room to be untidy and cluttered despite Resident 2's immobility and inability to clean his/herself. Surveyor noted: -framed artwork laying on the floor against the wall (not hanging) -white paper debris on the carpeting next to his/her bed -a laundry basket full of visibly soiled clothing and bedsheets -bathroom counter surface was not visible and completed covered with: a wash basin, 4 folded towels, a nightgown, a box of gloves, 2 hand towels, a loofa, tube of barrier cream, tube of lotion, hairspray, bottle of baby powder, bottle of mouthwash, and a bottle of nystatin powder. -next to the bathroom counter was a wire shelf that was messy and stuffed full of depends, approximately 7 towels, folded pajamas, an unfolded pajama top, single sock, shoes, used gloves, and bottle of soap -the bathroom floor was visibly un-mopped with various brown and white debris throughout -2 side-by-side end tables located between the entrance of his/her room and his/her bed that were both covered to not see the top surfaces: End table 1 - open wipes, deodorant, mouth spray, 2 tubes of Calmoseptine ointment, wound wash spray, lotion, saline wound wash, baby powder, 3 bottles of nystatin powder, a disposable incontinence pad, 3 tubes of unidentified creams, unopened package of gauze, pens, 2 call buttons, a lanyard, a lamp, a coaster, 1 bottle of unidentified cream, 1 container of unidentified ointment, a vase, shampoo, a box, and a hairbrush. End table 2 - Clorox disinfecting spray, pajamas, 3 clean folded towels, miscellaneous cords,	Y3244		

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miscellaneous books, magazines, and papers, a tube of zinc barrier cream, shampoo and body wash, a stuffed animal, Kleenex box, box of straws, bottle of wound cleanser, and a laundry basket of clean, folded incontinence pads.
-bookshelf next to Resident 2's bed had personal and memorial belongings on it, uneven stacked books, used tissue, a magazine, and an empty Mighty shake container.

On 08/28/2025 at approximately 10:30 AM, Surveyor interviewed Family Member J and inquired how Resident 2 had preferred to keep his/her room. Family Member J stated "it should not be in that state, [Resident 2] would not be okay with it. [S/he] used to keep [him/herself] quite busy cleaning, using a Swiffer, and keeping [his/her] room tidy and organized." S/he said Resident 2's room was always cluttered. Family Member J indicated s/he would like to clean it, but didn't want to affect what staff had out for their convenience.

On 09/10/2025 at 1:00 PM, Surveyor interviewed Hospice Director of Quality and Compliance (DQR) R who stated depending on an individual's ability and skin integrity issues, and whether or not they were able to move themselves, it would be recommended to reposition an individual every 2 hours if they were chairfast depending on assessment to prevent skin integrity issues. S/he said it would not be normal practice for a catheter to be placed strictly to reduce repositioning as there was risk for infection with catheters among other internal urology complications. S/he stated catheter placement would be dependent on the resident's skin integrity, mobility, bedbound or chairfast, frequent incontinence, and should involve consultation, risk mitigation, and discussion.

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Y3244	Continued From page 54 In conclusion, Resident 1 and Resident 2 were on hospice services and were fully dependent on provider staff for all activities of daily living. Resident 1 and Resident 2 were put at risk and experienced negative outcomes related to: autonomy due to choice in time of day to get out of bed and alternative foods and desserts offered to encourage appetite; pressure ulcers and skin impairment due to staff not following a toileting schedule, not keeping wounds and peri areas dry, poor food and fluid intake, catheter placement, and not repositioning frequently; malnutrition and significant weight loss due to documentation error, staff not consistently encouraging food and drink intake, mighty shake orders not being followed, and meal options not being provided; safety concerns and fall risk due to staff not consistently providing safety checks and following toileting schedules; unclean and urine-odor living environments due to housekeeping needs not being met and toileting schedules/catheter bag schedules; and overall health and condition due to their care needs not being met. On 09/03/2025 at approximately 10:30 AM, Surveyors interviewed Regional Director A and DON C who acknowledged Resident 1 and Resident 2's needs were not being met. Cross Reference: N0381 83.35(1)(a) Pre-Admission And Ongoing Assessments N0448 83.41(2)(a) Nutrition: Diet N0452 83.41(3)(b) Food Safety	Y3244		