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N 000	Initial Comments On 03/02/2026 with additional information gathered through 03/03/2026, Surveyors conducted an abbreviated survey and complaint investigation at Alten Haus Traditions. As a result two (2) deficiencies were identified and the complaint was substantiated. Census: 12	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure Resident 2 received all prescribed medications. On 02/27/2026 at 9:35 AM, Resident 2 was prescribed an antibiotic twice daily to treat a potential urinary tract infection (UTI). The medication was not administered until the morning of 03/03/2026, resulting in 7 missed doses. Findings include: On 03/02/2026 at 3:34 PM, Surveyor observed Caregiver E administering medications. Resident 2 volunteered a concern that s/he recently had a urinalysis for a suspected UTI, and even though it was negative, the medical provider wanted him/her to take an antibiotic and s/he was still	N 352		

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

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waiting for it. Caregiver E said s/he had no knowledge of situation, but would follow up on the concern.

Surveyor and Caregiver E returned to the medication cart. Caregiver E looked through all of Resident 2's medications, and an antibiotic was not present. Surveyor and Caregiver E reviewed Resident 2's observation notes. There was no mention of signs/symptoms of a UTI, a recent urine test or a newly prescribed antibiotic.

Surveyor and Caregiver E then went to Manager A's office. Manager A said s/he was unaware of any recently prescribed antibiotic for Resident 2. Manager A accessed the electronic portal (referred to as the Bridge) for Resident 2's medical provider. S/he subsequently determined there was an order placed Friday 02/27/2026, but said it came in after s/he had left for the day at 3:00 PM and s/he had not yet seen it today (Monday.) Manager A provided Surveyor with a copy of the note dated 02/27/2026 at 9:35 AM. Surveyor noted this was prior to Manager A's departure at 3:00 PM; s/he did not offer additional explanation. Manager B said s/he would immediately fax the note to the pharmacy.

On 03/02/2026 at 4:06 PM, Surveyor interviewed Registered Nurse (RN) J and Assistant Administrator (AA) B. RN J said their process is for management to review the Bridge communication daily, however it is the medical provider who facilitates the electronic prescription to the pharmacy. AA B said, "Normally, it goes right to pharmacy and then it comes with 2:00 PM medication delivery." AA B did not know why the medication had not arrived, but said they had been trying to resolve problems with their new pharmacy provider (new since 01/26/2026) and

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would try to get more information.

On 03/03/2026, Surveyor returned to the facility. At 12:56 PM, Surveyor observed the medication cart with Caregiver D and s/he confirmed Resident 2 started an antibiotic this morning. Present in the cart was a medication card for Nitrofurantoin Mono-MCR100 MG, to be taken twice daily for 7 days. The first administration of the medication was the morning dose on 03/03/2026.

On 03/03/2026, Surveyor interviewed Resident 2. S/he said s/he has a history of UTIs. Last week his/her lower back started to ache and that is a symptom s/he tends to have with UTIs. That is what prompted the urinalysis and as of today the back ache remains (note: s/he stated some back pain in baseline for him/her.) Resident 2 confirmed s/he first received the antibiotic this morning.

On 03/03/2026 upon request, the provider gave Surveyor a copy of the Bridge communication dating back to 02/23/2026.
--02/23: AA B wrote, [Resident 2] is having back pain...is unclear if it is a kidney infection/UTI...I don't know if you want to order a UA (urinalysis) first to rule that out."
--02/24: Nurse Practitioner (NP) I wrote, "As [s/he] is new to me...I am going to need a bit more detail...Does s/he have a history of UTI's..." S/he also asked if there were other symptoms or unrelated concerns with his/her back.
--02/26: NP I wrote, "Urinalysis was negative for infection...Can someone please respond to my previous questions..."
--02/26: AA B wrote, "[S/he] does have chronic back pain. [S/he] has had two UTIs in the last year or so..." S/he also wrote that back pain was

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N 352	Continued From page 3 a symptom associated with his/her last two UTIs. --02/27: NP I wrote, "Despite a very negative looking urinalysis, [his/her] urine culture did grow a large amount of [bacteria]" known to be resistant to antibiotics. "Order attached to initiate treatment of urinary tract infection." Time stamp: 9:35 AM. Surveyor noted doses of the medication were not given 02/27/2026 during the PM, 02/28/2026 AM or PM, 03/01/2026 AM or PM, 03/02/2026 AM or PM; this resulted in 7 missed doses. On 03/03/2026 at 2:21 PM, Surveyor interviewed the management team including Manger A, AA B, Licensee C and RN J. Licensee C said s/he learned the new pharmacy did not receive the prescription until the provider sent it yesterday and s/he suspected it may have gone to the previous pharmacy. The managers said they will continue to work with the new pharmacy to address any concerns that have occurred during the transition.	N 352		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility.	Y3244		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure all residents received adequate care within the capacity of the facility.

The provider did not ensure Resident 1 received pain and comfort medications prescribed by hospice, prior to the provision of cares scheduled every 2 hours. On 11/28/2025, 12/07/2025 and 12/08/2025, caregivers did not administer the medications prior to all scheduled repositioning and incontinence care. On those same dates, the care was not provided because Resident 1 was in too much pain. In addition, caregivers did not provide the care because they were the only staff scheduled and moving Resident 1 with only 1 caregiver caused Resident 1 extreme pain.

Resident 3 had respiratory impairment, complete heart block, CHF (congestive heart failure), and was hospitalized from 06/05/2025 through 06/09/2025 for acute respiratory failure. During the early morning hours on 06/19/2025, Caregiver K noticed Resident 3 felt nauseous, was shaky, had a tough time breathing, and requested to go to the hospital. Caregiver K notified on-call at 2:27 AM of these changes and was told to "Keep a close eye on [him/her]." There was no notification to Resident 3's physician regarding the changes, vitals completed, increased monitoring, or added intervention(s) for staff to monitor [Resident 3's] health. Caregiver K

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ignored Resident 3's request to go to the hospital and did not seek further medical treatment when Resident 3 had notable signs/symptoms of a physical change of condition. Consequently around 5:00 AM, approximately two (2) and a half hours later, Caregiver K found Resident 3 unresponsive, and not breathing. Caregiver K did not immediately call EMS (Emergency Medical Services), but instead called on-call and waited for Licensee C to arrive. When Licensee C arrived s/he observed Resident 3 and called EMS. EMS was notified at 5:36 AM thirty-six (36) minutes after Resident 3 was found unresponsive and not breathing. Subsequently, when EMS arrived and assessed Resident 3, it was determined s/he had passed away in the facility at 5:51 AM.

Findings include:

RESIDENT 1:

The Department received a complaint alleging concerns with the provision of incontinence care.

The provider is licensed to serve up to 15 non-ambulatory residents from the following client groups; advanced aged, developmentally disabled and irreversible dementia/Alzheimer's.

RECORD REVIEW

Surveyor reviewed Resident 1's closed facility record on 03/02/2026 at 3:25 PM and 03/03/2026 at 7:40 AM. Records included the face sheet, individual service plan (ISP), active cares, observation notes and medication administration records (MARs). Surveyor also reviewed hospice records on 03/03/2026 at 4:30 PM.

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Resident 1 was admitted from a sister facility on 08/21/2025. S/he was elderly, ambulated with a walker, had diagnoses to include Alzheimer's disease and had an activated power of attorney for health care. Resident 1 was frequently incontinent of urine and needed toileting assistance/incontinence checks every 45 minutes.

During November 2025, observation notes documented a change in condition of increased pain and refusals of care. Examples include:
--11/16: From 3:00 AM - 10:00 AM, "refused to toilet or allow staff to change [him/her]...is having a lot of pain in arms, lower back and butt which is making it difficult" for transfers.
--11/19: "Still complaining of pain" when trying to stand or sit. Staff wrote they documented this "weeks back" but "nothing has been resolved yet...Please advise on what actions can be taken since [s/he]'s been having this problem for weeks."
--11/21: resident refused toileting during 2nd shift.
--11/22: "observed wearing same clothes from previous morning with no depend (incontinence brief) on whatsoever. Staff this cannot happen..." Author: Manager A
--11/23: "1:15 AM - refuses to let staff toilet...continues to refuse to get up...will try again in 1/2 hour." At 10:00 AM - needs extra help due to pain and needs 2 staff to assist with standing. Hospice notified.

The facility MARs indicated PRN (as needed) pain medication was available beginning 11/24/2025:
--lorazepam as needed every 2 hours for anxiety, agitation or restlessness
--morphine as needed every 1 hour for shortness of breath or pain.

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Y3244	Continued From page 7 Hospice records documented the following: --Admission date 11/18/2025. Alert and oriented x1, increased confusion and forgetfulness, not able to participate in conversation and no skin issues. --11/23: RN (registered nurse) visit due to pain and increased difficulty standing. Upon arrival, resident showed no signs of pain or discomfort at rest, but showed signs of pain during a transfer. Discussed continued use of 2 assist for transfers and ensuring scheduled Tylenol for pain. --11/25: RN visit. No pain, but was "medicated twice today with morphine as staff reported [s/he] was crying this morning but was unable to share where pain was." Based on assessment, the sit-to-stand lift was discontinued and the need for a Hoyer lift was identified. A Broda chair was ordered. --12/01: RN visit. Identified the need for repositioning every 2 hours and for PRN morphine prior to cares and repositioning due to increased pain with "any movement." Has not gotten out of bed for 3 days. The ISP was updated as follows: --11/25: section titled "Pain History and Management" was updated, "in a lot of pain during cares and repositioning.: Staff should offer PRN pain medication "before all cares and transferring." This section also read, "is not always able to make [his/her] needs known" and staff will need to monitor for signs of pain. --11/30: updated to identify need for Hoyer lift, Broda chair, and 2 assist with transfers and toileting every 2 hours "to keep dry and skin clean and free from breakdown." --NOTE: The ISP was not updated to identify the need for repositioning every 2 hours. It also was not updated based on assessment to identify the	Y3244		

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number of staff necessary to provide repositioning assistance or incontinence care.

In late November and early December 2025, the notes documented times when care on 3rd shift was not provided due to pain or inability to provide the care with only 1 staff. On those same dates, the MAR documented PRN comfort and pain medication were not administered prior to cares. In addition, Resident 1 developed skin breakdown. Examples include:
--11/28: "5:15 AM - Writer has been unable to roll [Resident 1] during cares over the night...is uncomfortable and yells out in pain when [his/her] legs are being lifted or while [attempting to roll] during brief change." The MAR indicated PRN lorazepam and morphine were not administered during the overnight; the first administration was documented at 5:25 AM. A note authored by Manager A at 1:30 PM read, "had on 3 depends this morning when we got [him/her] up. This cannot happen! Make sure you are giving [him/her] morphine 20 mins prior to [his/her] cares, even on NOC (3rd shift)! This will help with the pain [s/he] is in when moving around!"
--12/01: "make sure you are repositioning [Resident 1] every 2 hours and checking [his/her] depend. We do not want [his/her] skin to start breaking down." Author: Manager A
--12/05: "make sure you are repositioning [Resident 1] every 2 hours. [S/he] is starting to get sores on [his/her] butt." Another note read, "The red areas on [his/her] left (buttocks) look really red & sore..."
--12/07: "5:00 AM - Writer was unable to perform cares due to resident being a two person assist." The MAR indicated PRN lorazepam and morphine were not given during the overnight.
--12/08: "Changing [Resident 1]'s brief is almost impossible on NOC shift with one

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person...couldn't move resident to change brief. Gave resident pain medication. [S/he] was wide awake and hurting when staff tried to clean [him/her] up from urine." The only administration of PRN lorazepam and morphine was at 1:20 AM.

Further review of hospice records revealed:
--12/09: "Morphine scheduled every 4 hours due to night staff not giving PRN meds."
--12/11: Resident 1 passed away.

INTERVIEWS

Surveyor interviewed Hospice RN H on 03/03/2026 at 9:07 AM. Hospice RN recalled Resident 1 experienced significant pain and said s/he needed pain medication prior to cares or "you couldn't even touch [him/her]." Hospice RN H said overall, their agency prefers the use of PRN pain and comfort medications for their patients, but if they determine caregivers are not giving the medications as needed to improve comfort and reduce pain, they will resort to scheduling the medication.

Surveyor interviewed Caregiver D on 03/03/2026 at 1:17 PM. Caregiver D said when Resident 1 first moved in, s/he ambulated with a walker, needed staff assistance with transfers and was offered toileting assistance every 45 minutes because s/he was frequently incontinent of urine. S/he recalled in early November, Resident 1 began experiencing "a lot of pain" and his/her memory and ability to communicate got worse. By the end of November, s/he could only be transferred with a Hoyer lift and when out of bed, was in a Broda chair. Caregiver D said at that point, toileting assistance consisted of checking and changing Resident 1's brief when s/he was in bed, and explained that when 2 staff provided the

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care it minimized Resident 1's pain. Caregiver D also said s/he would administer morphine and lorazepam before cares "so it was less painful for [Resident 1]. We found it very effective." Caregiver D said the staffing pattern on 1st shift was 2 caregivers, but on night shift there was only 1. Caregiver D recalled times when s/he would report for 1st shift at 6:45 AM, and night shift would state they had not provided incontinence care because they were working alone. Caregiver D would then administer the medications, wait 10-30 minutes, and along with another caregiver would provide incontinence care to Resident 1.

Surveyors interviewed the facility management team on 03/04/2026 at 2:21 PM, including Manager A, Assistant Administrator B and Licensee C. The managers acknowledged Surveyor's review of the records and concerns. Licensee C stated they routinely provide training to caregivers on care coordination for residents who receive hospice services, but some of the staff involved in Resident 1's care were newer and may not have received the most recent training.

RESIDENT 3

On 10/23/2025, the Department received a complaint alleging concerns with the care and treatment following a resident's change in condition.

RECORD REVIEW

On 03/02/2026, Surveyor reviewed Resident 3's closed record. Resident 3 was admitted to the facility on 08/02/2023 with diagnoses to include respiratory impairment, complete heart block with permanent pacemaker and CHF. The record

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indicated Resident 3 had a guardian, was receiving home health services and was a DNR (Do Not Resuscitate).

On 03/02/2026, Surveyor reviewed Resident 3's most recent ISP (Individual Service Plan) dated 12/30/2024, which indicated, the resident was able to communicate [his/her] wants and needs had a catheter, ambulated independently with a walker, and required staff assistance with bathing, dressing and toileting. Additionally, Resident 3's ISP indicated, "[Resident 3] experiences auditory and visual hallucinations. [S/he] often sees flashing lights and [his/her] voices, which is why [s/he] calls [his/her] anxiety episodes "rocketing."

On 03/02/2026, Surveyor reviewed Resident 3's observation notes which revealed the following:

~06/05/2025- "[Resident 3] was admitted to hospital due to retention of CO2."
~06/09/2025- "[Resident 3] has returned from the hospital. [S/he] is very tired, very quiet and not responsive. [S/he] is not hungry for dinner, so [s/he] is being assisted with cares by staff and going to bed...[S/he] has been on room air since Saturday per the hospital, but please keep a close monitor on [him/her]- as [s/he] doesn't quite [sic] [him/herself]. [Resident 3] is physically seeming to be doing better, able to stand and walk without knees buckling."
~06/19/2025- "[Resident 3] discharged from the system. Discharge Reason: Deceased."

The hospital "After Visit Summary" dated 06/09/2025 for Resident 3 indicated, "Acute respiratory failure with hypoxia and hypercapnia...Medication: Prednisone- You have been prescribed Prednisone, a steroid medicine.

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It has powerful effects on reducing inflammation, swelling and allergic reactions in all parts of the body...Take this medicine at regular intervals as described on the prescription label..."
***Surveyor noted Resident 3's prednisone order was not transcribed or documented on the June 2025 eMAR (electronic Medication Administration Record). On 03/03/2026, Surveyor questioned Assistant Manager B and Facility RN-J regarding Resident 3's prednisone order, neither could provide an answer.

A "Incident Report" for Resident 3 dated 06/19/2025 indicated, "Third Shift-Death... [Caregiver K] called on-call due to [Resident 3] experiencing anxiety and having a difficult time breathing. [Caregiver K] wanted to put on [his/her] oxygen, but [Resident 3] was refusing and saying [s/he] wanted to go to the hospital. It is typical for [Resident 3] when [s/he] is anxious to say [s/he] needs to go to the hospital. [Caregiver F] who was on-call, called [Caregiver K] back a few moments later and told [Caregiver K] to keep [Resident 3] comfortable and keep a close eye on [him/her]. [Caregiver F] explained when [Resident 3] is anxious [s/he] just needs some time to calm down. [Caregiver K] had checked on [Resident 3] shortly after this conversation and [Resident 3] had put [him/herself] in bed and was going to sleep. [Caregiver F] received a call from [Caregiver K] at 5 AM that [Resident 3] was not breathing. [Licensee C] was also contacted by phone at 5:09 AM by [Caregiver F], stating [Resident 3] was not breathing and wanted to know what to do. [Licensee C] said [s/he] would be right in and then arrived at 5:20 AM to assist. [Licensee C] contacted 911 as soon as [s/he] entered [Resident 3's] room and checked on [him/her] and could observe [s/he] was non-responsive. EMS arrived within a few

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minutes of [Licensee C] calling. The paramedics checked [Resident 3] and determined [his/her] death at 5:51 AM. EMS called the pronouncing doctor to help in determining time of death. The coroner was called, they did not answer, so voicemail was left...The medical examiner called back spoke with EMS involved and determined the medical examiner did not need to come out, and funeral home and family could be notified..."

On 03/03/2026, Surveyor reviewed an "Ambulance Service" report for Resident 3 which indicated, "Dispatch notified: 06/19/2025 at 5:35 AM, at scene: 06/19/2025 at 5:41 AM...Outcome: Dead at Scene, no transport...Chief Complaint: Cardio Respiratory Arrest...Medic found resident laying supine on [his/her] bed with CPR not in progress. [Resident 3] was not breathing and did not have a pulse. [Resident 3] was slightly cyanotic in the face. [Resident 3's] core was still warm however [his/her] extremities were cold. [Resident 3] was noted to have lividity on the posterior portion of [his/her] body in [his/her] torso. [Resident 3] was placed on a cardiac monitor to check for a heart rhythm. Four lead ECG showed asystole with pacemaker spikes with no capture. [Resident 3] did have a valid DNR bracelet around left wrist. CPR was not initiated. Medical control was called, resident's condition as well as resident having a valid DNR was explained over the phone, physician gave a time of death at 5:51 AM. [Resident 3] was not transported to the hospital due to obvious death."

On 03/03/2026, Surveyor reviewed text messages from a group chat between on-call staff, managers and Licensee C which revealed the following:

~06/19/2025 at 2:27 AM Caregiver F who was the

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on-call staff, texted the group chat stating, "[Caregiver K] called [Resident 3] is rocketing and is having a hard time breathing [s/he's] refusing [his/her] oxygen and telling [Caregiver K] [s/he] needs an ambulance to the hospital. [Caregiver K] said [s/he] felt cold [s/he] was asking for an ambulance...What should I do about that? I called [Caregiver K] back and said to keep an eye on [him/her]. [Resident 3] sounds congested [Caregiver K] said. I explained to [Caregiver K] about [Resident 3's] rocketing and if [s/he] has outbursts like that to give [him/her] a few minutes [s/he] usually calms down. [Caregiver K] checked on [Resident 3] and [s/he] was going to sleep. Ok thanks."
~06/19/2025 at 5:15 AM Caregiver F who was the on-call staff, texted the group chat stating, "Got a call from [Caregiver K] and [Resident 3] wasn't breathing. I called [Licensee C] and [s/he's] going there soon. I called [Caregiver K] back and told [her/him] to let hospice know that [Resident 3] passed away."
~06/19/2025 at 5:15 AM, Licensee C stated, "Is [s/he] on with hospice? I am on my way shortly."
~06/19/2025 at 5:16 AM, Caregiver L replies, "[Resident 3] is not on hospice."

On 03/02/2026, Surveyor reviewed Resident 3's vital history record which revealed no vitals (pulse, respirations, blood pressure, temperature or pulse ox) were completed after 9:14 AM on 06/16/2025.

On 03/02/2026, Surveyor reviewed Resident 3's record including observation notes, vital history, current ISP, care history, TAR (treatment administration record) and eMAR for 06/19/2025. Resident 3's record did not contain any documentation regarding Resident 3's change of condition that began sometime after 2 AM on

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Y3244	Continued From page 15 06/19/2025 or documentation of any monitoring, vitals or added intervention(s) when the resident was noted to have a physical change in condition. Additionally, the record contained no documentation regarding communication with Resident 3's physician regarding the change noted. INTERVIEWS On 03/02/2026 at 7:00 PM, Surveyor interviewed Caregiver K about Resident 3. Caregiver K verified s/he worked alone during the night shift on 06/18/2025 into the morning hours on 06/19/2025. Caregiver K stated, "During the morning of 06/19/2025 around 2:15 AM, I notified on-call [Caregiver F] by phone that [Resident 3] was having a hard time breathing, was shaky, not feeling right, felt like [s/he] was going to throw up and wanted to go to the hospital. On-call [Caregiver F's] response was [Resident 3] has oxygen, is attention seeking, was just in the hospital and to monitor [him/her]." According to Caregiver K on-call did not ask any additional questions or provide further instructions. Caregiver K went on to say, "[Resident 3] kept saying all night please call 911, I just want to go to the hospital. [Resident 3] said [s/he] didn't need any oxygen, [s/he] just wanted to go to the hospital. [Resident 3] was very adamant about going to the hospital. I told [Resident 3] I had to follow protocol and wait for on-call to give me the approval." Caregiver K confirmed [s/he] reached back out to on-call several times between 2:30 AM and 5:00 AM to update on-call about Resident 3's request to go to the hospital and [his/her] condition. Caregiver K stated, "When I called on-call I was told [Resident 3] is attention seeking, [s/he's] fine because [s/he] was just in the hospital and try to give [him/her] some water.	Y3244		

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I was never told to do vitals or send [him/her] out." Surveyor questioned Caregiver K if Resident 3's noted changes were reported to the resident's physician or EMS. Caregiver K stated, "No, they weren't, and I didn't send [Resident 3] out because on-call [Caregiver F] never told me to send [him/her] out. This was my first week on the job, so I was just listening to what I was told to do from the on-call person." Caregiver K confirmed s/he did not take any vitals or document any increased monitoring or checks. Surveyor asked Caregiver K what the facility's policy was when a resident has a noted change of condition. Caregiver K stated, "We need to go through on-call for further instructions. I was told you can never send a resident out to the hospital unless you get consent from on-call, and if you don't follow the policy you get in trouble." Caregiver K then stated, "When I called on-call at 5 AM to tell [Caregiver F] [Resident 3] was not breathing or responding, on-call [Caregiver F] told me I had to wait for [Licensee C] to get there before I could call 911, and [Licensee C] would handle everything. When [Licensee C] arrived [s/he] checked on [Resident 3] and called 911 right away...[Licensee C] was confused why I didn't send [Resident 3] out and said to me why didn't on-call tell you to send [him/her] out..."

On 03/02/2026 at 11:45 AM, Surveyor interviewed Facility RN-J regarding Resident 3. Facility RN-J indicated [Resident 3] used a walker, was able to make needs known, had a catheter and was not receiving hospice services. When Surveyor asked about Resident 3's death. Facility RN-J indicated, "I don't know a lot about [his/her] death...I didn't receive a call from any staff regarding [Resident 3] or [his/her] passing." Facility RN-J indicated, "The on-call person takes calls from staff starting at 3 PM until 7 AM,

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usually beginning on a Friday and ending on the following Friday." Facility RN-J confirmed s/he was not designated as an on-call person.

On 03/02/2026 at 2:10 PM, Surveyor interviewed Assistant Administrator B regarding Resident 3. Assistant Administrator B stated, indicated Resident 3 was able to make needs known and had home care services for his/her CHF and catheter. Assistant Administrator B stated, "[Resident 3] called [his/her] anxiety episodes "rocketing," where [s/he] would hear loud noises and see flashing lights." Surveyor then asked Assistant Administrator B regarding the day leading up to [Resident 3's] death. Assistant Administrator B stated, "[Resident 3] was doing fine during the AM/PM shift on 06/18/2025, but overnight [s/he] was nauseous." Surveyor and Assistant Administrator B looked at the 06/19/2025 incident report and above group chat for Resident 3. Assistant Administrator B stated, "It was a frequent thing for [Resident 3] to say [s/he] wanted to go to the hospital for being anxious...We would give [Resident 3] [his/her] PRN (as needed medication) routinely, which would provide relief." Assistant Administrator B confirmed Resident 3's most recent ISP did not contain any information regarding Resident 3's frequent request to go to the hospital for anxiety. Surveyor asked Assistant Administrator B what s/he would expect staff to do if they noticed a resident with a change of condition. Assistant Administrator B stated, "I would expect staff to monitor the resident closely...Take vitals and do frequent checks, especially if [Resident 3] was having a hard time breathing...I would've expected staff to do hourly checks on [Resident 3's] and take vitals, and if something was off, they should've sent [him/her] out." Surveyor and Assistant Administrator B then looked at Resident

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3's record. Assistant Administrator B confirmed Resident 3's record did not contain documentation of the resident's vitals or any additional monitoring or added intervention(s) on 06/19/2025. Assistant Administrator B stated, "I see where we're having a lapse in documentation. I would've expected staff to document the checks and vitals for [Resident 3]." Assistant Administrator B further confirmed s/he would expect staff to call 911 when there was a suspected death/emergency regardless of code status.

On 03/02/2026 at 3:00 PM, Surveyor interviewed Caregiver D regarding Resident 3. Caregiver D verified s/he worked with Resident 3 often and stated, "[Resident 3] would get anxious about a lot of things, like being in a room with a lot of people. If [Resident 3] was anxious [s/he] would go to [his/her] room listen to music, call family or ask for a PRN, which would help." Surveyor then ask Caregiver D if Resident 3 would request to go to the hospital when [s/he] was anxious. Caregiver D stated, "[Resident 3] never ask me to go to the hospital when [s/he] was anxious."

On 03/03/2026 at 1:20 PM, Surveyor interviewed Licensee C regarding Resident 3's death. Licensee C confirmed Resident 3 was not receiving hospice services, passed away in the facility on 06/19/2025 and stated, "I believe [Resident 3's] death was heart related." Licensee C confirmed Caregiver K was working alone at the time of the above incident on 06/19/2025. Surveyor questioned Licensee C regarding the above incident report/group chat message on 06/19/2025. Licensee C stated, "I don't recall if I received a phone call or woke up and seen the group chat and said I'm going in. I don't know why [Caregiver K] or someone didn't call 911

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sooner when [Resident 3] was having a change in condition...It's our policy to call 911." Licensee C verified when s/he arrived at the facility and observed [Resident 3] s/he called 911."

On 03/03/2026 at 2:25 PM, during the exit conference meeting Surveyors discussed the above information with Licensee C, Facility RN-J, Assistant Administrator B and Manager A. Licensee C stated the on-call person should be notifying or assisting staff with notifying outside agencies including home health, physicians, family and EMS with any change of condition. Licensee C indicated they plan to provide additional training for all staff, including on-call staff regarding notifying outside agencies of an accident/injury or change of condition.

In conclusion, Resident 3 experienced a physical change in condition and requested to go to the hospital around 2:27 AM on 06/19/2025. There was no notification to the resident's physician or EMS regarding the changes, and no increased monitoring or added intervention(s) for staff to monitor [Resident 3's] health. Resident 3's condition worsened and s/he was found unresponsive, and not breathing at 5:00 AM. EMS was not contacted until 5:36 AM, three hours after Resident 3 had notable signs/symptoms of a physical change of condition. Once EMS was contacted Resident 3 had passed away in the facility and was pronounced deceased at 5:51 AM.