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N 000	Initial Comments On 06/02/2026 to 06/08/2026, Surveyor conducted 2 complaint investigations at Huntington Place Memory Care 1. Two deficiencies were identified. One of 2 complaints was substantiated. Census: 11	N 000		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure each resident lived in a safe environment, including conditions that are hazardous to the resident because of the residents 'conditions or disabilities. From 05/11/2026 to 06/03/2026, staff documented at least 18 entries in observation notes where Resident 2 had gone into fe/male resident rooms without their permission, followed fe/male residents around the facility, or engaged with fe/male residents within the facility by misidentifying fe/male residents as his/her	N 358		

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

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spouse. The provider did not increase supervision, did not implement safety measures for all residents, and did not ensure a safe physical environment related to Resident 2's disease progression.

The provider is licensed to care up to 11 residents in the following client groups: advanced age and irreversible dementia/Alzheimer's. It's important to note, the facility shares an entryway, common sitting area, and long hallway with a sister memory care facility that is licensed through the Department with a capacity of another 8 residents.

Findings include:

On 05/27/2026, the Department received a complaint alleging concerns with a resident crawling into bed with fe/male residents.

On 06/02/2026, Surveyor conducted a complaint investigation and identified the following:

On 06/02/2026 at 9:15 AM to 10:15 AM, Surveyor was seated in the provider's common sitting area which is shared by both memory care units. Surveyor observed Resident 2 walk back and forth between the units. Resident 2 was observed unsteady while ambulating.

On 06/02/2026, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 05/11/2026 with diagnoses of severe late-onset Alzheimer's disease and dementia with behavioral disturbance which includes agitation. Resident 2 had an activated healthcare power of attorney. Resident 2's temporary service plan (TSP) dated 05/11/2026 documented: "Wandering: [Resident 2] exhibits wandering

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behaviors related to severe late onset Alzheimer's disease with mood disturbance and dementia with behavioral disturbance. Identified triggers include looking for spouse, a strong desire to ambulate frequently and periods of confusion regarding where to go or what direction to take. Care staff will provide close monitoring, frequent redirection, and reassurance when wandering behaviors are observed. Interventions include offering structured walking opportunities, gentle guidance back to safe and familiar areas, use of calm verbal cues, and consistent regarding [his/her] location and safety. Staff will also attempt to engage [him/her] in purposeful activity or companionship when [s/he] appears restless. If interventions are not effective in managing wandering behaviors or ensuring safety, staff will notify the nurse and/or supervisor immediately for further evaluation and intervention. 5/21 PCP called and resident assessed for behaviors and not being able to sleep, medication changes made and staff are aware that resident needs to be monitored closely, keep resident away from other apartments and close residents doors if they allow. Behavior expression monitoring level of assistance: [Resident 2] demonstrates behavior expressions requiring occasional intervention related to severe late onset Alzheimer's disease with mood disturbance and dementia with behavioral disturbance. Identified triggers include frustration with communication difficulties, anxiety related to confusion or separation from familiar persons (including spouse), unmet perceived needs, and environmental changes. Behavioral expressions may include anger, aggression, and increased anxiety. Care staff will utilize calm and reassuring communication, provide redirection, allow time for processing, and reduce environmental stimulation when needed. Staff will also attempt to identify

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and address underlying needs promptly, offer reassurance, and provide structured routines to reduce anxiety and agitation. If interventions are not effective in managing behaviors or ensuring safety, staff will notify nurse and/or supervisor for further assessment and intervention. 5/27 PCP notified of behaviors and medication adjustments are being made. PCP to see resident in 5/29 and 6/1 then again on 6/5."

Resident 2's observation notes documented:

"-05/11/2026: Resident had a very rough night after family left at supper time, a lot of exit seeking and wondering the halls, knocking on doors and looking for [his/her] [wife/husband]. Staff tried redirecting [him/her] and offering food, reminded [him/her] [his/her] [wife/husband] had surgery and was recovering. [S/he] was REDIRECTED once in a while with helping folding napkins many different times. [S/he] ended up sitting on another resident bed while they were already in bed for the night and [s/he] adamant [s/he] was [his/her] [wife/husband] and refused to get up and find [his/her] own room, [s/he] grow more aggressive, swinging and yelling at staff, staff was finally able to get resident out other resident's room, staff offered a snack and [s/he] enjoyed it. [S/he] was assisted into clean nighttime clothes and went to bed. [S/he] was back up and out by the office 15 mins later and was redirected with folding napkins when PM shift left.

-05/12/2026 [completed by Former RN D]: ... [fe/male] admitted to memory care on 05/11/2026 following hospitalization related to Alzheimer's Dementia with agitation and aggression in the home setting. Prior to hospitalization, resident's spouse was hospitalized recovering from surgery

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and [Family Member C] was temporarily providing care. Resident confusing [Family Member C] as being [his/her] spouse and became increasingly upset and agitated when [s/he] was unable to fulfill the caregiving and bedtime routines normally provided by [his/her] [wife/husband], including going to bed with [him/her] at night. This confusion and inability to process changes in routine contributed to verbal and physical aggression, prompting hospitalization. No verbal and physical aggression was reported during hospital stay. Upon arrival to facility, resident was accompanied by [Family Member C] and [Family Member E], who remained with [him/her] for several hours to assist with transition. During evening and bedtime hours, resident became anxious and repeatedly searched for [his/her] spouse, at approaches another [fe/male] resident due to confusion and need for reassurance. Staff contacted [Former RN D] for assistance with de-escalation and behavioral support. Resident was eventually successfully redirected, assisted with changing, and settled into bed without further incident.

-05/13/2026: resident very anxious today, exit seeking and wandering, [s/he's] also packed up [his/her] closet multiple times. Redirection very briefly effective but almost immediately back to behaviors. [Resident 2] became very agitated and aggressive after dinner. [S/he] thought [Resident 3] was [his/her] [wife/husband] and was trying to get [him/her] to leave with [him/her]. [S/he] was yelling at [him/her] and also at staff. Writer was able to remove [Resident 3] from the area and put [him/her] in the med room. [Resident 2] tried to prevent writer from closing med door with [his/her] foot and body. [S/he] was also hitting and kicking writer. Writer called [Former RN D] and [Executive Director A] for assistance. Writer was

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able to eventually get [Resident 2] to take a PRN and with assistance was able to get [him/her] to lay down in [his/her] room.

-05/14/2026: [completed by Former RN D]: "Summary of 05/13 included" .....Distraction and redirection techniques were attempted without success. Medication room door closed to prevent further visual triggers, which assisted de-escalation. Resident was eventually administered PRN medication per order and was safely redirected to [his/her] room where [s/he] laid down. [Former RN D] contacted neurology the following morning to discuss behavioral concerns and medication management. Interventions include immediate resident-to-resident separation for safety, removal of triggering stimuli, initiation of 1:1 redirection attempts, PRN medication administration per order, close staff supervision during escalation, staff de-escalation and safety interventions, and notification of [Former RN D] and [Executive Director A] and neurology for further behavioral management planning. Care plan reviewed and updated accordingly.

-05/14/2026: res was anxious and agitated after supper. [S/he] looking for [his/her] [wife/husband]. Staff were able to redirect with snacks and one on one attention. Res basically needed someone with [him/her] at all times until [s/he] went to bed at 830pm.

-05/15/2026: starting @ 930, resident got up from bed every two or three minutes Helped resident to the bathroom the first time, during which [s/he] did void, but helped [him/her] back to bed after each subsequent stirring. Resident couldn't verbalize any reason for getting up beyond asking 'Where's [Family Member E]?' Resident fell

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asleep after writer sat in [his/her] room with [him/her] while charting, but this is not a viable solution, especially with only two care staff in building.

-05/16/2026: [completed by Former RN D]: reached out to PCP regarding worsening afternoon/evening behaviors and increased unsteadiness requiring 1:1 assistance. Current level of supervision is not sustainable and exceeds what the facility can provide. Inquired whether a hospice assessment would be appropriate at this time. Also requested follow-up regarding whether PCP has spoken with spouse and [Family Member E] about current condition and recommendations.

-05/16/2026: resident had a very rough shift, especially after supper. Resident keep going into other [fe/male] resident's rooms and frightening them, [s/he] is looking for [his/her] [wife/husband] and thinks other [fe/male] residents are [his/her] [wife/husband].

-05/17/2026: resident has a bit better shift today, still following other [fe/male] resident's and they are keeping the room doors locked for safety.

-05/18/2026: ....Going in several rooms looking for [his/her] [wife/husband] wanting to know where [s/he] is and getting upset when [his/her] [wife/husband] is not in there. Res rooms that [s/he] is going into are getting upset that [s/he] keeps going in there several times looking for [his/her] [wife/husband]. Res rooms [s/he] keeps going in looking for [his/her] [wife/husband] is [Resident 3] and [Resident 1], [Resident 4]. [S/he] did go in [Resident 5's] room also today looking for [his/her] [wife/husband]. Res continues to struggle with agitation and anxiety after supper.

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PRN given after supper but was not effective. Staff have to give [him/her] one on one attention for [his/her] own safety as well as the safety of others. [His/her] behaviors are affecting the staff's ability to take their breaks, give showers, and pass meds on time.

-05/19/2026: res was following [fe/male] res around the facility. [S/he] thought that [s/he] was [his/her] [wife/husband].

-05/20/2026: completed by [Former RN D]: [Resident 2] continues to exhibit increased agitation, aggressiveness, restlessness, and unsteadiness, particularly during later afternoon and evening hours. [S/he] has been seeking out [fe/male] residents and currently requires near-constant 1:1 supervision from after dinner through overnight ....Redirection during the later hours has been challenging, especially when [s/he] attempts to locate [his/her] spouse. The PCP has been contacted and is reaching out to Geriatric Psych and neurologist for recommendations. [Former RN D] is awaiting their recommended plan of care. [Executive Director A] was contacted regarding continued behavior and care challenges ... ...Res keeps walking without [his/her] walker was pushing writer looking for [his/her] [wife/husband] wanting to know where [his/her] [wife/husband] is and when [s/he] coming in to see [him/her] .....Res was following [Resident 6] around thinking its [his/her] [wife/husband] and writer said its not [his/her] [wife/husband], [s/he] got very upset and stated [s/he] might as well be now let me go to [him/her].

-05/23/2026: Resident has had no sleep all night and so far, [s/he] is still up, staff tried several times to lay resident down, it is impossible to

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keep up with resident going into everyone's rooms constantly there is no stopping or redirecting with resident [s/he] is upsetting most other residents ....Resident is yelling at other residents, [s/he] is currently following rm 114 making resident walk around facility faster to get away from [him/her] when trying to redirect [s/he] is becoming combative ... ...Resident stayed in bed for 15 minutes and then was up wandering and trying to get [fe/male] residents to go to bed with [him/her]. Many of the other residents were upset by this behavior. Res was also following writer around while writer was passing meds and trying to push [his/her] way into everyone's room. Many interventions were tried but all were unsuccessful. Res was assisted back into bed at least 10 times but [s/he] keeps getting up even though [s/he] can barely walk. Resident needs one on one care for [his/her] and others safety which is negatively affecting the entire building. We are not staffed adequately to ensure the safety of this resident and the other 17 residents in this building.

-05/26/2026: resident is expressing high restlessness and mild agitation. [S/he] has been up and down since 10pm. Resident tried to open the entrance door while staffs were doing cares for other's but was redirected. Resident is now sleeping 3:30am.

-05/27/2026: a group of residents were playing jeopardy with the activity person, After it was over [Resident 2] got up and tried to get [fe/male] resident to leave with [him/her]. The [fe/male] resident got upset and [Resident 7] stepped in. [Resident 2] thought it was [his/her] [wife/husband] so [s/he] got very upset with [Resident 7] for touching [his/her] [wife/husband]. [Resident 2] pushed [Resident 7] and tried to

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punch [him/her]. Writer heard commotion from down the hall and stepped in between the 2 [men/women]. Both [men/women] were swearing at each other and [Resident 7] said if [Resident 2] comes near [him/her] again [s/he] will knock [him/her] out. All 6 residents that were in the group were very upset by the confrontation. Writer did [his/her] best to calm everyone down and separate them .....Res has been awake all shift and needing one on one care from staff. Res was trying to go in people's rooms and generally upsetting anyone that [s/he] came in contact with. Writer was unable to take a break and also was unable to pass all meds on time. This residents needs are unsustainable for staff.

-05/28/2026: resident has been up and down all night. Staff has redirected [him/her] multiple times back to [his/her] room, tried giving snacks played music for [him/her] as well as resident was very restless, one care staff was with resident 90% of the night ... ...Res was awake and wandering all afternoon. [S/he] was in a good mood and wasn't bothering other residents too much. [His/her] focus today seemed to be on this writer. [S/he] was following writer around and at times being sexually inappropriate.
-05/29/2026: resident has been up and down all night, very agitated, resident tried to flush [his/her] clothes down the toilet, staff tried to get underwear on [him/her] and resident was pushing and trying to punch staff, staff tried music, sitting in the chairs outside of the med room, laying down, and snacks, and nothing was helping resident calm down. Staff called [Executive Director A] as well as family and resident was sent out ... ...Res returned from ER around 6:30 am. Res appeared lethargic, very unsteady on [his/her] feet. Res unaware of [his/her] surroundings."

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N 358	Continued From page 10 Resident 2's primary care physician notes documented: "05/15/2026: patient ...seen today for initial intake and establishment of care at [provider's name]. Patient currently housed in the memory care unit. Patient's medical history included but not limited to severe late onset Alzheimer's dementia with mood disturbance, dementia with behavior disturbance which includes agitation, anxiety disorder, and depression. Facility reports patient has been restless and agitated throughout whole day and every day since being in the facility. Patient follows [fe/male] residents around and into the rooms causing increase in anxiety and restless for the [fe/male] residents. Patient requiring multiple staff to sit down and which limits staff for other residents....Staff reports poor sleep and after discussion with staff, pateient would benefit from mirtazapine for insomnia and disinhibition, reducing increase desire to follow [fe/male] residents. -05/29/2026: ...reported by staff to be in the emergency room last night with behavioral issues. Facility reports other concerns many providers are making medication changes to patient's medication list. Facility staff report increased behavioral issues (agitation, restlessness, anger outburst, physical aggression.) Taking off clothes, flushing them down toilet, hitting staff, throwing TV, Sent to ED ...Patient's spouse reports history of "anger outbursts" while living at home previously with [him/her]. Spouse reports worsening moods and behaviors since [s/he] has been ill and in the hospital. Also stating worsening moods and behaviors since move to ALF. Spouse reports previous angry outburst which led to move to ALF.	N 358		

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N 358	Continued From page 11 -06/03/2026: resident was up all night walking around, resident did go into another residents room staff got [him/her] to come back out and sit in the chairs by the med room. Around 4:30 resident was sitting in the sun room on side 1 and pulled the cover off of the fire alarm setting off the loud alarm." Interviews: On 06/02/2026 at 9:55 AM, Surveyor interviewed Caregiver B regarding any incidents of residents going into Resident 1's bed without his/her permission. Caregiver B stated s/he was not aware of any incidents regarding Resident 1, but was aware of Resident 2 as a newer resident who is always anxious, looking for his/her spouse, and wanders into fe/male resident rooms thinking their his/her spouse. Caregiver B reported Resident 2 was going through medication changes, but was not aware of his/her TSP having any specific interventions addressing him/her going into fe/male resident rooms or following them around the facility. Caregiver B reported when trying to redirect or remove from someone's room, Resident 2 will get aggressive in your face. Caregiver B reported some residents lock their doors at night, but not all. On 06/02/2026 at 10:20 AM, Surveyor interviewed Executive Director A regarding concerns alleged in the complaint. Executive Director A confirmed s/he was made aware by staff of an incident regarding Resident 2 crawling into Resident 1's bed. Executive Director A stated s/he was still reviewing resident records to see if anything was documented and if Legal Representative F was notified. Executive Director A reported Resident 2 had been admitted for 2	N 358		

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weeks and during the first 2 days, s/he was going to fe/male resident rooms looking for his/her spouse. Executive Director A stated the facility got Resident 2 signed up with their in-house physician provider and med changes were ongoing. Executive Director A stated the facility had to provide 1:1 support for Resident 2 related to his/her behaviors and fall risk. Surveyor asked for clarification on staffing levels for each shift. Executive Director A stated there are 2 staff for each shift (1st, 2nd, 3rd). Surveyor asked if staff schedules were reviewed, would it show an increase in supervision (1:1) for Resident 2. Executive Director A state "no", staff would have to provide that support through the 2 staff assigned.

On 06/03/2026 at 2:54 PM, Surveyor interviewed Legal Representative F via phone. Legal Representative F reported his/her family member had heard from staff that a fe/male resident had crawled into Resident 1's bed and it took multiple staff to remove the fe/male resident. Legal Representative F stated s/he was not notified of this incident and was unsure of the date. Legal Representative F reported his/her family member noted this fe/male resident had done this to other residents. Legal Representative F stated s/he notified Resident 1's hospice provider and they were unaware of the incident occuring. Legal Representative F stated Resident 1 is vulnerable, cannot do anything for him/herself, has very poor memory, and was worried about the facility keeping him/her safe.

On 06/05/2026 at 11:02 AM, Surveyor interviewed Former RN D via phone. Former RN D reported s/he left the facility on 5/20 because s/he did not like how Executive Director A was running operations and not following regulations. Former

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RN D reported s/he assessed Resident 2 for placement, discussed concerns with Executive Director A about staff's ability to manage him/her, but was told Resident 2 was being admitted regardless. Surveyor asked if s/he was aware of what date Resident 2 had crawled into Resident 1's bed. Former RN D stated 05/11/2026. Former RN D stated s/he asked Executive Director A if s/he was going to notify his/her POA or report the incident to the Department. Former RN D reported Executive Director A noted the incident did not require a self-report. Former RN D reported concerns with Executive Director A telling staff not to document certain incidents. Former RN D stated s/he told staff to document "everything" so s/he could get support from higher ups on caring for Resident 2.

On 06/08/2026 at 9:42 AM, Surveyor conducted an exit conference and shared findings with Executive Director A and RN G via phone. Surveyor voiced concerns fe/male residents' health/safety was not being protected while Resident 2 misidentified fe/male residents as his/her spouse. Surveyor noted current interventions were not effective evidenced by staff observation entries, supervision was not increased, and the only ongoing plan to mitigate Resident 2's behaviors included medication changes. Executive Director A acknowledged an understanding of the above concerns. Executive Director A reported that Former RN D assessed Resident 2 for admission, and s/he was responsible for updating care plans. Surveyor noted through investigation, Resident 2 had crawled into Resident 1's bed on 05/11/2026. Executive Director A acknowledged s/he was aware of the incident but was unable to find records correlating the date of the incident. Executive Director A stated Former RN D was

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N 358	Continued From page 14 responsible for updating families of any incidents. Executive Director A stated the facility is trying their best to manage Resident 2 but understand if behaviors do not decrease, the provider will decide if they can meet Resident 2's needs. Executive Director A stated s/he would work with RN G on updating resident care plans and inputting safety measures for the unit.	N 358		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not prepare and implement a written temporary service plan (TSP) that met the immediate needs of Resident 2. Resident 2 experienced 5 falls between 05/11/2026 to 06/03/2026. Resident 2's TSP dated 05/11/2026 indicated s/he was a high fall risk but did not include any interventions for staff to follow. Findings include: On 06/02/2026 at 9:15 AM to 10:15 AM, Surveyor was seated in the provider's common sitting area which is shared by both memory care units. Surveyor observed Resident 2 walk back and forth between the units. Resident 2 was observed unsteady while ambulating.	N 385		

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N 385	Continued From page 15 On 06/03/2026, Surveyor reviewed Resident 2's record and identified the following: Resident 2 was admitted to the facility on 05/11/2026 with diagnoses of severe late-onset Alzheimer's disease and dementia with behavioral disturbance which includes agitation. Resident 2 had an activated healthcare power of attorney. Resident 2's temporary service plan (TSP) dated 05/11/2026 documented: ...23. Morse Fall Scale: 1. Has the Resident ever fallen before? No. 2. Does the resident have more than one diagnosis? Yes (15). 3. What ambulatory aids if any, does the resident use? Uses crutches, cane, or walker (15). 4. Does the resident have an intravenous apparatus or heparin lock inserted? No. 5. What type of gait does the resident exhibit? Impaired (15). 6. Mental status measures the resident's self assessment of his/her own ability to ambulate. Overestimates or forgets limits (15). 7. Count the number to the right of each answer above. High Risk 45+." No fall interventions were included on the TSP. Resident 2's primary care physician notes documented: "05/15/2026: patient ...seen today for initial intake and establishment of care at [provider's name]. Patient currently housed in the memory care unit. Patient's medical history included but not limited to severe late onset Alzheimer's dementia with mood disturbance, dementia with behavior disturbance which includes agitation, anxiety disorder, and depression .....Facility reports patient walks too quickly down [his/her] body allows and also leaning forward and without [his/her] walker putting [him/her] at risk for fall. Reports [s/he] has fallen twice since admission. Fall was witnessed and patient got up immediately after fall ...Contacted patient's	N 385		

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[son/daughter] who reported patient's increased restlessness at home and recent use of clonazepam 0.5 mg twice daily as needed for restlessness. Discussed plan with patient's [son/daughter]. Will start risperidone 0.5 mg twice daily for agitation and restlessness and continue clonazepam 0.5 mg as needed twice daily. .....Patient is partially dependent of ADLs. Patient supposed to ambulate with walker but has not been using walker.
-05/29/2026: ...reported by staff to be in the emergency room last night with behavioral issues. Facility reports other concerns many providers are making medication changes to patient's medication list .....Also discussed no further medication changes at this time, as recently patient's Seroquel was discontinued and [s/he] was started on Risperidone for continued increased agitation, physical aggression towards staff. Risperidone started on 5-22-26. Spouse reports several recurrent falls prior while on Seroquel. Discussed Seroquel being pretty sedating. Plan not to make any further medication changes today to see the full effect of Risperidone, explained to spouse this could take up to 2 weeks. Numerous medications listed on patient's medication list at ALF."

Resident 2's incident reports documented:
"05/11/2026: resident has just finished playing BINGO in the front room and was going into [his/her] room and tripped over [his/her] foot and fell. No c/o pain or discomfort. [Former RN D] and POA notified.

-05/13/2026: staff heard a loud thug, and when they entered residents' room, resident was attempting to get up off the floor on their own. Staff assisted resident back to the bed so that resident would not fall trying to stand up. At this

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time resident had regular socks on and stated that they were trying to get up to use the bathroom and slipped and fell. Resident is not complaining of pain at this time. Resident was very unsteady on their feet while walking to the bathroom with staff. On the way back to the bed staff had resident use their walker. Staff put grippy socks on for the night. When staff called [wife/husband] about fall, they recommended some slippers or more grippy socks for resident.

-05/19/2026: staff heard noise from resident's room and upon entering staff found resident on their knees in front of their recliner. Resident was able to turn and put their bottom onto the recliner with little assistance from staff. Staff then assisted resident back into bed and gave resident a prn as resident stated that their knees hurt from falling.

-05/20/2026: resident had a unwitnessed fall in their bathroom."

Resident 2's observation notes documented: "-05/12/2026: Per staff, resident had just finished playing BINGO in the front room and was ambulating toward [his/her] room when [s/he] tripped over [his/her] foot and fell. No complaints of pain or discomfort noted. [Former RN D] notified and walked staff through initial assessment; resident observed attempting to get [him/herself] up at that time. [Former RN D] completed in-person post fall assessment the following day. Post-fall assessment completed with resident to be found at baseline ambulation, denies pain, and no non-verbal signs of distress observed. No apparent injury noted. Interventions include completion of post-fall neuro assessment and head-to-toe check with no injury identified, reinforcement of fall precautions, environmental

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safety check completed, increased monitoring per facility protocol, and care plan reviewed due to recent fall.

-05/14/2026: .....Grippy socks were applied for nighttime safety. [Wife/husband] was notified of fall per protocol and recommended use of slippers or additional grippy socks for improved traction. [Former RN D] completed in-person post fall assessment the following day with no apparent injury noted. Post-fall assessment completed with resident at baseline ambulation, denies pain, and no non-verbal signs of distress observed. Interventions include completion of post-fall neuro assessment and head-to-toes check with no injury identified, reinforcement of fall precautions, use of walker for all ambulation, application of non-slip footwear, environmental safety check completed, increased monitoring per facility protocol, and care plan updated to reflect recent fall. Consideration for PT/OT evaluation and environmental safety evaluation to further reduce fall risk and support safe ambulation ... ... [S/he] is extremely unsteady while ambulating. Writer tried to get [him/her] to use [his/her] walker, but even with it [s/he] is very unsteady.

-05/15/2026: ...Writer then assisted res to the dining room to watch the brewer game. [S/he] had some snacks and then fell asleep in the dining room chair. Writer went to get [his/her] 8pm meds and [s/he] woke up and started staggering down the hallway falling against the wall and handrails. It took both staff to get [him/her] to [his/her] room and [s/he] could barely walk. Both staff assisted [him/her] with cares and [s/he] went to bed.

-05/16/2026: ... ...[S/he] emptied out [his/her] sock underwear and sock drawer and was

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N 385	Continued From page 19 walking fast around the building almost falling many times. -05/19/2026: ...[S/he] has an extremely hard time ambulating after supper also. Writer gave one on one attention for safety until writer was able to give [his/her] scheduled meds and assist [him/her] into bed. Resident slept off and on until writer left at 10pm getting up often. [S/he] is very unsteady each time that [s/he] got up. -05/20/2026: resident has been unable to relax (1am) resident has been given pain med, food, drink and has allowed resident to walk to and from the living room and back to their room. Resident falls asleep for a short time then is up trying to change clothes or just walk. Staff is taking turns sitting with resident, currently sitting in chair in front of charting room ....resident has been unable to relax all night. Resident maybe slept for 2 hours in the chair in front of the charting room. As soon as resident was awake they were unable to sit still, kept wanting to stand up .....Res keeps walking with out [his/her] walker, was pushing writer looking for [his/her] [wife/husband] wanting tot know where [his/her] [wife/husband] is and when [s/he] coming in to see [him/her]. Walks like [s/he] is going to gall at any min. Several times writer and the med passer and activity aid have all asked [him/her] to please use [his/her] walker so [s/he] don't fall and res refuses to use it what so ever .....completed by [Former RN D]: Staff heard resident walking in [his/her] room and then a thud; upon entering, resident was crawling from the bathroom and used the toilet bar to get up. Staff assisted resident with slippers and walker, returned [him/her] to bed, and took vitals with no apparent injury noted. Staff called [Former RN D] to inform them of the fall and [Former RN D] directed staff	N 385		

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through assessment, finding no apparent injury. [Former RN D] later saw resident in the morning and found [him/her] sleeping in the lobby chair, arousable and at baseline. PCP and AHCPOA were notified. Resident does not use a call pendant and requires frequent reminders and assistance to use [his/her] walker or cane, which [s/he] tends to refuse. Staff will continue to encourage and assist with ambulation, ensure footwear is applied, maintain clear pathways, and provide increased observation, especially during nighttime or periods of agitation. Environmental modifications, including grab bars and accessible seating, are in place to reduce fall risk. Staff will monitor for signs of pain, bruising, or changes in behavior or mobility, and document all incidents, refusals, or concerns. Verbal cues, redirection, and positive reinforcement are used to support safe mobility and reduce agitation .....Writer was asked to call emerg contact which is [his/her] [wife/husband] and [wife/husband] was asking why [s/he] keeps falling all the time and if [s/he] is now allowed to come see [him/her] that someone from here stated [s/he] is not allowed to come see [him/her] or there kids. Writer asked med passer to please call [Former RN D] to see if [s/he] is allowed to come and see [his/her] [wife/husband]. [Former RN D] stated yes [s/he] is. [His/her] [wife/husband] then stated to me that [s/he] will just call [Family Member E] in Chicago and ask what [s/he] thinks because [s/he] is a md. Writer said ok. Writer did tell [him/her] to please reach out to [Former RN D] about why [s/he] keeps falling or if [s/he] has any questions like that writer explained that [s/he] is not a nurse that [Former RN D] is RN and [s/he] might be able to answer that better .....Res slept until around 7pm. [S/he] took [his/her] meds and had supper then went back to sleep in [his/her] bed. [His/her] movements are very slow and sluggish

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and [s/he] appears to be overmedicated.

-05/23/2026: after supper resident immediately started wandering around unsteadily. Writer gave resident some snacks and was able to redirect until 7pm .....Res was assisted back into bed at least 10 times but [s/he] keeps getting up even though [s/he] can barely walk. Resident needs one on one care for [his/her] safety and others safety which is negatively affecting the entire building.

-05/24/2026: ....edited, resident woke up right after I wrote this and is now wandering around the facility in [his/her] underwear. Writer and care staff are trying to assist [him/her] to get dressed.

-05/31/2026: resident asleep in dining room chair entire shift, would not get up to get changed or go to room for either staff until 4:45am. When resident did stand [s/he] was so unstable and weak it took both staff to walk [him/her] and only got to chair by fireplace before [his/her] entire weight was leaning on us and legs almost giving out the entire way .....Resident woke up at about 3:30 pm and was very wobbly and unsafe when walking, two staff assisted [him/her] to [his/her] walker to the bathroom and put clean clothes and depend on [him/her]. Assisted [him/her] to lay down in bed.

-06/03/2026: resident slid [him/herself] out of chair onto the floor, resident proceeded to lay on [his/her] side and then become increasingly frustrated while staff waited for lift assist resulting in resident getting [him/herself] back into the chair."

On 06/08/2026 at 9:42 AM, Surveyor conducted an exit conference and shared findings with

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N 385	Continued From page 22 Executive Director A and RN G via phone. Surveyor voiced concerns for the number of entries in Resident 2's record regarding his/her unsteadiness, unwillingness to use his/her walker, and 5 falls in 3+ weeks of being admitted. Surveyor shared fall interventions were noted in observation notes but did not get updated to the TSP. Executive Director A stated Former RN D was responsible for updating care plans. Surveyor asked who was responsible for updating care plans after Former RN D left. Executive Director A stated it would be the nurse, and we just hired a new one. Executive Director A acknowledged an understanding of the above concerns. Executive Director A stated s/he would work with RN G on updating resident care plans, including Resident 2's as his/her 30-day care plan would be due soon.	N 385		