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	0015962	A. BUILDING: _____ B. WING _____	C 03/03/2026

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N 000	Initial Comments On 02/18/2026, with information gathered through 03/03/2026, Surveyors conducted a standard survey, 3 complaint investigations and a self report review. Two (2) of 3 complaints were substantiated. As a result of the survey, 5 deficiencies were issued. Census: 17	N 000		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This is a repeat deficiency. See Statement of Deficiency (SOD) KV2P11, dated 02/02/2022. Findings include: The provider is licensed as a class CNA (non-ambulatory) to provide care for up to 42 residents in the following client groups: advanced age and irreversible dementia/Alzheimer's. On 02/04/2026, 02/10/2026 and 02/16/2026, the Department received complaints regarding concerns with staffing, call wait times, and prompt and adequate care.	N 396		

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

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N 396	Continued From page 1 On 02/18/2026, Surveyors conducted an onsite visit to the facility. At approximately, 9:45 AM, Surveyors toured the facility. There are 2 distinct areas, an enhanced care consisting of 15 rooms in 3 hallways and a memory care, with 4 hallways connecting to be a square, area behind secured doors consisting of 20 rooms with delayed egress, requiring a code to get in/out of the memory care area. RESIDENT 1 Resident 1 was admitted to the facility on 02/05/2026 with diagnoses to include dementia, heart failure, atrial fibrillations and type II diabetes. Resident 1's individual service plan (ISP) dated 02/10/2026 indicated the following: * independent with meals and eating and drinking * staff escort to and from dining room for meals; staff provide stand by assist while ambulating with assistive device * states staff should observe for signs/symptoms of high/low blood sugar * observe feet while completing assistance with dressing/bathing * assist with making healthy food choices and encourage to avoid foods high in vitamin K * 2 hour checks Facility incident report dated 02/11/2026 - indicated Resident 1 had a fall on 02/06/2026 - " resident was observed sitting on bedroom floor next to [his/her] bed. Resident was alert, incontinent of urine, and present with epistaxis." "EMS then transferred resident to gurney and transported to Ascension Columbia St. Mary's Ozaukee Hospital for evaluation." "Resident was	N 396		

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treated and returned same day." "The care plan was updated to encourage toileting during wellness checks."

Resident 1's ISP updated 02/11/2026 indicated the following:
* staff to assist with cutting food into bite sizes
* Resident 1 has difficulties swallowing
* Resident 1 had a choking episode on 02/11/2026 where s/he choked on a hamburger. There were Special Instructions on the top of page 1 stating "Chopped diet trial 2/12/26."

On 02/13/2026, the Department received a self-report from the facility for Resident 1. Resident 1 had a choking episode at breakfast on 02/13/2026, and Resident 1 passed away. The self-report did not reflect current staffing levels at the time of incident.

On 02/18/2026, Surveyors reviewed the staff schedule for 02/13/2026. The schedule noted Caregiver O, Caregiver P and Caregiver Q were highlighted in red, meaning no show or called off. Caregiver L was scheduled for enhanced care AM, and Assistant Director E was listed in memory care AM.

On 02/18/2026 at 10:19 AM, Surveyors interviewed Assistant Director (AD) E. AD E stated s/he thought on 02/13/2026 residents had scrambled eggs and ham for breakfast. AD E stated s/he didn't arrive until 8:50 AM, and acknowledged that Caregiver F had called in. AD E stated there was a choking incident in the memory care area, but s/he was unsure which staff were present. AD E stated s/he believed Activity Director G or Maintenance I were in memory care. AD E confirmed there should

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always be someone in the dining room when residents are eating. AD E acknowledged s/he was informed by Administrator B after the incident what had happened. AD E stated s/he saw all the emergency personnel, including the fire department and the police. AD E confirmed there were no caregivers for the memory care side and s/he worked the memory care unit for the remainder of the shift.

On 02/18/2026 at 11:00 AM, Surveyors interviewed Activity Director G. Activity Director G confirmed s/he worked on 02/13/2026 and started at 8:00 AM. Activity Director G stated his/her office is upstairs in the residential care apartment complex (RCAC) area. Activity Director G stated s/he normally starts his/her day by cleaning in the RCAC activity room and grabs snacks for the activities for the day. Activity Director G stated Sous Chef H asked him/her if s/he had seen any caregivers to pass breakfast in the RCAC, which s/he stated s/he had not. Activity Director G stated s/he then had 2 residents, 1 from the RCAC and 1 from the enhanced care stating there were no staff passing breakfast and food was late. Resident 6 stated s/he did not get his/her breakfast. Activity Director G stated s/he passed breakfast in the RCAC and believes s/he headed down to talk to Administrator B around 8:45 AM.

On 02/18/2026 at 11:28 AM, Surveyors interviewed Maintenance I. Maintenance I stated s/he did not come down to memory care till about 8:45 AM, and paramedics were already in the memory care. Maintenance I stated s/he was working on the boiler. Maintenance I stated there is generally 1 person in each unit, but s/he was unaware there was no staff in the memory care area the morning of 02/13/2026, until s/he had

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N 396	Continued From page 4 come downstairs. On 02/18/2026 at 11:40 AM, Surveyors interviewed Chef J. Chef J stated Resident 1 was on a mechanical diet after s/he choked on 02/11/2026. On 02/12/2026 the diet was changed to a chopped diet. Chef J showed Surveyors the difference in diets. Mechanical soft was cut into small pieces, where chopped was cut into bite size pieces. Chef J stated his/her staff pushed the food cart into the dining room. Chef J stated all food is plated with dome lids and any special diets have the resident name on the lid. Chef J confirmed caregivers pass the food to the residents. On 02/18/2026 at 12:19 PM, Surveyors interviewed Sous Chef H. Sous Chef H confirmed kitchen staff dropped hot boxes in the dining room, but kitchen staff did not find out until 9:00 AM there was no staff on the memory care in the CBRF. Sous Chef H stated, "I don't know who actually passed the meal." Sous Chef H acknowledged s/he only saw the dirty dishes. Sous Chef H confirmed there were plates left in the hot box and was unsure if everyone ate breakfast. Sous Chef H stated sometime residents refuse a meal. Sous Chef H confirmed the ham was cut on Resident 1's tray to bite size pieces, but other plates were not cut. Sous Chef H confirmed residents are only given spoons and forks, and that there are no knives in the memory care. Sous Chef H confirmed s/he did not know who served the plates and that it was possible a resident could have taken a plate out of the hot box. On 02/18/2026 at 12:50 PM, Surveyors interviewed Caregiver K. Caregiver K confirmed his/her replacement in the memory care side did	N 396		

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not show up and that s/he gave his/her keys to Caregiver L, who was working on the enhanced care side. Caregiver K stated his/her shift was 7:00 PM to 7:00 AM. Review of Caregiver L's punches reflected s/he left the facility at 7:24 AM.

On 02/18/2026 at 1:02 PM, Surveyors interviewed Caregiver L. Caregiver L stated s/he didn't recall who was working on the memory care side on 02/13/2026. Caregiver L confirmed s/he had received the keys from NOC shift in the memory care and hung the memory care keys in the nurses station and never checked if the keys were there at the end of his/her shift. Caregiver L confirmed s/he was working on the CBRF enhanced care by his/herself, did not work on the memory care side, do any cares or pass any food trays. On 02/19/2026 at 4:05 PM, Surveyors interviewed Caregiver L a second time. Caregiver L did acknowledge s/he set plates on the table for breakfast, did not feed any residents, did not pass any meds or do any cares, and returned to the enhanced care side. Caregiver L stated s/he does not ask for help. Caregiver L acknowledged s/he has nothing to do with the memory care unit, s/he just walked around the unit and left. Caregiver L confirmed Caregiver K did give him/her the med keys.

On 02/18/2026 at 3:25 PM, Surveyors interviewed DON A. DON A stated s/he was unaware of choking episodes prior to incident. DON A acknowledged s/he finds out of about change in conditions through secure notify app. DON A stated s/he changed the diet from regular to mechanical soft after the choking incident on 02/11/2026. DON A acknowledged the next day DON Y changed Resident 1 to a chopped diet. DON A confirmed kitchen staff plate food and put in the hot box. DON A stated s/he thought

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Caregiver L passed breakfast morning of 02/13/2026. DON A was unaware there was no staff in the memory care unit on 02/13/2026.

On 02/18/2026 at time 3:32 PM, Surveyors interviewed Administrator B. Administrator B stated s/he arrived on 02/13/2026 at 8:20 AM. Administrator B stated s/he checked the schedule to see who was working and went to the enhanced care side and realized only 1 staff was in the CBRF and that there was not a caregiver on the memory care side. Administrator B stated by the time s/he got to the elevator Police were there. Administrator B stated Resident 1 was in chair in the dining room, Family N was on the left side, and Police Officer attempted the Heimlich. Administrator B stated s/he went to call his/her manager and directed traffic. Administrator B confirmed s/he had gotten the memory care med keys from Caregiver L. Surveyors requested the staff schedule. Administrator B stated s/he was trying to hire additional staff and had interviews scheduled for today, 02/18/2026. Administrator B stated staffing is a 1:8 ratio, but there is only 6 residents on the memory care side. Administrator B stated "unsure how to answer if there is staff in the dining room" "sometimes yes, sometimes no." Administrator B stated typical staffing is 2 for the enhanced CBRF, 1 for the memory care side, and the 2nd on enhanced side can float.

On 02/19/2026 at 1:52 PM, Surveyors interviewed Family N. Family N stated on 02/13/2026 him/her and his/her spouse arrived at the facility at 8:25 AM. Family N entered the memory care where s/he observed Resident 1 eating breakfast. Family N stated s/he talked with Resident 1 a couple minutes. Family N acknowledged s/he did not see any staff, however at times it is hard to

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find staff. Family N went to put items in Resident 1's room when s/he saw Caregiver L scurry by. Family N asked Caregiver L if s/he was the caregiver for Resident 1 and Caregiver L replied s/he was not as s/he was working on the enhanced care side and there was a delay with staff, and Caregiver L left the memory care side. Family N went back to the dining room where s/he observed Resident 1 struggling and choking. Family N stated s/he started yelling for help, no one came to help. Family N started the Heimlich and tried to have Resident 1 cough/spit the food out. Family N acknowledged s/he tried everything to help Resident 1, yelling for help, pushing pendant, no one responded. A few minutes later Family N spouse arrived in the dining room and Family N told him/her to call 911. Family N spouse went to let emergency personnel in when s/he heard sirens and greeted them at the door. Police were the first on the scene, and then the ambulance. Emergency personnel tried Heimlich and then started CPR. Family N stated there were a lot of people, Fire/Police/EMS, and still saw no staff.

On 02/19/2026 at 6:54 PM, Surveyor received the death certificate from Family N. The death certificate identified Box 31 - date of death - 02/13/2026, Box 32 time of death - 10:22 (Estimated), box 41 Part 1 - The conditions listed are the diseases, injuries, or complications that caused date.
Immediate Cause: "CHOKING"
There were no contingent causes listed on the death certificate.

On 02/23/2026 at 9:23 AM, Surveyors received an email from Chief Nursing Officer (CNO) X with the investigation summary for Resident 1's choking incident on 02/13/2026. The outcome of

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the investigation reflected "Four NOC shift employees left the community on February 13, 2026, without ensuring appropriate staffing coverage. During this period, a resident experienced a choking incident in the dining room and could not be revived despite life-saving efforts by family member and first responders. Resident abandonment was substantiated, the involved employees were suspended, terminated, and reported for caregiver misconduct."

On 02/24/2026 at 3:39 PM, Surveyors sent a follow-up email to DON Y for clarification on changing Resident 1's diet from mechanical soft to chopped diet and to include assessments for the change to Resident 1's diet. Surveyors shared Resident 1's note from Bluestone, 02/11/2026, identifying Resident 1's choking episodes and needing more prompting and cueing to ensure he does not eat too quickly. As of 03/03/2026, DON Y did not respond or provide any clarification.

On 02/25/2026, approximately 4:00 PM, Surveyors interviewed Fire Chief (FC) V. FC V stated, on 02/13/2026, they were called for Resident 1 choking. There were no staff present and Resident 1's family called 911.

RESIDENT 10
Resident 10 was admitted to the facility on 01/08/2025 with diagnoses to include unspecified dementia, Alzheimer's disease, sepsis, depression and anxiety disorder.

Resident 10's individual service plan (ISP) indicated the following:
* utilize my pendant to appropriately call for staff
* staff will identify factors/interventions that

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N 396	Continued From page 9 help keep me safe and prevent elopement * walker for ambulation * 4-hour toileting program * Help with setup and verbal cues to complete dressing Resident 10's progress notes indicated: * 02/11/2026 12:48 PM, Late entry by DON A - "Resident reported having noted vomiting episodes and wanted to be seen EMS. EMS was contacted and came to do an evaluation. On EMS assessment, resident was taken to Aurora for further evaluation." On 02/25/2026, approximately 4:00 PM, Surveyors interviewed FC V. FC V stated while on-site another resident in the memory care approached his/her team for help as Resident 10 couldn't find any staff. FC V stated, "We created the call at 09:06:00 after the patient flagged us down (no staff around) and did not leave the scene until 09:32:33 because of the delay." FC V expressed concerns regarding patient care and conditions, and stated Resident 10 sought them out. FC V stated s/he attempted to contact facility Director of Nursing but hasn't received a return call. The provider did not ensure employees were sufficient in numbers on 02/13/2026, which resulted in Resident 1 choking and passing away and Resident 10 suffering a change in condition resulting in a transfer to the hospital.	N 396		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform	N 409		

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N 409	Continued From page 10 controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on record review and staff interview, the facility did not ensure the proof-of-use record for scheduled II medication was accurate and audited on a daily basis. Findings include: On 02/18/2026, Surveyors requested the drug counting between shifts for narcotics from Administrator B. The drug counting between shifts for February was missing staff signatures on 02/02/2026, 02/03/2026, 02/04/2026, 02/09/2026, 02/10/2026, 02/11/2026, 02/12/2026, 02/13/2026 02/17/2026 and 02/18/2026. "ED or Designee Daily Audit for Proof of Use Records" was initialed on 02/03/2026 and 02/04/2026. Surveyors requested the Drug Counting Between Shifts policy, which stated "Proof-of-use records must be completed by two med passers or nurses for all controlled substance administration. Administration of the narcotic medication (whether scheduled or prn) must be documented on the (medication administration record) MAR in addition to the proof-of-use record." "The "Med Passer and Executive Director Verification of Controlled Substance Count Sheet" must be completed each shift by the off-going and on-coming med passers or nurses. The Executive Director or designee (may be nurse or	N 409		

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N 409	Continued From page 11 team lead) must audit and sign the "Med Passer and Director Verification of Controlled Substance Count Sheet" on a daily basis." On 02/18/2026 at 3:25 PM, Surveyors interviewed Director of Nursing (DON) A. DON A confirmed the drug counting between shifts was all the documentation s/he had. DON A acknowledged there were missing signatures between shifts and that only 2 of 17 days the daily audit was completed by management as required. DON A confirmed the executive director or nurse should be auditing proof of use for the med audit. DON A acknowledged "correct cart wasn't audited daily for February." The facility did not ensure the proof-of-use record for scheduled II medication was accurate and audited on a daily basis.	N 409		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not make reasonable attempts to keep all rooms free from odors for 3 of 3 residents (Residents 3, 4 and 7) reviewed. Residents 3, 4 and 7's bedrooms contained a strong urine like odor. Findings Include: On 02/10/2026, the department received a complaint regarding room cleanliness and odors.	N 489		

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N 489	Continued From page 12 On 02/18/2026, at approximately 9:30 AM, Surveyor toured the facility. During the tour, Surveyor observed a strong urine like odor in the hallway near Resident 3's room. Surveyor interviewed Caregiver D at 9:42 AM regarding the odor. Caregiver D verified the odor in the hallway was from Resident 3's room. Caregiver D stated s/he had not had time to go and check on Resident 3. Caregiver D acknowledged the prior shift that left at 7:00 AM would have done Resident 3's last round. Caregiver D stated Resident 3 is a heavy wetter. Caregiver D stated there is supposed to be 3 staff, but s/he is unsure where the other caregiver is. Caregiver D stated it seems to happen a lot where staff do not show up. Caregiver D acknowledged they work 12-hour shifts, 7:00 AM - 7:00 PM and 7:00 PM - 7:00 AM. Caregiver D confirmed s/he will check on Resident 3 as soon as s/he is done passing meds. On 02/18/2026 at 9:50 AM, Surveyor interviewed Resident 4. Resident 4's room had an odor resembling urine. On 02/18/2026 at 9:55 AM, Surveyor interviewed Resident 5. Resident 5 stated s/he should be checked on every 2 hours, but sometimes it is 4 hours before s/he sees any staff. On 02/19/2026 at 1:52 PM, Surveyors interviewed Family N. Family N stated s/he visited the morning of 02/13/2026 and found Resident 1's room disheveled, BM on toilet, toilet not flushed, and a bandaid on the floor with ants on it. Resident 7 On 02/18/2026, during the tour, Surveyor attempted to knock on Resident 7's room door,	N 489		

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however, Resident 7 was not in the room and the door was locked.

On 02/18/2026 at 1:20 PM, Surveyor interviewed Caregiver D. Caregiver D confirmed that Resident 7 fell on 02/06/2026 and was soaked. Caregiver D stated the fall alert went off within 5 minutes of his/her start time and Resident 7 was soaked through his/her pants. Caregiver D stated s/he had trouble finding Resident 7's information. Caregiver D stated it took 3 staff to change/clean Resident 7. At approximately 1:30 PM, Surveyor requested Caregiver D to open Resident 7's room. Caregiver D granted the request and stated Resident 7 was currently at the hospital and was unsure if Resident 7 would be returning to the facility. Upon entering Resident 7's room, Surveyors noted a strong urine-like odor. Caregiver D stated, this was the "normal" smell in Resident 7's room. Caregiver D indicated Resident 7 was resisting cares toward the end of his/her stay and not allowing staff to change his/her brief as often as it should have been. Surveyors observed several black garbage bags on the floor and a soiled chuc pad on the chair.

On 02/18/2026 at 2:30 PM, Surveyor interviewed Family Member R. Family Member R verified they were a family member of Resident 7. Family Member R stated s/he kept telling facility staff that Resident 7's room smells of urine. Family Member R stated Resident 7 refused to wear pants for several weeks prior to going to ER and would sit in a recliner chair. Family Member R stated in September, family members picked up Resident 7's recliner chair and had it professionally cleaned because of the smell in his/her room. Family Member R stated s/he voiced concerns several times about the odor in Resident 7's room to facility staff.

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N 489	Continued From page 14 On 02/19/2026 at 12:20 PM, Surveyor interviewed Case Manager S. Case Manager S verified s/he was managed care organization case manager assigned to Resident 7. Case Manager S stated earlier in February 2026, s/he made a visit to see Resident 7. Case Manager S stated upon walking into Resident 7's room the urine smell was "profound, strongest urine smell I've experienced." Case Manager S stated s/he observed that Resident 7's "bedding and sheets were soiled, feces stained...it was not good." On 02/23/2026 at 2:15 PM, Surveyor interviewed Paramedic T. Paramedic T stated s/he was the paramedic responding to Resident 7 on 02/06/2026 for transport to the hospital. Paramedic T stated upon entering Resident 7's room, Resident 7 was noted to be laying in bed with an incontinence pad underneath him/her and Resident 7 was wearing an incontinence brief. The incontinence pad was noted to be "soaked, with various stains in multiple different spots, varying in color and dryness." Paramedic T stated Family Member R was present when paramedics arrived in Resident 7's room. Paramedic T stated Family Member R showed Paramedic T pictures of Resident 7's room which revealed a messy, disheveled room for weeks on end with garbage laying around.	N 489		
Y3100	50.09(1)(f) Resident's Rights In Certain Facilities (f) Physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including, but not limited to: 1. Privacy for visits by spouse or domestic partner. If both spouses or both domestic partners under ch. 770 are residents of the same	Y3100		

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Y3100	Continued From page 15 facility, the spouses or domestic partners shall be permitted to share a room unless medically contraindicated as documented by the resident ' s physician, physician assistant, or advanced practice nurse prescriber in the resident ' s medical record. 2. Privacy concerning health care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discreetly. Persons not directly involved in the resident ' s care shall require the resident ' s permission to authorize their presence. 3. Confidentiality of health and personal records, and the right to approve or refuse their release to any individual outside the facility, except in the case of the resident ' s transfer to another facility or as required by law or 3rd-party payment contracts and except as provided in s. 146.82 (2) and (3). This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure residents were free from recording. The provider had two (2) cameras recording residents. Findings include:	Y3100		

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Y3100	Continued From page 16 On 02/18/2026 at approximately 9:30 AM, Surveyor toured the facility and observed 2 cameras in the provider's facility. One camera was located by the 1st floor elevator, positioned to view the secured doors going into and out of the memory care unit. The other camera was located by on the wall by the "servery" room, positioned to view the secured doors going into and out of the memory care unit. On 02/18/2026 at 2:30 PM, Surveyor interviewed Administrator B regarding the cameras. Administrator B confirmed there were 2 cameras in the facility and verified the location as noted above. Administrator B stated the cameras are used as a resource only. Administrator B elaborated and stated if/when a resident elopes off the memory care unit, they can look back on the video to see what happened and where the resident went. On 02/25/2026, Surveyor reviewed the department's facility folder for the provider and did not locate an approved waiver regarding the use of a camera and recording residents. The provider did not ensure residents were free from recording.	Y3100		
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	Y3244		

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Y3244	Continued From page 17 facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Residents 1, 4, 5, 7, 8 and 9, received adequate and appropriate care within the capacity of the facility. Findings include: The provider is licensed as a class CNA (non-ambulatory) to provide care for up to 42 residents in the following client groups: advanced age and irreversible dementia/Alzheimer's. On 02/10/2026, the department received a complaint regarding care and treatment concerns. CALL LIGHTS On 02/18/2026 at 9:55 AM, Surveyors interviewed Resident 5. Resident 5 stated s/he should be checked on every 2 hours, but sometimes it is 4 hours before s/he sees any staff. On 02/18/2026 at 10:07 AM, Surveyors interviewed Administrator B regarding resident care concerns. Surveyors requested Call Alert	Y3244		

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List for 02/10/2026 - 02/17/2026. Call alert list reflected the following calls exceeding 20 minutes:

Resident 5	Time Rang	Time to respond
02/10/2026	16:17	25 min
	14:41	1hr 24 min
	11:33	25 min
02/11/2026	19:05	23 min
	17:39	21 min
	8:28	23 min
02/12/2026	18:38	20 min
	17:24	59 min
	13:18	20 min
02/13/2026	19:21	31 min
02/14/2026	14:11	36 min
02/15/2026	20:31	20 min
	17:44	38 min
	16:25	24 min
	15:25	36 min
	12:45	20 min
	9:11	38 min
02/16/2026	18:43	46 min
	13:52	34 min
02/17/2026	23:21	28 min
	16:26	1 hr 10 min
	15:30	44 min
	8:43	20 min

Resident 4	Time Rang	Time to respond
02/10/2026	16:02	21 min
	13:25	30 min
	6:05	30 min
02/11/2026	17:06	28 min
02/13/2026	18:48	20 min
	16:07	25 min
	7:23	41 min
02/15/2026	17:48	52 min
	10:45	6 hr 47 min
02/16/2026	16:09	46 min
	2:11	25 min

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Y3244	Continued From page 19 Resident 8 Time Rang Time to respond 02/11/2026 18:11 28 min 02/12/2026 13:11 34 min 02/13/2026 13:22 27 min 02/15/2026 15:11 20 min 02/16/2026 11:44 28 min 02/17/2026 23:22 28 min 9:50 51 min Resident 9 Time Rang Time to respond 02/12/2026 18:01 21 min 02/13/2026 10:49 1hr 13 min 7:42 36 min 02/14/2026 16:54 1 hr 7 min 14:03 28 min 02/15/2026 16:02 37 min 02/16/2026 16:10 31 min 10:28 29 min 02/17/2026 9:51 24 min On 02/23/2026 at 3:00 PM, Surveyors interviewed Chief Nursing Officer (CNO) X regarding call alert times. CNO X stated they monitor call times daily and anything over 10 minutes they look at. Sometimes calls get stuck in the system and staff check on those residents every 30 minutes. Surveyors shared findings with several call alerts exceeding 20 min's. RESIDENT 1 Resident 1 was admitted to the facility on 02/05/2026 with diagnoses to include dementia, heart failure, atrial fibrillations and type II diabetes. Resident 1 had a fall on 02/06/2026, staff observed alert from resident's room and Resident 1 was observed sitting on bedroom floor next to bed, incontinent of urine.	Y3244		

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Y3244	Continued From page 20 Resident 1's individual service plan (ISP) dated 02/10/2026 indicated the following: * independent with meals and eating and drinking * staff escort to and from dining room for meals; staff provide stand by assist while ambulating with assistive device * states staff should observe for signs/symptoms of high/low blood sugar * observe feet while completing assistance with dressing/bathing * assist with making healthy food choices and encourage to avoid foods high in vitamin K * 2 hour checks Resident 1's ISP updated 02/11/2026 indicated the following: * staff to assist with cutting food into bite sizes * Resident 1 has difficulties swallowing * Resident 1 had a choking episode on 02/11/2026 where s/he choked on a hamburger. There were Special Instructions on the top of page 1 stating "Chopped diet trial 2/12/26." Resident 1's Progress Notes indicated: * On 02/06/2026 DON A wrote "On 2.6.26 at 7:25am, Staff observed alert from resident's room. Upon investigation, resident was observed sitting on bedroom floor next to [his/her] bed. Resident was alert, incontinent of urine, and presenting with epistaxis." * On 02/06/2026 at 17:37, DON A wrote "Contact with [Family N], [family] to address concerns r/t recent fall and care, writer addressed immediate concerns with noted implementations and updates." * On 02/11/2026 at 17:15, DON A wrote	Y3244		

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"Resident was observed in dining room eating hamburger when it was observed that [s/he] was choking on a piece of food." Immediate action: "Staff with noted concern called for assistance and called 911. Nurse arrive and observed resident was alert and presenting with no distress and no longer choking."

* On 02/11/2026 at 19:02, DON A had a late entry "Communication with [Family N] to discuss events of choking incident. [Family N] did inform writer of incidents of swallow difficulty through the weekend and that [s/he] was cutting [his/her] meals. With concern of swallowing, writer did recommend trialing mechanical diet, however after further discussion, family felt cutting [his/her]foods would be effective as they were performing this through past weekend."

* On 02/12/2026 at 14:21, DON Y had a late entry "Resident receiving chopped foods during meals. No choking episodes observed."

* On 02/13/2026 8:30, DON Y wrote "[Resident 1] having chopped breakfast meal per care plan, when [s/he] experienced a choking episode." Resident assessment "First responders continued Heimlich maneuver to dislodge food. Emergency services unable to dislodge food" "Medical examiner on site to premises; [Resident 1] pronounced deceased"

On 02/18/2026 at 1:20 PM, Surveyors interviewed Caregiver D. Caregiver D confirmed that Resident 1 fell 02/06/2026 and was soaked. Caregiver D stated the fall alert went off within 5 minutes of his/her start time and Resident 1 was soaked through his/her pants. Caregiver D stated s/he had trouble finding Resident 1's information.

On 02/19/2026 at 1:52 PM, Surveyors interviewed Family N. Family N acknowledged s/he had

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concerns with Resident 1's care. Resident 1 had a fall on 02/06/2026, ambulance called. Staff were unable to find any information for Resident 1 and Resident 1 was sent to the wrong hospital. Family N acknowledged the paramedics told him/her how they found Resident 1, urine soaked and laying on the floor, and that staff were unable to state for how long or when last time staff checked on Resident 1. Family N stated his/her family had a meeting with Administrator B. Administrator B apologized and asked for an opportunity to make things right. Family N stated Administrator B ensured the family it wouldn't happen again.

On 02/24/2026 at 2:09 PM, Surveyor interviewed Paramedic T. Paramedic T stated s/he was on call for Resident 1. Resident 1 was on the floor, staff were unable to describe what had happened, how long Resident 1 was on the floor and/or when Resident 1 was checked on last. Paramedic T stated Resident 1 was incontinent and his/her brief was urine soaked, as were his/her pants front and back from waist to his/her ankles. Paramedic T stated Resident 1's bed was also soiled and his/her room and a odor of urine. Paramedic T stated staff were unable to provide them with emergency contact information, who the doctor was, which hospital the resident should be transported to and what medications resident was currently on. Paramedic T stated s/he was also on the call 02/11/2026 when Resident 1 was choking on his/her supper. Paramedic T stated by the time they arrived, Resident 1 was not choking, and the obstruction was cleared. Paramedic T stated they did vitals and did not transport Resident 1 per POA.

On 02/23/2026 at 2:29 PM, Surveyor interviewed

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Lieutenant U. Lieutenant U stated s/he was on call for Resident 1 on 02/06/2026. Lieutenant U stated the room smelled of stale urine and Resident 1 was 4' - 5' from his/her bed laying on the ground. Lieutenant U stated they observed dried blood on Resident 1's hand and both knees. Lieutenant U stated morning staff found Resident 1 while making their rounds. Resident 1's bed was soaked in urine and had sweat pants on that were completely soaked in urine. Resident 1's pants were soaked front and back all the way through and all the way down both legs. Resident 1 also had a brief on that was completely saturated. Lieutenant U stated the smell in the room was stale urine and none of the urine was even remotely warm. Lieutenant U stated the assessment was completed and they requested paperwork from the caregivers. Caregivers replied Resident 1 just arrived yesterday and they did not have any paperwork for him/her. Lieutenant U went to the front desk and requested paperwork and was told by person at the front desk s/he had texted someone. Lieutenant U expressed it is extremely frustrating not having the information which delays residents being transferred.

Resident 7
Resident 7 was admitted to the facility on 03/02/2023 with diagnoses to include depression, nutritional deficiency, hypertension, anxiety and Alzheimer's disease.

Resident 7's most recent comprehensive assessment dated 07/22/2025 indicated the following:
*Experiences hallucinations or delusions; demonstrates paranoid or suspicious behaviors; and demonstrates restless or anxious behaviors, however, the assessment states these

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behaviors do not significantly disrupt care or living environment

*The assessment does not indicate Resident 7 is resistive to cares

*Under skin integrity - the assessment indicates Resident 7 has no impairment with the ability to respond to pressure related discomfort; Resident 7 has occasionally moist skin requiring an extra linen change approximately once a day; Resident 7 walks frequently outside of room at least twice a day and inside room at least once every two hours during waking hours; Resident 7 has no limitation in mobility and is able to make major and frequent changes in position; and lastly, Resident 7 moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move, maintains good position in bed or chair at all times. Resident 7 was assessed "not at risk" for skin breakdown.

*Resident 7 was assessed to be independent with grooming, oral hygiene, mobility and transferring with use of walker

*Is occasionally incontinent of bladder and continent of bowel, Resident 7 is independent with toileting

Resident 7's most recent ISP dated 07/28/2025 indicated the following:

*staff cue, reorient and supervise or assist me as needed

*Administer psychotropic medications per physician order for mood management, evaluate for worthlessness or guilt, change in appetite/eating habits, change in sleep patterns, or decreased ability to concentrate

*Resident 7 has been noted by family and staff to be resistant to changing clothes, despite it being soiled, old, reused for several days. Staff are to strongly encourage fresh clean

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clothing daily, explain the reasons and allow as much freedom to choose preferred articles of clothing as appropriate. It notes Resident 7 occasionally refuses assistance with showers. Staff are to strongly encourage hygienic practices. Staff to re-attempt multiple times and different staff members as necessary. If Resident 7 is resistive to ADLs, staff are to stop, ensure safety and re-approach at a later time.

*Skin will be checked weekly after showers/bathing. Staff will inform nurse of any changes

*Resident 7 is independent with grooming, oral hygiene, toileting, transferring and mobility. The ISP indicates staff will report to the nurse if s/he has a change in abilities.

*Resident 7 is incontinent of bladder and continent of bowel and uses the bathroom independently along with incontinence care. Staff are to report changes in bowel and bladder patterns to the nurse.

Surveyor reviewed Resident 7's "Progress Notes." The following was noted:

*On 01/14/2026 a nurse practitioner wrote, "Resident was seen today for a follow-up visit. [S/he] continues to be uncooperative, refusing help. Resident reports that [s/he] sits in [his/her] chair all day and refuses assistance with hair care. Resident also reported that [s/he] stopped wearing pants because [s/he] doesn't want to ask for help pulling them up...PCP suspects behavioral/depressive etiology...no new orders."

*On 01/26/2026 a LATE ENTRY was made which stated, Resident 7 was seen by behavioral health. The behavioral health specialist noted the following, "...visited with patient this morning...addressed [his/her] preference for wearing only underwear and no pants during the

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day. Pt[patient] stated it's due to being more comfortable in [his/her] chair and "that's how [s/he] likes it", but staff report this is likely related to difficulty putting pants on independently. Discussed implementing a structured toileting schedule and proactive care approach to set [him/her] up for success while promoting independence as much as possible. Will continue to follow and visit monthly for ongoing support..."

*On 01/28/2026 a LATE ENTRY was made which stated, "PCP [primary care physician] informed of concern about acute confusion. PCP assessed an[sic] noted patient vitals normal and exam reassuring and unremarkable. PCP noted progression of dementia with related behaviors."

*On 01/29/2026 Director of Nursing (DON) A wrote, "Resident noted with L[left], knee pain and inability to stand or tolerate slight movement. No noted inflammation, swelling, or structural abnormalities. No reported traumas. At rest noted 5/10 pain, when touched or moved noted "80/10" pain. PRN[as needed] Tylenol provided." DON A noted to request x-ray from physician.

*On 02/02/2026 x-ray results were noted to be "no acute fracture or dislocation is identified" looks to be arthritic changes. Physician and Power of Attorney (POA) updated. Physician interested in doing steroid injection.

*On 02/03/2026 DON A conducted a visit to see Resident 7. Resident 7 was "resting in bed watching TV and visiting with family. Resident noting 10/10 pain at rest. Writer informed of PCP recommendation for steroid shot. Resident was in agreement. Writer offered PRN Tylenol for presenting pain and [s/he] was receptive to admin."

*On 02/03/2026 a LATE ENTRY was made,

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"Writer upgraded resident's bed with hospital bed to improve offloading from recliner and to promote easier access to perform incontinent cares. Resident appreciative of change."

*On 02/06/2026 DON A wrote a note that stated, "Resident being evaluated at [hospital] for concern for UTI and confusion. POA updated.

On 02/18/2026 at 11:45 AM, Surveyors interviewed Director of Nursing (DON) A. DON A stated Resident 7 was recently complaining of increased knee pain and upon assessment there was no swelling or redness. DON A stated s/he informed Resident 7's physician about the assessment and requested an X-ray and therapy. The physician ordered the X-ray which just showed arthritis. Physician did not order any additional pain medications outside of Tylenol. DON A thought if they could get Resident 7 moving more that would help. DON A indicated Resident 7 liked to sit in his/her chair and was increasingly having heavy incontinence episodes. Resident 7 was having difficulty standing because of the knee pain. DON A stated staff were helping Resident 7 more with transfers and toileting because of the difficulty with standing. DON A stated s/he ordered a hospital bed to help mitigate any potential for bedsores because Resident 7 would just sit in chair. DON A stated s/he did not do a change in condition assessment at that time. DON A stated Resident 7 was sent out to the hospital on 02/06/2026 for concerns related to UTI and stroke like symptoms. DON A stated family was present and saying s/he was bed bound but Resident 7 was not bed bound. S/he had planned on doing a change in condition assessment when Resident 7 came back from hospital.

On 02/18/2026 at 1:35 PM, Surveyor interviewed

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Caregiver D regarding Resident 7. Caregiver D stated one of the last times s/he assisted Resident 7, 3 caregivers were needed to assist changing Resident 7 cause Resident 7 was resisting cares. Caregiver D stated s/he started to notice a change with Resident 7 sometime in January but was unable to provide exact date.

On 02/18/2026 at 2:30 PM, Surveyor interviewed Family Member R. Family Member R stated s/he was the Power of Attorney for Resident 7. Family Member R stated s/he started to notice a decline with Resident 7 within the last 6 months and specifically in November after Resident 7's birthday. Family Member R stated the ISP was done in July 2025 and Family Member R did not agree with some of the things written in it. Family Member R gave an example of Resident 7 not completing his/her oral cares and the facility listing it as Resident 7 being independent in doing them. Family Member R stated Resident 7 will say "yes" to everything because of his/her dementia diagnosis. Family Member R stated s/he refused to sign the ISP and requested a meeting to discuss it. The facility conducted the July ISP meeting without Family Member R. In September or October, Family Member R and Case Manager S requested the facility reassess Resident 7 because they both felt Resident 7 was needing more. Family Member R stated s/he was noticing it was harder for Resident 7 to get to bathroom by self, Resident 7 was having more incontinence episodes. Family Member R indicated the assessment never happened. Family Member R stated s/he received a call from the facility that Resident 7 was complaining of knee pain. Family Member R stated Resident 7 should have had knee surgery years ago but never did. S/he was able to get around using a walker and a lift chair in his/her room. Family

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Member R stated Resident 7 was complaining of knee pain more and more. Family Member R stated DON A wanted Resident 7 to do therapy, and Family Member R stated Resident 7 has tried that before and will not do it again. Family Member R stated s/he did not know it had come to the point that staff were assisting Resident 7 more and more. Family Member R indicated Resident 7 was not wearing pants anymore due to not being able to put them on by self. Family Member R stated in the last few weeks, Resident 7 didn't want to go to dining room, 2 caregivers had to help Resident 7 into wheelchair. Family Member R stated that is when facility staff informed him/her that Resident 7 was refusing to get out of chair/bed, toileting and bathing. Family Member R stated on 02/06/2026 Resident 7 smelled of urine and she had been in the same shirt for days. Family Member R stated staff said Resident 7 was refusing to let staff toilet and change clothes. Family Member R stated on 02/06/2026, Resident 7 was sent to the hospital and diagnosed with a UTI and "sores on [his/her] buttocks." Family Member R stated hospital staff said the sores were most likely from moisture and sitting for long periods of time. Family Member R stated at the ER, hospital staff reported that Resident 7's shirt was soaking wet and had feces all the way up his/her back. Family Member R stated Resident 7 was admitted to the hospital for 6 days and discharged to a skilled nursing facility. Resident 7 was not returning to the facility.

On 02/18/2026 at 3:15 PM, Surveyor interviewed Caregiver M. Caregiver M stated s/he was familiar with Resident 7. Caregiver M stated towards the end of Resident 7's stay staff were needing to assist Resident 7 in getting up and on the toilet, Resident 7 was not using the walker anymore. Caregiver M stated the last time s/he

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worked with Resident 7 was towards the end of January and s/he did not see any visible wounds on buttocks, it wasn't red therefore no creams needed to be applied. Caregiver M stated they were to try to get Resident 7 up every 2 hours but Resident 7 did refuse frequently. Caregiver M stated the last few months Resident 7 was wanting to stay in his/her room, would not come out for meals or activities, which was a change. Caregiver M indicated Resident 7 did complain of knee pain and towards end of Resident 7's stay would refuse cares or assistance. Caregiver M stated staff would change Resident 7 right by recliner chair so she had soft place to sit. Caregiver M indicated at least the last 3 weeks to a month of his/her stay, Resident 7 was using the wheelchair because his/her knee hurt to move it. Caregiver M stated s/he started to see Resident 7 get more "reclusive" and not get up on his/her own in the fall of 2025.

On 02/19/2026 at 12:20 PM, Surveyor interviewed Case Manager S. Case Manager S verified s/he was from the managed care organization and was the case manager for Resident 7. Case Manager S indicated Resident 7 became a member of the managed care organization about 7 months ago and at that time, Resident 7 was very outgoing and independent with all activities of daily living (ADLs). Case Manager S stated right around when Resident 7 turned 80 years old (November 2025) is when s/he started to see a decline. Case Manager S stated Resident 7 was "spirited, participating in activities, cracking jokes, feisty and very mobile" and then one day Resident 7 did not want to leave bed for anything, it was not like him/her. Case Manager S stated s/he and Family Member R did request an assessment in November and had a care conference to go over some of the

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care concerns and changes with Resident 7. DON A was going to address some of the concerns and they were going to involve Family Member R and do the reassessment but they were giving them 3 months. During that time, Resident 7 continued to decline - refusing showers/baths, not getting dressed, not getting out of bed. Case Manager S stated because Resident 7 was refusing those cares were not happening. Resident 7 continued to decline - laying in soiled clothing and not wanting to get out of bed. Case Manager S stated the facility found a hospital bed to put in Resident 7's room and Case Manager S was told it would help assist with cares because staff were having a difficult time changing Resident 7 in his/her recliner. However, Case Manager S stated Resident 7 just laid in bed then too, refusing to get out. Case Manager S stated Resident 7 was sent to the hospital on 02/06/2026 and was diagnosed with a UTI and they found a number of pressure sores that were pretty severe. Case Manager S stated s/he was informed that hospital staff felt the pressure sores developed due to staff not doing a thorough job of cleaning Resident 7 because Resident 7 was covered in feces and urine along with being immobile. Case Manager S indicated Resident 7 was discharged from the hospital to a skilled nursing facility. Case Manager S stated s/he has seen slight improvements since being at skilled nursing facility, is more open cares and therapies, the UTI has been resolved.

On 02/24/2026 at 2:09 PM, Surveyor interviewed Paramedic T. Paramedic T stated s/he responded to the call for Resident 7 - upon arrival the resident was with his/her POA (Power of Attorney). The POA reported concerns that the patient was not receiving adequate care. Paramedic T stated, the crew noted a strong,

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stale odor of urine in the room. The room appeared unclean, and Resident 7 was lying on a chuc pad wearing a brief that was heavily soiled with multiple dark brown, dry urine stains. Paramedic T stated Resident 7 was more altered than reported baseline, however s/he was still able to state that s/he did not believe s/he was being cared for appropriately.

On 03/03/2026, Surveyor reviewed Resident 7's hospital record. Resident 7 was admitted to the hospital on 02/06/2026 for possible UTI and confusion. The following notes were written regarding Resident 7's condition upon arriving at the emergency department:

*"Patient presents via PW[Port Washington] EMS [Emergency Medical Services] from Lincoln Village with a c/c [chief complaint] of AMS[altered mental status]. Patient has hx [history] of dementia and is A&Ox2 [alert & oriented] at baseline. Per EMS report on arrival to [hospital] patient's family has a private nurse who comes in one time a week to check in on patient. On this private nurse's arrival patient was found to be soiled in what appeared to be a couple day's worth of stool/urine in an unchanged brief...Patient A&Ox2 on arrival with no complaints of pain. Patient was visibly soiled with urine and stool up to [his/her] neck."

*"This is an 80-year-old [fe/male] with a history of dementia with surrogate decision maker, hypothyroidism, hyperlipidemia, chronic airway obstruction, depression, pulmonary nodule presenting with increased confusion and mild elevation of temperature, brought in by EMS. The patient states that [s/he] otherwise has been doing okay and denies any complaints. On arrival the patient was noted to be covered in urine and stool by the nursing team that noted a completely soiled

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undergarments[sic] with urine and stool extending along the patient's backside up to [his/her] upper back and neck. [S/he] reports no abdominal pain or diarrhea. [S/he] also reports no fevers or chills. [S/he] has not experienced any new chest pain or respiratory difficulties today. [S/he] reports no instances of abuse or fear at [his/her] facility. The patient denies any falls or injuries. The patient specifically denies any headache, neck pain, chest pain, back pain, abdominal pain, diarrhea, nausea or vomiting. The patient does complain of pain at the anogenital region at sites of skin breakdown. [S/he] typically manages [his/her] own diaper changes but has been unable to do so recently. [S/he] was brought in due to confusion and a temperature of 99.9 degrees Fahrenheit. [S/he] resides in a memory care facility. A private nurse visits [him/her] weekly at the facility, and during today's visit, [s/he] appeared more confused than usual."

*A physical exam conducted at the hospital on 02/06/2026 stated, "...2 cm [centimeter] diameter region of breakdown to left buttock superior lateral to the gluteal cleft see image attached, no significant erythema or necrotic lesions throughout remainder of exam."

*A wound consult while in hospital noted, "Per pt [patient] report [s/he] typically wears a brief daily and usually makes it to the bathroom without incident. [S/he] endorses sitting most of the day, as [s/he] is unable to walk outside. Pt states [s/he] has a chair cushion, but it sounds like it is a kitchen chair cushion not an offloading cushion. Pt has stage 3 PIs [pressure injuries] on bilateral buttocks. Wounds are likely from a bedpan, although pt states [s/he] does use a bedpan [s/he] does not recall sitting on one for long periods of time. Wound bases are maroon, pink and red with slough, peri wound skin is moist, peeling with blanchable erythema, small

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Y3244	Continued From page 34 serosanguinous drainage noted. Barrier cream with zinc applied to wounds left open to air. Barrier cream will create a chemical barrier helping to reduce the chance of skin breakdown from moisture..." The provider did not ensure residents received adequate and appropriate care within the capacity of the facility.	Y3244		