STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008939	A. BUILDING: _____ B. WING _____	R-C 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE KENOSHA	10108 74TH ST KENOSHA, WI 53142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 02/04/2026, with information gathered through 02/19/2026, Surveyors conducted a verification visit and 3 complaint investigations at Brookdale Kenosha. One deficiency was recited with 6 new deficiencies; therefore, a total of 7 deficiencies were identified. Three of 3 complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 47	{N 000}		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interviews, the provider and its operation did not comply with all laws governing the Community-Based Residential Facility (CBRF). The licensee did not ensure compliance with DHS 83 was achieved and maintained. As a result of this survey, a total of 7 deficiencies were identified. One of the 7 deficiencies was a repeat violation. See Statement of Deficiency (SOD) CZIO11, dated 09/17/2025. Three of 3 complaints were substantiated. The licensee did not ensure resident records were kept at the facility and were available for staff to provide care and services. The provider did not ensure the posting of notices requirement	N 196		

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

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N 196	Continued From page 1 was followed. Findings include: The facility was licensed as a class CNA (non-ambulatory) community based residential facility (CBRF), serving up to 60 residents within the client groups advanced age, irreversible dementia/Alzheimer's, and public funding. At the time of the survey, 47 residents resided at the facility. Complaints On 09/26/2025, the Department received a complaint alleging residents incontinence products were not being changed as needed; A caregiver was observed displaying aggressive behaviors towards residents; One resident had an injury on her/his head from an unknown origin. On 10/10/2025, the Department received a complaint alleging a resident's care plan was not followed and the resident sustained injuries during falls. The resident was allegedly unresponsive and was moved into a wheelchair and pushed into a common area of the facility. On 01/15/2026, the Department received a complaint alleging 2 fires occurred at the facility on 01/11/2026; Gloves were not available for proper infection control; Multiple residents had behaviors and/or falls that were not managed due to inadequate staffing; and there was a concern residents were not receiving the correct medications and some were being missed. All three complaints were substantiated. Posting of Notices	N 196		

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N 196	Continued From page 2 On 10/06/2025, the provider was issued SOD CZIO11 and Notice and Order Letter. The Notice and Order Letter included the posting of notices, which stated, " . . . According to Wis. Admin. Code DHS §§ 83.13(3)(a) and 83.14(2)(h), each facility shall immediately upon receipt post next to its CBRF license, and in a public area that is visually and physically available, any citation/statement of deficiency, notice of revocation, notice of non-renewal, and any other notice of enforcement action. Citations and statements of deficiency shall remain posted for ninety (90) days following receipt. Notices of revocation, non-renewal, and other notices of enforcement action shall remain posted until a final determination is made. Therefore, the license shall immediately post this Notice and Order letter and it shall remain posted until a final determination is made." On 02/04/2026, 02/05/2026, and 02/18/2026, Surveyors were on site at the facility. Surveyors did not observe SOD CZIO11 and the accompanying Notice and Order Letter posted within the facility. On 02/18/2026, at approximately 1:45 PM, Surveyors interviewed Executive Director (ED) A. Surveyors inquired if SOD CZIO11 and the Notice and Order Letter were posted within a public area of the facility. ED A reported they were available at the front desk and were not posted. ED A confirmed the requirement. ED A reported due to resident behaviors they did not post it within the facility. Records Not Available	N 196		

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N 196	Continued From page 3 On 02/04/2026, at 9:10 AM, Surveyors opened a verification visit and 3 complaint surveys at Brookdale Kenosha. Executive Director (ED) A and Director of Nursing (DON) B were the designated representatives at the facility throughout the survey. Upon entering the facility, Surveyors requested documents from ED A and DON B, which were needed to verify corrections had been made and to investigate the complaints. On 02/04/2026, at 11:40 AM, ED A reported Regional Health Director (RHD) D was refusing to allow Surveyors access to documents related to incidents involving residents. On 02/05/2026, at 11:30 AM, Surveyors returned to Brookdale Kenosha to continue the survey. Surveyors had requested resident assessments, progress notes, and incident summaries for multiple residents. At 2:15 PM, ED A reported RHD D was attempting to retrieve documents they no longer had access to from Brookdale Kenosha. ED A reported getting the documents could have taken up to 24 hours, as a request for the records was required. On 02/05/2026 and 02/06/2026, Surveyor received resident files by email from ED A. On 02/06/2026, at 12:11 PM, Surveyors received an email from ED A which stated, " . . . We have received all that we are going to receive from Brookdale. All has been sent to you via email. We have provided you everything that we have on the Sinceri side while you were in the community . . . " On 02/18/2026, at 11:45 AM, Surveyors conducted an exit conference at Brookdale Kenosha CBRF, with ED A, DON B, RHD D, and Regional Director of Operations (RDO) E. The following was reported:	N 196		

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N 196	Continued From page 4 On 10/31/2025, Sinceri Senior Living (SSL) lost all access to the programs/systems Brookdale Kenosha (BDK) used to store resident files (including assessments), billing, payroll, timecard records, employee files, and serval other facility related documents/information. RDO E reported Person F, on behalf of SSL, negotiated with representatives from BDK in regard to documents/information which would be turned over to SSL during their transition period of assuming care for the residents at the facility. BDK had many resident records which were not shared with SSL, and therefore, not accessible to Surveyors during the survey. On 02/04/2026, at 12:21 PM, Assisted Living Regional Director (ALRD) F called BDK licensee representative, Licensee G. ALRD F was connected to a voicemailbox for Licensee G's assistant. ALRD F left a message identifying who s/he was, and that s/he needed to talk to Licensee G as soon as possible because Surveyors were onsite at BDK to conduct a survey and needed access to records. ALRD F stated in the voicemail s/he needed Licensee G to call back as soon as possible due to Surveyors not being able to obtain the needed records at the facility. ALRD F further explained Brookdale Senior Living was still responsible as the licensee for BDK. On 02/05/2026, at approximately 9:00 AM, ALRD F received a voicemail message, from a person who identified as Licensee G's assistant, informing ALRD F they told Licensee G about the message. Licensee G did not return ALRD F's call request. Notice of Change of Ownership (CHOW)	N 196		

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N 196	Continued From page 5 On 02/03/2026, Surveyors reviewed the facility files, and identified the following: A Letter of Intent - CHOW was written on 03/14/2025 and was received by the Department on 03/14/2025. The CHOW was expected to take place on or about 09/01/2025. A Notice of a CHOW letter was written on 11/03/2025 and was received by the Department on 11/12/2025. The letter stated, " . . . The change of ownership is scheduled to occur upon regulatory licensure approval from the Wisconsin Department of Health . . . " During Surveyors' onsite visits, ED A and Wellness Director B reported Sinceri Senior Living assumed care of the residents as of 11/01/2025, after Brookdale Kenosha turned the facility over to them. As of 11/01/2025, all staff at the facility were employed with Sinceri Senior Living and no longer had access to the systems with resident and staff information, which Brookdale Kenosha used during their operation of the facility.	N 196		
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.	N 381		

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N 381	Continued From page 6	N 381		

This Rule is not met as evidenced by:
Based on observation, interview, and record review the Community Based Residential Facility (CBRF) did not ensure each residents' needs, abilities, and physical and mental condition were assessed when there was a change in needs, abilities, or condition for 1 of 1 resident (Resident 8). Resident 8 had 2 falls with injuries, of which post fall assessments were incomplete or not completed.

Findings include:

On 02/05/2026, at 12:15 PM, Surveyors observed Resident 8 seated at a dining table in a wheelchair. Resident 8 had a baseball sized bruise on the left side of her/his face/head. Resident 8's spouse, Person H was visiting and Surveyors interviewed her/him. Person H reported the following:

Resident 8 had an unwitnessed fall on 02/01/2026, which caused bruising to her/his face. Resident 8 did not typically utilize a wheelchair and Person H was unaware of why s/he was seated in a wheelchair. Person H was unaware of reports completed by the facility for the fall Resident 8 had on 02/01/2026.

On 02/05/2026, at approximately 2:15 PM, Surveyor requested all assessments completed for Resident 8, and any information on the fall from 02/01/2026. Surveyor did not receive a post fall assessment for the fall Resident 8 had on 02/01/2026.

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N 381	Continued From page 7 On multiple days beginning on 02/04/2026 through 02/18/2026, Surveyors reviewed Resident 8's records and the following was identified: Resident 8's admission record face sheet documented s/he was admitted to the facility on 10/24/2024, with diagnoses including Alzheimer's disease with early onset, and dementia moderate, with agitation. Resident 8's individual service plan, dated 09/24/2025, documented a history of seizures and was at a heightened risk for falls. Post Fall Evaluation, dated 09/22/2026, did not identify risk factors which may have contributed to the fall. The assessment was incomplete and did not provide information needed to prevent future falls. Fall Incident Report, generated on 02/04/2026, identified Resident 8 had an unwitnessed fall on 02/01/2026. Resident 8 was found lying on left side in the dining room. Memory Care Observations documented Resident 8 had a hematoma to the left side of her/his forehead and a small laceration. Resident 8's files did not contain evidence a post fall assessment was completed following the fall on 02/01/2026. On 02/06/2026, Surveyors interviewed Executive Director (ED) A. ED A reported all available and requested documents had been provided.	N 381		
N 384	83.35(1)(d) Retain written report of assessment. Assessment documentation. The CBRF shall prepare a written report of the results of the assessment and shall retain the assessment in	N 384		

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N 384	Continued From page 8 the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure written reports, for 1 of 1 resident (Resident 8), of the results of assessments prior to admission, annually, and following changes were retained in the resident's record. Resident 8's pre-admission assessment and annual assessment were not retained in her/his record. Between 01/10/2025 and 02/01/2026, Resident 8 had 8 falls which resulted in changes in needs, abilities, and/or condition, and the post fall assessments were not available, nor retained in Resident 8's record. Findings include: On multiple days beginning on 02/04/2026 through 02/18/2026, Surveyors reviewed resident records and the following was identified: Resident 8's admission record face sheet documented s/he was admitted to the facility on 10/24/2024, with diagnoses including Alzheimer's disease with early onset, and dementia moderate, with agitation. Resident 8's record did not contain an initial assessment for calendar year 2024 or an annual assessment for calendar year 2025. Resident 8's individual service plan (ISP), dated 09/24/2025, documented Resident 8 was at a heightened risk for falls. Resident 8's ISP documented falls for the following dates, which did not include post fall assessments: 01/10/2025 - Fall requiring an emergency room (ER) visit, with a diagnosis of closed fracture to left side maxilla, closed fracture of nasal bone,	N 384		

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N 384	Continued From page 9 tooth avulsion, and influenza A. 02/12/2025 - Fall requiring an ER visit, with a diagnosis of eyebrow laceration, fracture of nasal bone, and left hip hematoma. Admitted to the hospital. 03/09/2025 - Fall requiring an ER visit, with a diagnosis of laceration to forehead and sutures. 04/12/2025 - Fall requiring an ER visit, with a diagnosis of right clavicle fracture. Admitted to the hospital. 05/18/2025 - Fall - Opted out of transport to the ER. On 05/19/2025, saw an orthopedic doctor and was diagnosed with a fracture of 3rd metacarpal. 06/04/2025 - Fall - Bruises to left eyebrow and rug burn on left cheek and nose. Interventions included possible hospice care. 06/26/2025 - Fall - Walked through the back dining room and tripped over a chair. Unknown injuries. The above 7 documented falls did not have a post fall assessment in Resident 8's record. On 02/18/2026, at 11:45 AM, Surveyors interviewed Executive Director (ED) A, Director of Nursing (DON) B, Regional Health Director (RHD) D, and Regional Director of Operations (RDO) E, and the following was reported: DON B and ED A reported they provided Surveyors with all documentation available to them which had been requested during the survey. ED A confirmed Sinceri took over	N 384		

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N 384	Continued From page 10 operations from Brookdale on 11/01/2025. RDO E reported records management was negotiated prior to the transition from Brookdale to Sinceri. They did not have access to resident assessments conducted prior to 11/01/2025. ED A confirmed resident records were required to be kept and made accessible to facility staff.	N 384		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure 1 of 1 resident (Resident 4) had a comprehensive individualized service plan (ISP) which identified the resident's needs and desired outcomes, program services, frequencies and approaches of the needed care, measurable goals with specific time limits for attainment, specified methods for delivering care, and who was responsible for delivering the care,	N 386		

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N 386	Continued From page 11 for the refusal of medications and combative behaviors. Findings include: The facility was licensed as a class CNA (non-ambulatory) community based residential facility (CBRF), serving up to 60 residents within the client groups advanced age, irreversible dementia/Alzheimer's, and public funding. On multiple days beginning on 02/04/2026 through 02/18/2026, Surveyors reviewed resident records and the following was identified: Resident 4 Resident 4 was admitted to the facility on 09/22/2025, with diagnoses including unspecified dementia, moderate, with anxiety. Facility progress notes on 12/17/2025, at 12:11 PM, documented, "On December 16th around 1945 (7:45 PM), [Licensed Practical Nurse (LPN) C] was made aware that [Resident 4] had struck a staff member in the face. [LPN C] was informed that [Resident 4] was displaying aggressive behaviors while trying to provide care. [Resident 4] did cause injury to the staff member. The staff member experienced a nosebleed. This resulted in the staff member being sent out to the ER (emergency room) . . . [LPN C] and staff have been made aware to keep a safe distance while providing cares and reapproaching [Resident 4] when [s/he] is displaying aggressive behavior." Facility progress notes on 12/19/2025, at 12:39 PM, documented, "[DON B] updated PCP (primary care provider) regarding [Resident 4's] refusals of medications especially eye drops and	N 386		

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N 386	Continued From page 12	N 386		

ointments, [Resident 4] continues with aggressive behaviors at times with staff and [her/his] own family members, approach is very huge with [Resident 4] and staff has been educated on approach, [DON B] sent message to PCP inquiring the use of ABH (Ativan, Benadryl, and Haldol) cream for [Resident 4] due to behaviors and refusals of medications, [DON B] awaiting response from PCP, [DON B] did speak with POA (power of attorney) and POA is open to trying cream and discontinuing medications as [s/he] reported this is a sign that [Resident 4] is refusing medications [sic]. [DON B] sent message to PCP to call POA and discuss discontinuing medications."

Resident 4's ISP, dated 10/27/2025, did not document Resident 4's refusal of medications or aggressive/combative behaviors. Comments under the area of medications documented, " . . . [Resident 4] is on scheduled Seroquel twice daily for anxiety and agitation. [Resident 4] has a PRN (as needed) order for lorazepam 0.5 mg (milligrams) for anxiety or agitation." Behavior management was documented as not applicable in Resident 4's ISP.

On 02/18/2026, at 11:45 AM, Surveyors interviewed Executive Director (ED) A, Director of Nursing (DON) B, and the following was reported:

Resident 4's ISP did not have anything for behaviors listed. DON B and LPN C were responsible for creating and updating ISPs. ED A reported Resident 4 had behaviors in the past but has not had any behaviors recently. S/He reported it may have been from Resident 4's move to the facility from out of state. A new ISP was created for Resident 4 following Surveyors 1st and 2nd days at the facility.

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N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review, observations, and interviews, the provider did not implement and follow individual service plans (ISPs) as written for 1 of 1 resident (Resident 8). Interventions were added for Resident 8, following falls, and there was no evidence the interventions were implemented and followed. Findings include: Record Review On multiple days beginning on 02/04/2026 through 02/18/2026, Surveyors reviewed Resident 8's records and the following was identified: Resident 8's admission record face sheet documented s/he was admitted to the facility on 10/24/2024, with diagnoses including Alzheimer's disease with early onset, and dementia moderate, with agitation. Resident 8's ISP, dated 09/24/2025, documented s/he had a history of seizures and was at a heightened risk for falls. Resident 8's ISP documented the following fall incidents and added interventions: On 04/12/2025, Resident 8 had a fall and the intervention added was Resident 8 was to wear a gait belt with transfers and walking.	N 388		

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N 388	Continued From page 14 On 06/04/2025, Resident 8 had a fall and the intervention added was possible hospice care. There was no indication of another intervention to prevent further falls. Resident 8's ISP did not contain further information on hospice care. On 06/26/2025, Resident 8 had a fall and the intervention added was for staff to ensure safe walkways in common areas. Resident 8's file did not contain evidence s/he had been admitted to hospice care. Observations On 02/04/2026, 02/05/2026, and 02/18/2026, Surveyors were on site at the facility. Resident 8 was not observed wearing a gait belt. The walkways in common areas were cluttered with paint cans, drop cloths, and other items used for painting. Painters were actively working throughout the facility. Residents were observed freely moving about throughout the facility and were unable to navigate the walkways in common areas safely. Throughout the onsite visits, Executive Director (ED) A and other staff had to request the painters relocate and move items out of the way of residents moving about the facility on multiple occasions. Interviews On 02/05/2026, at 12:15 PM, Surveyors interviewed Resident 8's spouse, Person H, who was visiting. The following was reported: Resident 8 had 10 emergency room visits in 2025 from falls, which resulted in multiple injuries to include a broken collar bone. Resident 8's ISP was not updated as changes occurred. There had been no fall preventions implemented after falls	N 388		

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N 388	Continued From page 15 occurred. The only intervention Person H felt had been implemented and had worked to prevent falls, was when Resident 8 received 1:1 services. Person H reported s/he has "given up," and "[Resident 8's] going to continuing falling until [s/he] kills [her/himself] falling." On 02/18/2026, at 11:45 AM, Surveyors interviewed ED A and Director of Nursing (DON) B, and the following was reported: A gait belt for transfers and walking was added as an intervention after Resident 8 fell on 04/12/2025. The gait belt was used for a short time due to Resident 8 having been a very active person. ED A reported it was "demeaning" to walk Resident 8 around with a gait belt since s/he walked around quickly without much assistance. When Resident 8 went out for an injury, it slowed her/him down and they were able to manage fall prevention with staff intervention. DON B did not confirm hospice services were ever implemented for Resident 8.	N 388		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement	{N 389}		

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{N 389}	Continued From page 16 with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 residents (Resident 2, Resident 7, Resident 3, and Resident 8) had an updated individual service plan (ISP) when there was a change in their needs. Resident 2's and Resident 7's ISPs did not include information they were receiving hospice services. Resident 3's ISP was not updated to include toileting checks after a fall. Resident 8's ISP was not updated to include updated nutritional guidelines and additional fall interventions. This is a repeat deficiency. See Statement of Deficiency (SOD) CZIO11, dated 09/17/2025. Findings include: Resident 2 On 02/04/2026, Surveyors reviewed Resident 2's ISP. Resident 2 was admitted to the facility on 07/24/2023. The most recent ISP was signed on 12/09/2025. Resident 2 was enrolled with hospice on 10/30/2024. The ISP made no mention that Resident 2 was on hospice or who the hospice company was. On 02/04/2026 at 10:00 AM, Surveyors interviewed Wellness Director B. Wellness Director B confirmed that s/he was responsible for updating resident care plans. Wellness Director B also confirmed Resident 2 was on hospice services. Wellness Director B did not have a reason as to why Resident 2's ISP did not reflect hospice providing services to Resident 2.	{N 389}		

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{N 389}	Continued From page 17 Resident 7 On 02/04/2026, Surveyors reviewed Resident 7's ISP, dated 10/15/2025. Resident 7 was admitted on 09/12/2023. Resident 7's ISP did not mention Resident 7 was enrolled in Hospice services. On 02/04/2026 at 10:08 AM, Surveyors interviewed Wellness Director B. Wellness Director B stated, after Resident 7's fall with fractures, the ISP was not updated, and the most current ISP was from 10/15/2025. Resident 7 was enrolled with hospice on 01/16/2026. Wellness Director B confirmed the ISP was not updated with Hospice. Resident 3 Resident 3 was admitted to the facility on 07/28/2025, with a history of falls. Progress notes documented Resident 3 had an unwitnessed fall on 08/10/2025. Resident 3 was transported to the emergency room and required surgery for a right femur fracture. Following surgery, Resident 3 was in rehab for several weeks and returned to the facility on 09/15/2025. Facility progress notes on 09/15/2025, at 4:57 PM, documented, " . . . Resident returned to the community from rehab stay due to right femur fracture, resident is 50% weight bearing on right leg, resident is able to stand with assistance pivot and transfer into wheelchair with assist of one [sic] . . . " Resident 3's ISP, dated 09/15/2025, documented, " . . . Escort and Mobility: . . . Comments: . . . Interventions are for staff to toilet [Resident 3] every 2 hrs (hours) . . . " Resident 3's ISP, in the	{N 389}		

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{N 389}	Continued From page 18	{N 389}		

area of 'Bathroom Assistance,' did not include measurable goals with specific time limits for attainment, or the frequencies of the needed care. This area did not mention every 2-hour checks/toileting.

On 02/04/2026, at 3:52 PM, Surveyors interviewed Director of Nursing (DON) B and the following was reported: Upon Resident 3's return to the facility on 09/15/2025, her/his ISP was updated and should have included toileting every 2 hours. DON B reported the facility completed checks of Resident 3 every 2 hours but had not been documented when the checks were completed. On 09/16/2025, at 4:25 PM, Resident 3 was located in her/his apartment after an unwitnessed fall; at 3:30 PM, DON B checked on Resident 3 and s/he denied needing to use the restroom.

On 02/18/2026 at 11:45 AM, Surveyors interviewed Executive Director (ED) A, Director of Nursing (DON) B, and the following was reported:

The facility had attempted to work on therapy with Resident 3. S/He was known to slip off the couch/chair while watching television. The facility implemented frequent checks of Resident 3 and kept everything s/he needed next to her/him. Staff were performing hourly checks of Resident 3 but they were not logged. DON B reported the goal was to keep Resident 3 in the common areas with her/his cell phone.

Resident 8

Resident 8 was admitted to the facility on 10/24/2024, with diagnoses including Alzheimer's disease with early onset, and dementia moderate, with agitation. Resident 8's individual service

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{N 389}	Continued From page 19	{N 389}		

plan, dated 09/24/2025, documented a history of seizures and was at a heightened risk for falls. Resident 8's ISP did not include updated information related to fall interventions after his/her falls in fall documentation below.

Resident 8's physician's orders documented, " . . . double portions/increased protein," which was active as of 09/26/2025. Resident 8's most current ISP, dated 09/24/2025, documented regular meal portions under the area of nutrition.

Post Fall Evaluation, dated 09/17/2025, identified Resident 8 had a fall resulting in an ER visit with a diagnosis of closed fracture of nasal bone and closed fracture of multiple ribs to the left side. Resident 8 possibly had a seizure, causing the fall. There were no interventions added to the ISP.

Post Fall Evaluation, dated 09/22/2025, identified Resident 8 had a fall and was assigned a 1:1 caregiver during 2nd and 3rd shifts. The fall and any interventions were not included in Resident 8's ISP.

Post Fall Evaluation, dated 10/07/2025, identified Resident 8 had a fall resulting in a friction burn to forehead and nose redness/scrapes to bilateral knees. Risk factors contributing to the fall identified a change in medical/cognitive status. The fall and any interventions were not included in Resident 8's ISP.

Fall Incident Report, generated on 02/04/2026, identified Resident 8 had an unwitnessed fall on 02/01/2026, and was found lying on her/his left side in the dining room. The fall and any interventions were not included in Resident 8's ISP.

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{N 389}	Continued From page 20 On 02/18/2026 at 11:45 AM, Surveyors interviewed Executive Director (ED) A, Director of Nursing (DON) B, and the following was reported: Resident 8's ISP had not been updated after the fall on 09/22/2025. DON B reported following Surveyors' 1st and 2nd days at the facility, Resident 8's ISP was updated. DON B and Licensed Practical Nurse (LPN) C were responsible for creating and updating ISPs. Surveyor's were not provided with an updated ISP for Resident 8. Cross Reference: N0408 83.37(1)(i) - PRN Psychotropic Medication	{N 389}		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN	N 408		

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N 408	Continued From page 21 psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident's (Resident 5's) individual service plan (ISP) included rationale for use and a detailed description of the behaviors which indicate the need for administration of as needed (PRN) risperidone. Findings include: On 01/15/2026 the Department received a complaint which alleged residents' behaviors were not being managed and they were not receiving medications needed to keep them calm. On 02/05/2026, at 10:30 AM, Surveyors reviewed Resident 5's record, and the following was identified: Resident 5 was admitted on 04/15/2025. The most recent ISP was signed and dated 10/28/2025. Per Resident 5's Medication Administration Record (MAR), on 10/08/2025 an order was received for risperidone 0.5 milligram (mg) tablet (tab), take ½ tab (0.25 mg) by mouth 3 times daily as needed for anxiety/hallucinations. The ISP did not contain the PRN medication, nor the detailed description of the behaviors indicating the need for the administration of the medication. On 02/18/2025 at 12:00 PM, Surveyors interviewed Wellness Director B. Wellness Director B confirmed that Resident 5 has an order for the PRN risperidone, but the medication has not been administered. Wellness Director B	N 408		

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N 408	Continued From page 22 stated s/he understood the regulation requirements for when a resident is prescribed a PRN psychotropic and would ensure the ISPs are updated. Cross Reference: N0389 83.35(3)(d) - Service Plans Updated Annually Or On Changes	N 408		