

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019652	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/22/2026
NAME OF PROVIDER OR SUPPLIER BRIGHT SKY LIVING COMMUNITY OF CHIPPEWA		STREET ADDRESS, CITY, STATE, ZIP CODE 1126 EVERGREEN LN CHIPPEWA FALLS, WI 54729		
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N 000	Initial Comments On 07/13/2026, Surveyor completed 2 complaint investigations at Bright Sky Living Community of Chippewa Falls. Data collected through 07/22/2026. Two of 2 complaints were substantiated. Four deficiencies were identified. Census: 7	N 000		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written report was sent to the Department within 3 working days after incidents requiring hospital admission or emergency room treatment of Resident 1. Findings include: On 07/13/2026 at 9:30 AM, Surveyor requested all incident reports for Resident 1. Assistant Administrator (AA) A provided Surveyor with Resident 1's incident reports. An incident report dated 04/13/2026 at 7:45 AM indicated Resident 1 had fallen, hit his/her head, 911 was called, and Resident 1 was admitted to the	N 165		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 165	Continued From page 1 hospital. At 9:50 AM, Surveyor asked AA A if s/he submitted a report to the Department related to the 04/13/2026 incident. AA A stated s/he did not. S/he was unaware that a report had to be submitted for that situation.	N 165		
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 record review and interview, the provider did not assess Resident 1's needs, abilities, and physical and mental condition when there was a change in needs, abilities, or condition. Findings include: On 07/13/2026 at 9:30 AM, Surveyor interviewed Assistant Administrator (AA) A. AA A stated s/he went to the hospital to assess Resident 1 for return. AA A stated s/he checked to make sure	N 381		

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N 381	Continued From page 2 Resident 1 was a 1-person assist as they only staff 1 person per shift. AA A stated s/he did not look at Resident 1's skin in the hospital. AA A reported that Resident 1 returned as a 1-person assist, with a catheter, and appeared to be his/her normal self. At 2:00 PM, Surveyor reviewed multiple staff notes from 05/01/2026 through 05/05/2026 and noted that staff assisted Resident 1 to and from the toilet multiple times, helped get Resident 1 in and out of bed, and transferred him/her to and from his/her recliner. At 2:45 PM, Surveyor reviewed Resident 1's After Visit Summary (AVS) from his/her hospital stay dated 04/16/2026 through 05/01/2026. Under the "Lines/Drains/Airways/Wounds" section of the AVS, the following was noted: -An Indwelling Urinary catheter placed 04/27/2026 -A coccyx wound documented on 04/14/2026, during a previous hospitalization, remained present upon discharge. -A buttocks wound located on "left lateral lower" documented on 04/14/2026, during a previous hospitalization, remained present upon discharge. -"Right planter blacken circular area of calluse [sic]" noted on 04/17/2026, remained present upon discharge. On 07/14/2026 at 6:30 AM, Surveyor requested all assessments completed on Resident 1. At 2:56 PM, Surveyor received an email that read, "Here is [Resident 1's] assessment." At 3:30 PM, Surveyor reviewed Resident 1's only documented assessment. Resident 1's	N 381		

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N 381	Continued From page 3 assessment was dated 02/11/2026, 5 days prior to Resident 1's admission to the facility. Resident 1's assessment noted that s/he was independent with dressing, eating, grooming, oral care, and toileting. Resident 1's assessment indicated that his/her skin was in "good" condition and there was no skin breakdown. It was noted under gait/balance that Resident 1 walked with and without a walker, and s/he had some decreased muscular coordination. A handwritten note on the bottom of the assessment indicated that Resident 1 was independent in all major areas. On 07/16/2026 at 10 AM, Surveyor reviewed Resident 1's hospital notes provided by Adult Protective Services (APS). The hospital note, dated 05/01/2026 read, in part: " ... [s/he] required assistance for mobility and demonstrated slow progress, with persistent balance deficits, posterior lean during transfers, and fatigue with activity. By discharge, [s/he] was able to ambulate short distances with a front-wheeled walker and contact guard assistance ... and had difficulty communicating [his/her] basic needs. Staff supervision and support were recommended, and [his/her] group home confirmed that [his/her] cognitive status was consistent with baseline. [S/he] developed acute urinary retention requiring Foley catheter placement, failed a voiding trial, and the catheter was replaced; outpatient urology follow up was planned. [S/he] also experienced constipation ... had a bowel movement prior to discharge ... [s/he] was deemed appropriate to return to [his/her] group home with continued support for ADLs (activities of daily living), IADLs (instrumental activities of daily living), and supervision for safety and cognitive needs." On 07/20/2026, Surveyor interviewed AA A and	N 381		

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N 381	Continued From page 4 Administrator B about updating assessments. AA A stated that s/he went to the hospital to assess Resident 1 before his/her return to the facility on 05/01/2026. AA A reported that his/her main focus when s/he went to assess Resident 1 was his/her mobility. S/he stated the only time they completed an in-depth assessment that included wound and skin assessments was the pre-admission assessment. AA A stated that s/he went to the hospital to look at Resident 1 and stated there was no abnormal stuff going on with his/her skin. Administrator A confirmed there was no documented assessment of Resident 1 before his/her return to the facility on 05/01/2026. Resident 1's was not assessed when there was a change in needs, abilities, or conditions. Resident 1 returned from the hospital and needed mobility assistance, had a urinary catheter, and multiple wounds. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 381		
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	N 389		

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N 389	Continued From page 5 involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not review and revise the individual service plan (ISP) when there was a change in Resident 1's needs, abilities, or physical or mental condition. Findings include: On 07/13/2026 at 9:30 AM, Surveyor interviewed Assistant Administrator A (AA). AA A stated Resident 1 returned from a hospitalization on 05/01/2026 and was a 1-person assist. AA A stated Resident 1 had a catheter in place at discharge, which was new. AA A stated initially when Resident 1 returned s/he was a 2-person assist into his/her recliner but that was the only time s/he required 2 staff for a transfer. At 9:35 AM, Surveyor requested Resident 1's last 2 ISPs. At 9:40 AM, AA stated that Resident 1 only had 1 ISP. Surveyor reviewed the ISP dated 03/23/2026. Resident 1's ISP, read in part: "Mobility- Ambulation - Independent- no assistance needed with ambulation" "Mobility-Transfer- Independent- no assistance needed with transferring" "Mobility-Wheelchair- No wheelchair in use." "Toileting Needs- Needs reminders/help to use the bathroom through the day and night"	N 389		

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N 389	Continued From page 6 "Skin- Denies Skin problems" At 2:00 PM, Surveyor reviewed multiple staff notes from 05/01/2026 through 05/05/2026 and noted that staff assisted Resident 1 to and from the toilet multiple times, helped get Resident 1 into and out of bed, and transferred to and from his/her recliner. At 2:45 PM, Surveyor reviewed Resident 1's After Visit Summary (AVS) from his/her hospital stay dated 04/16/2026 through 05/01/2026. Under the "Lines/Drains/Airways/Wounds" section of the AVS, the following was noted: -An Indwelling Urinary catheter placed 04/27/2026 -A coccyx wound documented on 04/14/2026, during a previous hospitalization, remained present upon discharge -A buttocks wound located on "left lateral lower" documented on 04/14/2026, during a previous hospitalization, remained present upon discharge -"Right planter blacken circular area of calluse [sic]" noted on 04/17/2026, remained present upon discharge. On 07/16/2026 at 10 AM, Surveyor reviewed Resident 1's hospital notes provided by APS (Adult Protective Services). The hospital note, dated 05/01/2026 read, in part: " ... [s/he] required assistance for mobility and demonstrated slow progress, with persistent balance deficits, posterior lean during transfers, and fatigue with activity. By discharge, [s/he] was able to ambulate short distances with a front-wheeled walker and contact guard assistance ... and had difficulty communicating [his/her] basic needs. Staff supervision and support were recommended, and [his/her] group	N 389		

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N 389	Continued From page 7 home confirmed that [his/her] cognitive status was consistent with baseline. [S/he] developed acute urinary retention requiring Foley catheter placement, failed a voiding trial, and the catheter was replaced; outpatient urology follow up was planned. [S/he] also experienced constipation ... had a bowel movement prior to discharge ... [s/he] was deemed appropriate to return to [his/her] group home with continued support for ADLs (activities of daily living), IADLs (instrumental activities of daily living), and supervision for safety and cognitive needs." On 07/20/2026, Surveyor interviewed AA A and Administrator B about ISPs. Administrator B stated that they did not make ISP changes for 3 days after a change in condition; this was meant to find the Resident's new baseline. AA A stated when Resident 1 returned to the facility s/he was a 1-assist and used a wheelchair to get around. Surveyor asked if Resident 1's ISP was updated upon any of his/her changes including mobility assistance, catheter, and wounds. Administrator A stated, "Nope. I did not update [his/her] ISP." Resident 1's ISP was not updated to show the changes with his/her mobility level now requiring assistance with staff, a walker, and at times a wheelchair. In addition, it was not noted that Resident 1 had a catheter or how to care for that catheter. Resident 1's ISP also did not indicate that s/he had any wounds or skin breakdown.	N 389			
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined	N 431			

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N 431	Continued From page 8 under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident's physician or dietician. 3. The CBRF shall document communication with the resident's physician and other health care providers, and shall record any changes in the resident's health or mental health status in the resident's record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure appropriate health monitoring and arrangement of necessary medical services for 1 of 1 sampled resident (Resident 1) during the 4 days following hospital discharge by failing to monitor the resident's condition, identify significant changes in status, and obtain timely medical evaluation. Findings include: The Department received multiple complaints related to resident care, treatment, and neglect.	N 431		

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N 431	Continued From page 9 On 07/13/2026 at approximately 9:00 AM, Surveyor arrived at the facility and was greeted by Caregiver C. At approximately 9:10 AM, Surveyor interviewed Caregiver C. Caregiver C reported that s/he had worked at the facility since they opened in 2024. Surveyor asked Caregiver C about skin assessments. Caregiver C stated that caregivers were responsible for skin assessments, and they usually completed them on shower days. Surveyor interviewed Caregiver C about Resident 1. S/he stated that at baseline, Resident 1 was a little confused but was ambulatory and independent with most tasks. Caregiver C reported that Resident 1 never had wounds that s/he was aware of. Caregiver C stated that s/he got Resident 1 up on 05/04/2026 and did not notice any skin concerns. Caregiver C reported that on 05/05/2026 s/he checked on Resident 1 throughout the shift but could not get him/her to wake up. S/he reported that s/he had to sternal rub Resident 1 to get a response, and even then, s/he would just moan and groan. Caregiver B stated that s/he notified Assistant Administrator (AA) A of those findings and was told to continue monitoring him/her. At approximately 9:30 AM, Surveyor interviewed AA A. AA A indicated that s/he was wondering when the State was going to come, as s/he noted that Adult Protective Services (APS) and Law Enforcement had already investigated the incident related to Resident 1's death and s/he anticipated the State would also follow up. On 07/13/2026 at approximately 9:40 AM, Surveyor requested Resident 1's record from AA A.	N 431			

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N 431	Continued From page 10 At 9:50 AM, AA A explained to Surveyor that when Resident 1 moved into the facility on 02/16/2026 s/he was independent with all ADLS (activities of daily living). AA A stated that Resident 1 never had any wounds. AA A stated that on 04/13/2026 Resident 1 had fallen, hit his/her head, was admitted to the hospital, and later transferred to a TCU (transitional care unit) within the hospital. AA A reported that Resident 1 returned to the facility on 05/01/2026. AA A reported that when Resident 1 returned to the facility s/he was walking, and a 1-person assist. AA A stated that Resident 1 had a catheter upon return, which was new, but otherwise appeared to be his/her "regular" self. S/he noted that Resident 1 had a distended stomach when s/he returned and ended up having multiple large bowel movements which s/he noted as "blowouts" and then became really tired. AA A reported that they regularly performed skin assessments on shower days, and they never noticed any skin concerns with Resident 1. Resident 1 was sent back to the hospital via EMS (emergency medical services) on 05/05/2026 due to being found with black stuff all over his/her mouth and on his/her shirt. AA A reported that Resident 1 never returned to the facility as s/he passed away. At approximately 2:00 PM, Surveyor reviewed Resident 1's shift notes. The following notes related to Resident 1's condition read, in part: -05/01/2026 12:59 PM, "Resident returned from the hospital around 12:30 pm. Resident was a two person assist from wheelchair to [his/her] recliner". -05/01/2026 4:13 PM "Writer asked resident if [s/he] wanted to get up and [s/he] stated no". -05/02/2026 6:24 PM "[Resident 1] stayed in a room in a recliner, [sic] the entire shift except for the last 30 minutes ... [Resident 1] did not say	N 431			

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N 431	Continued From page 11 anything to any of the residence [sic]. [S/he] was not verbal throughout the shift. [S/he] sat in a recliner in [his/her] room with the TV (television) on, but [s/he] was not watching the TV sometimes [s/he] would nap and sometimes [s/he] would just be staring off into nothing. [Resident 1] was transferred from the recliner into the bathroom toilet. Staff [sic] sit on the toilet for about 20 minutes before staff decided to take [him/her] off the toilet [sic] once staff took [him/her] off the toilet [Resident 1] had a very large BM (bowel movement) on the bathroom floor. [S/he] continued to have large BMs from about 5:27 PM to well after 7 PM. Just consistently having loose bowel movements while on the toilet. [Resident 1] was was [sic] on the toilet when the staff shift was over". -05/02/2026 11:15 PM "[Resident 1] was on the toilet when staff arrived [s/he] was showered and had to be placed back on the toilet due to BM [s/he] continued to have BM until about 9 PM [sic] [s/he] was then transferred into bed and was dead weight and dropped to the floor so two staff were required to transfer [him/her] [sic] [his/her] vitals were taken throughout the shift and communicated with management [s/he] refused to drink anything so meds were unable to be given this shift [sic] [s/he] is currently in bed. When staff went in to check on [him/her] at 11 pm [s/he] seemed more alert than earlier this shift... continues to have BM and has been changed twice more [sic] as of midnight since being put in bed at ten pm." -05/03/2026 3:00 AM "Called staff to check in on how [Resident 1] was doing. Staff stated that [Resident 1] had 2 more bowel movements and had been given a shower to get cleaned up. Staff stated that [Resident 1] was laying down watching TV and sleeping off n [sic] on. Staff stated [Resident 1] had appeared to have perked up and	N 431		

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N 431	Continued From page 12 had drank some water. Staff is continuing to check on [Resident 1] continuously for any changes. -05/03/2026 3:27 PM. "[Resident 1] was awakened by the staff and showered for the day. [Resident 1] refused to take [his/her] meds this morning and [s/he] refused to eat breakfast this morning ... [s/he] did have a few bites of lunch ... [s/he] is still continuing to refuse [his/her] meds." -05/05/2026 1:05 AM. "[S/he] was in bed when staff arrived [sic] [S/he] refused meds and remained in bed [sic] appeared to be asleep on checks [s/he] was offered water each time staff went to check on [him/her] and [s/he] didn't drink anything." -05/06/2026 5:13 PM "Resident was in [his/her] room and appeared to be resting upon this writers arrival. [S/he] was non-complaint with taking [his/her] medication this shift. [S/he] was also non-complaint with eating any meals this shift. This writer did notify manager. [S/he] had a total out put [sic] of 24 ml (milliliters). [S/he] is currently in [his/her] room in bed appeared to be resting." On 07/16/2026 at 10:00 AM, Surveyor reviewed hospital notes provided by APS. A history and physical (H&P) dated 04/13/2026 at 2:07 PM read, "[Resident 1] presented to the ED (emergency department) via EMS (emergency medical services) on 4/13 after an unwitnessed fall at [his/her] group home. [S/he] was unable to provide exact details of fall, states [s/he] hit back of head." A physical examination note indicated under skin: "Bruise noted to right great toe." A discharge note dated 05/01/2026 read, in part, " ... [s/he] required assistance for mobility and demonstrated slow progress, with persistent	N 431			

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N 431	Continued From page 13 balance deficits, posterior lean during transfers, and fatigue with activity. By discharge, [s/he] was able to ambulate short distances with a front-wheeled walker and contact guard assistance ... and had difficulty communicating [his/her] basic needs. Staff supervision and support were recommended, and [his/her] group home confirmed that [his/her] cognitive status was consistent with baseline. [S/he] developed acute urinary retention requiring Foley catheter placement, failed a voiding trial, and the catheter was replaced; outpatient urology follow up was planned. [S/he] also experienced constipation ... had a bowel movement prior to discharge ... [s/he] was deemed appropriate to return to [his/her] group home with continued support for ADLs (activities of daily living), IADLs (instrumental activities of daily living), and supervision for safety and cognitive needs." A H&P note dated 05/06/2026 at 1:44 AM read in part, " ...with recent admission to Mayo hospital from 4/13-4/16 for acute kidney injury, subsequently discharged to TCU from 4/16 to 5/1. Patient reportedly was oriented times two to three at baseline, was able to ambulate with assistance with walker, needed moderate assistance with ADLs ... Contacted EMS when patient had hematemesis (vomiting blood). Patient was intubated in ED (emergency department). [S/he] was profoundly hypotensive on arrival and aggressively resuscitated. Hemoglobin had been 12 on discharge four days ago, dropped to 6.5 with suspected GI (gastrointestinal) bleed. Patient did receive three units of whole blood, one unit packed red blood cells, and one unit of FFP (fresh frozen plasma) due to INR of 1.7... [S/he] was noted to have creatinine elevated at 8, potassium of 6.5, lactate of four in bicarb of 17 initially ... Patient also had a diffuse inflammation	N 431		

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N 431	Continued From page 14 of fluid in small bowel concerning for enteritis or colitis ... I did express my concerns that the patient has extensive pressure injuries and there may have been a delay in care in [his/her] being transferred from group home ... I did discuss with [HCPOA (healthcare power of attorney)] that patient does have severe sepsis with septic shock, possible GI bleed with acute anemia and multi system organ failure". Under the skin assessment it read: "Cool, mottling noted to knees. Patient have [sic] extensive pressure sores noted to bilateral ankles which have the appearance of ligature marks and great toe of the left foot, bilateral plantar surfaces and sacrum with pressure injuries." The History of Present Illness section of the H&P read in part, " ... Information is limited as patient was altered upon arrival ... according to family and group home staff patient had been lethargic and mostly unresponsive for at least last 24 hours. Upon arrival [his/her] GCS (Glasgow Coma Scale) was noted to be 3 with no appreciable pain response. [S/he] was also having agonal respirations. [S/he] did have coffee ground emesis all over [his/her] chest and had a BM. The stool did not appear bloody. [S/he] was hypotensive to the 60s. Given [his/her] altered mental state and [his/her] overall clinical condition [s/he] was intubated ... admitted to the CCU (critical care unit) for further management." Another physical exam noted under this H&P note read, "Multiple new pressure ulcers (not present on previous admission) on back and feet". On 07/22/2026 at 8:40 AM, Surveyor reviewed a note written in response to a wound care	N 431		

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N 431	Continued From page 15 consultation for Resident 1. The note, dated 05/06/2026 at 11:33 AM, indicated that Resident 1 was noted to have the following wounds: - "Pressure Injury Deep tissue Arm Left; Upper; Posterior Purple" - "Pressure Injury Deep tissue Sacrum" - "Pressure Injury Deep tissue Foot Left Pressure injury all around foot" - "Pressure Injury Deep tissue Foot Right" - "Diabetic Ulcer Foot Right; Plantar" - "Pressure Injury Deep tissue Toe Great Left" - "Pressure Injury Deep tissue Heel Right; Plantar" - "Pressure Injury Deep tissue Elbow Posterior; Right" - "Pressure Injury Deep tissue Back Left; Upper; Right" - "Pressure Injury Stage 2 Back Left; Mid" At 1:00 PM, Surveyor reviewed the APS Elder Abuse Investigation report. The report noted that on 05/07/2026, APS traveled to the hospital where Resident 1 was admitted, to take pictures of the pressure sores reported. It noted that Resident 1's nurse showed the APS worker a picture of Resident 1's coccyx wound on 04/22/2026 (taken during his/her previous hospitalization) that showed an almost healed pressure sore. The current picture showed a very large pressure sore covering his/her coccyx and up his/her back. The investigation report indicated that on 05/18/2026, APS went to the facility and spoke with AA A regarding the situation. While at the facility APS also spoke with Caregiver C. Caregiver C told APS that s/he tried getting Resident 1 up on 05/05/2026 but s/he was unresponsive. Caregiver C stated that Resident 1 was making noises. Caregiver C told APS that s/he called AA A who asked about the color of	N 431			

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N 431	Continued From page 16 Resident 1's lips and if s/he was breathing. Caregiver C told AA A that his/her lips looked fine, and s/he was breathing. Caregiver C was told to continue to check on Resident 1. APS asked AA A if s/he was concerned about Resident 1's presentation and AA A told him/her that s/he was not because s/he had a history of being exhausted. AA A also told APS that s/he believed Resident 1 was dehydrated from having multiple bowel movements earlier that week. APS asked about Resident 1 not drinking and only have 24 mls (milliliter's) of urine output and AA A told APS that this was not abnormal for Resident 1. The summary and impressions part of the investigation read, in part, "Following this investigation, it was determined harm was caused to [Resident 1] due to the negligence by staff at [facility]. Staff at the facility seemed ill-prepared to deal with [Resident 1's] medical issues resulting in staff not turning and moving [Resident 1] every two hours which is typical protocol for individuals with pressure sores. Management wasn't aware of the pressure sores and reported the staff wasn't either which is hard to understand given how extensive they were. Staff, on two occasions, with input from management, delayed getting [Resident 1] the medical attention [s/he] needed." At 2:30 PM, Surveyor reviewed Resident 1's Autopsy results provided by APS. The autopsy read: "Introduction: An autopsy is performed on the remains of [Resident 1] at the Ramsey County Medical Examiner's Office on 05/21/2026 at 1140 hours. [S/he] died after possible neglect." "External examination- ½ to 1 ½ inch pink pressure ulcers are over the bony prominences of	N 431		

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N 431	Continued From page 17 the upper back. A 3 ½ x 2 inch pink pressure ulcer is on the left side of back. A 5 x 2 inch pink pressure ulcer over the sacrum, and ¼ to ¾ inch pink pressure ulcers over the posterior bony prominences of the pelvis ... There are ecchymoses under the right 2-4 fingernails. A 3 x 2 inch pressure ulcer with black eschar is on the left arm. 1 and ½ inch pink are over the right elbow. 2 ½ inch pink pressure ulcers are on the heel of the right foot. 3 x 2 inch pressure ulcers with black eschar are on plantar surfaces of the feet." On 07/20/2026 at 1:30 PM, Surveyor interviewed Administrator B and Assistant Administrator (AA) A about Resident 1's wound progression. Administrator B and AA A stated that Resident 1 never had wounds while under their care. AA A stated Caregiver C, Caregiver D, and AA A all assessed Resident 1 multiple times between 5/1/2026 and 5/5/2026 and never noted wounds or skin concerns. Surveyor explained that the AVS summary provided to the facility upon Resident 1's discharge on 05/01/2026, noted that a coccyx, buttock, and toe wound were present upon exam at admission on 04/14/2026 and still present on discharge 05/01/2026. AA A and Administrator B continued to deny that the wounds were there prior to his/her hospital visit and reported they were not present when s/he returned back to the facility. Surveyor inquired how they believed the additional wounds/bruising noted upon the 05/05/2026 admission developed. AA A and Administrator B stated they had no idea, but they knew s/he did not have any wounds/bruising during his/her time at their facility. Surveyor explained that pressure injuries generally develop over a period of time and were not typically expected to appear suddenly. Administrator B stated, "Correct." Surveyor asked	N 431		

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N 431	Continued From page 18 what the providers policy was on repositioning. Administrator B and AA A stated they did not have a policy on that because all residents were independent. Surveyor asked if staff repositioned Resident 1 after his/her return to the facility on 05/01/2026 until 05/05/2026 due to his/her decreased mobility. Administrator A and AA A stated they did not because Resident 1 had still gotten up to his/her recliner or wheelchair. Surveyor interviewed AA A and Administrator B about the frequency of bowel movements Resident 1 had starting on 05/02/2026. Surveyor stated that it was noted in staff notes that Resident 1 had a large bowel movement on the bathroom floor and continued to have loose bowel movements from approximately 5:27 PM until 9:00 PM, at which time s/he was transferred off the toilet and described as dead weight and fell to the floor. It was noted that Resident 1 had 2 more bowel movements between 10 PM and 12 AM. An additional follow-up note from Administrator A noted that staff reported to Resident 1 had another 2 additional bowel movements. AA A stated that this was not something that concerned them, as s/he reported that Resident 1 had returned from the hospital with a distended abdomen and figured that s/he had been backed up for a while. Surveyor interviewed AA A and Administrator B about Resident 1 being unresponsive for about 24 hours prior to the facility calling 911 on 05/05/2026. Staff charting noted that Resident 1 appeared to be sleeping, refused all medications, food, and water on the 05/04/2026 into 05/05/2026 night shift. The staff note on 05/05/2026 day shift stated Resident 1 refused all medications, meals, and did not get up. AA A stated that this was not unusual for Resident 1 as	N 431			

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N 431	Continued From page 19 s/he often had bouts of exhaustion. Surveyor stated that Caregiver C mentioned how s/he had to sternal rub Resident 1 on 05/05/2026 day shift to get a response from him/her. When Caregiver C called AA A it was noted to just continue to monitor him/her. Administrator B stated s/he was not aware that Resident 1 was that unresponsive and would have sent him/her out if s/he was aware of that. Surveyor asked if the documented output of 24ml of output for Resident 1 was concerning. AA A stated that s/he did not believe it was concerning, as Resident 1 had not been drinking that much fluid, so s/he would not expect much output. Administrator B stated that since the incident with Resident 1, they had created some new policies which included a more thorough skin assessment, and a new repositioning policy for all residents. The provider did not ensure Resident 1 had proper health monitoring when s/he arrived at the ED after being unresponsive for approximately 24 hours, with 9 pressure injuries, 1 ulcer, and multiple acute medical conditions. Cross Reference: N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments. N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 431			