STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525132	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Central Health Care	2400 Marshall Street, Ste A Wausau, WI 54403

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility did not provide adequate supervision to prevent accidents for 2 of 4 sampled residents (R51 and R3).R51 sustained four falls without adequate supervision or a root cause being determined, the last fall resulted in R51 suffering major injury, causing R51's overall decline and admission to hospice services. This is being cited at actual harm. R3 had multiple falls, the care plan was not updated with the interventions to prevent falls. Findings include: The facility's policy, titled Nursing Home Falls Prevention and Management, revision dates 09/21/23 and 07/31/25, read in part, Fall Huddle is a brief meeting immediately after the fall that includes staff caring for the individual who fell and their family, if able to participate. Implementing interventions, this process includes communicating the interventions to relevant staff, documenting interventions, and ensuring interventions are put into action. Care plan interventions will be monitored for effectiveness and modified as needed. Interventions should be implemented correctly and consistently. [MVCC] will provide adequate supervision to mitigate accidents and falls. The facility's procedure, titled Nursing Home Fall Prevention and Management Procedure, revision dates 09/21/23 and 07/31/25, read in part, Post Fall Review and Management; Interventions must be: Balanced with other priorities of/for the individual. Fall interventions must be put into place to prevent future falls. Team will add any interventions based on the root cause of the fall. Ensure documentation has been completed appropriately, and plan of care has been updated. Example 1 R51 is an [AGE] year-old-female who fell at home, resulting in a right ankle fracture. R51 was hospitalized from [DATE]-[DATE], for a surgical procedure to repair her right ankle. R51's hospital discharge instructions indicated R51 to be non-weight bearing for eight weeks, with a cast to her right ankle. R51 was admitted to the facility on [DATE] for short-term rehab with a goal to return home. Upon admission, R51 was alert and oriented to self and her surroundings but was forgetful at times. R51's diagnoses included dementia, Alzheimer's, depression, and insomnia. On 12/04/24, the facility completed a fall risk assessment, which confirmed R51 was at high risk for falls. R51's base line care plan, dated 12/04/24-12/06/24, included the following: -Skin integrity: Interventions (as applies): dependent for repositioning (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-ADL status, self-care deficit: Interventions (as applies): bed mobility substantial/maximum assistance, transfers with full body lift and two staff, dressing dependent, hygiene dependent, shower dependent, toileting dependent, wheelchair mobility dependent. -Nutritional Status -Psychotropic drug use -Sleep -Discharge -Bowel and Bladder: Interventions: Bed pan, incontinence briefs, toilet. Resident can express need to void. Prompt to toilet to decrease incontinence. (Note, R51's baseline care plan did not include an area for falls). On 12/05/24 at 4:00 PM, R51 was found on the floor in front of her recliner. R51 stated she didn't like a piece of tape that was on her right ankle cast and was trying to pull it off, she then slid forward onto her buttocks and onto the floor. There was no injury noted. Hoyer sling and chux pad were on the chair underneath R51 at the time of the fall. New Intervention: remove sling and chux pad when in chair. On 12/05/24, following R51's fall, the facility completed a fall risk assessment and R51 continued to be at high risk for falls. On 12/12/24, R51's care plan was updated to include: -FALLS: INTERVENTIONS: Keep call light in reach, keep personal items in reach, low bed, floor mat, occupy resident with meaningful distraction, remove chux and hoyer sling when in recliner. On 01/16/24, R51 attended an orthopedic appointment. R51's cast was removed, with instructions to wear an orthopedic walking boot when up. R51's transfer status was changed from hoyer lift to pivot stand transfer with assistance of one. Staff assistance of one with ADLs. R51 was able to ambulate short distances with walker and staff assistance or use manual wheelchair for mobility. Due to R51 no longer having a cast, and transfer status change from hoyer to pivot transfer, the following were discontinued from her care plan, remove sling and chux when in chair and floor mat. R51's care plan dated 01/01/25-01/30/25 included the following: -12/12/25, FALLS: INTERVENTIONS: keep all light in reach. -12/12/25, keep personal items and frequently used items within reach. -12/12/25, occupy resident with meaningful distractions. On 02/08/25 at 7:00 AM, R51 had her call light on. Staff went to answer and found R51 sitting on the floor next to her bed. R51 stated she ambulated herself to the bathroom and then walked back to her (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	bed. When she went to sit she underestimated the bed and slid to the floor. Upon assessment a skin tear to the back of R51's right hand was noted. An x-ray was ordered and was negative for injury. On 02/10/25, progress notes indicated a new intervention to encourage R51 to call for assistance. Note, this intervention was not added to R51's care plan. On 02/10/25, the facility completed a fall risk assessment, which showed R51 to be a high fall risk. On 02/20/25, R51 was moved from short term rehabilitation to long term care, as discussion with R51/POA/staff, it was determined R51 was not safe to return home. On 02/28/25, R51 attended an orthopedic appointment. R51's walking boot was discontinued. Orders included, R51 may use walking boot as needed for ambulation on uneven ground, weight bearing as tolerated, and continue with therapies. On 02/28/25, R51's care plan included FALLS: -02/28/25, Follow accident and safety standards of care. (Safety and Accident Prevention, Standards of Practice: Falls, use gait belt, keep bed at transfer height, ensure bed wheels are locked before helping resident in/out of bed, lock wheelchair before transfer, use wheelchair pedals for long distances, offer grippy socks or shoes for walking/transferring, maintain a clutter free environment, call light and personal items within reach). (Note, this change was a facility wide change to all resident care plans. The accident and safety standards of care are facility practices and not resident specific. There is no root cause to determine if the fall was related to R51's toileting needs). -02/28/25, See CNA Care Card for resident specific interventions. On 03/08/25, R51's CNA Care Card included FALLS/SAFETY: -Interventions: low bed. On 07/28/25 at 8:45 AM, staff found R51 on the floor next to her bed with her back up against the frame towards the foot of bed and sitting on her butt. R51 stated she just got back from going to the bathroom and was trying to get self up out of bed and slid to the floor. No injuries noted. Progress notes read, Resident is known to self-transfer and not appropriate for a low bed and a mat. Grippy socks were worn during incident. Reminders for resident to use call light for any transfers. Note, this intervention was not added to R51's care plan, R51's care plan was unchanged with no revisions until 08/14/25. There is no root cause to determine if R51 needed a change in her toileting schedule, as again she was trying to get to the bathroom. On 07/28/25, the facility completed fall risk assessment. R51 remained a high fall risk. On 07/30/25, a new BIMS assessment was completed and R51 scored 05/15, indicating severe cognitive impairment. On 08/12/25 at 11:50 PM, R51 was found lying on the floor next to her bed. She was lying on her back (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	with her feet facing the head of the bed. Resident was hoyered back into bed. Bruising noted to right knee 8cm x 4cm blue/purple in color. Bruising to right medial ankle 7cm x 3cm brown/blue in color. Left elbow blood blister dark purple in color 2 cm x 0.3 cm. Left posterior forearm bruise 1cm x 0.7cm red/purple in color. Resident reports pain 10/10 to left hip, unable to move the leg. Provider notified with orders to send to emergency room (ER) for evaluation. On 08/13/25, PROGRESS NOTE: Resident will be returning to facility shortly as family has elected to not pursue surgical option but instead enroll in Aspirus Hospice. Hospice team is not expected until this evening to admit. On 08/13/25, HOSPITAL DISCHARGE SUMMARY: Pt to have significant femur fracture and closed fracture of left pelvis. Orthopedic team was updated on pts wishes and was already considering conservative management for this pt due to severe dementia and advanced age. Will send pt back to facility with a few days of Roxanol and Ativan for pain control. Hospice team will assume care from here on. Hospice orders: d/c'd all oral meds, ordered morphine scheduled every four with as needed dose available every two hours. Ativan scheduled every four hours, with as needed dose every four hours also available. Oxygen via nasal cannula, as needed. On 08/14/25, R51's care plan included FALLS: -02/28/25-08/14/25, Discontinued, Follow Accident and Safety Standards of Care. D/c reason, problem discontinued. -02/28/25-08/14/25, Discontinued, See CNA Care Card for resident specific interventions. D/c reason, problem discontinued. Note, no other changes related to falls on R51's care plan and no root cause determined as to why R51 was getting out of bed. PROGRESS NOTES: -08/14/25, resident has been in bed all day per the orders of hospice. Resident taking comfort meds. She has not appeared to be in any pain, only when staff reposition her. Continues O2 via nasal cannula. Has not had much oral intake, just a few sips of water and juice with medications. -08/14/25, Resident continues to call out during repositioning. Staff were informed to round following pain medication administration to minimize repositioning-related discomfort. Oral care provided during rounding, and a cool washcloth applied to forehead for comfort. -08/15/25, Resident has been mouth breathing. Resident only appears to be in a lot of pain with movement. However, does moan and groan with slight movement as well. No intake of food this shift, and liquids were minimal. -08/18/25, appears to be comfortable, however repositioning is somewhat painful. Hospice remains attentive and did bring in an airbed, however, is not in place yet due to painful repositioning. he does not appear to be in pain at rest but continues to exhibit facial grimacing and moaning during repositioning. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 08/18/25 at 11:00 AM, Surveyor observed R51 in bed. Observed low bed, mattress on floor. R51 was wearing O2 via NC, and R51's door states to speak with family (located in adjacent room, before visiting R51). On 08/18/25 at 11:05 AM, Surveyor interviewed R51's family. Family reported the facility has updated the family after each fall and that interventions were put into place. Family reported R51 was very social, attended all activities, had many friends at the facility, and often encouraged other residents to attend activities. The family will be holding a facility birthday party for R51 on 08/20/25, as they do not believe R51 will live until her 90th birthday, which is at the end of the month. On 08/20/25 at 7:43 AM, Surveyor interviewed hospitality assistant (HA) I. HA I has worked at the facility approximately one year. HA I stated she was familiar with R51. HA I stated HAs are informed after resident care plans are updated, such as after a fall. HA I stated the interventions for R51 were staff reminders for her to call for help, check on her frequently, ask her if she needs to use the bathroom. HA I stated the facility was not using a low bed prior to R51's most recent fall. On 08/20/25 at 7:57 AM, Surveyor interviewed Certified Nursing Assistant (CNA) J. CNA J stated R51 was one assist with cares, would use her call light and sometimes she would self-transfer. CNA J stated, We tried to monitor her often and get in her room right away. CNA J stated staff would lock R51's wheelchair next to her bed, remind her to use her call light, and make sure her shoes are close to bed. Surveyor asked CNA J how she knows these are interventions, and she stated, I guess I don't know to be honest. CNA J reported staff did not use low bed prior to most recent fall. On 08/20/25 at 8:03 AM, Surveyor interviewed Registered Nurse (RN) K. RN K stated R51's interventions were R51 is supposed use call light, staff remind R51 to use call light. RN K stated, Mostly reinforcement to call for help. We have a fall huddle after each fall. A nurse might update care plan or the unit manager. There should be an intervention after each fall, I don't know why they are not in there (EHR). On 08/20/25 at 10:06 AM, Surveyor interviewed Unit Manager (UM) L and Director of Nursing (DON) B. UM L and DON B reported the facility has a performance improvement plan (PIP) in place from 07/30/25, due to identified inconsistencies in falls, appropriate interventions, documentation, and follow through pertaining to falls. Corrective actions: Fall huddles to be completed immediately after fall, Interdisciplinary Team (IDT) review interventions at morning meeting, made changes to fall event template in electronic record on 07/30/25, updated Falls Prevention and Management Procedure 07/31/25. Staff meeting on 08/06/25, discussed PIP. UM L stated they did not update individual resident care plans, specifically did not update R51's fall care plan after 07/30/25. On 08/20/25 at 3:28 PM, Surveyor interviewed RN M, who was the nurse present at the time of R51's fall with major injury. RN M reported she was on another unit when the incident occurred and was updated by the CNA working on the unit. RN M assessed R51, stating R51 was trying to get up when she came into the room. R51 did complain of pain to her hip and provider was updated and ordered to send R51 to ER. RN M stated R51's interventions were low bed, wheelchair next to bed, ensure a clear pathway, and frequent monitoring. RN M stated frequent monitoring on NOC shift is not an appropriate intervention, as there is only a nurse and a CNA on NOC shift, and there are currently 20 residents on the unit. RN M reported R51's bed was in low position when the fall occurred. RN M stated nurses update the care plan with a new intervention, however RN M did not update the care plan as R51 was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	sent to ER, and that was the immediate intervention. On 08/21/25 at 8:00 AM, DON B provided Surveyor with updated PIP and correction of all resident fall interventions were reviewed and updated as of 08/20/25. On 08/21/25 at 8:52 AM, Surveyor interviewed R51's physician assistant (PA) U. PA U stated she was not aware of R51's multiple falls as she started with the facility in 05/2025. Surveyor discussed with PA U R51's multiple falls with lack of interventions and lack of increased supervision to prevent falls. Surveyor asked PA U if the lack of increased supervision and care plan interventions could have contributed to R51's fall, serious injury, and overall decline. PA U replied, Yes, I see that as a risk. There should be interventions in place. Example 2 R3 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia with other behavioral disturbance, anxiety disorder, and adjustment disorder with depressed mood. Most recent Minimum Data Set (MDS), dated [DATE], shows a Brief Interview for Mental Status (BIMS) score of 3/15, which indicates R3 is severely cognitively impaired. On 02/09/25, R3 had an unwitnessed fall in the dining room while leaning in wheelchair to pick up a dropped item. On 02/10/25, a progress note shows an intervention of remind R3 to ask for assistance with picking up dropped items. The intervention was added to the care plan on 03/12/25. On 04/26/25, R3 had an unwitnessed fall while self-transferring to the toilet. On 04/27/25, a progress note shows an intervention of post signage in room to remind R3 to ring for assistance. This intervention was not added to care plan. On 05/10/25, R3 had an unwitnessed fall in the dining room. On 05/11/25, progress notes show interventions of frequent monitoring, continues grippy socks/proper footwear at all times, special cushion properly placed in wheelchair, and remind resident to not lean forward in wheelchair. Frequent monitoring and footwear interventions were not new, and the cushion positioning and reminders not to lean forward, were not added to the care plan. On 06/13/25, R3 had an unwitnessed fall in R3's room. R3 had been incontinent but could not tell staff what R3 was doing when the fall occurred. On 06/13/25, a progress note shows and intervention of remind R3 to use call light for assistance. This intervention was not added to the care plan. R3 has a BIMS of 3, showing severe cognitive impairment. R3 would not be able to recall to use the call light. On 06/13/25, a progress note indicates facility would request a psych medication review. No indication this was completed. On 06/14/25, a progress note shows and intervention of frequent checks. This intervention is not new (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure each resident (R), or their representative had the right to participate in the care planning process after each Minimum Data Set (MDS) assessment for 4 of 4 residents (R6, R2, R3, and R48) reviewed for care conferences.This is evidenced by:The facility's policy titled Person centered Service Policy dated 04/01/24, read in part. 2. Definitions, Care Plan: An individual plan for each resident describing goals, interventions, approaches built by the Interdisciplinary team (IDT) with input from the resident or resident representative.Resident's Goal: The resident's desired outcomes and preferences for admission, which guide decision making during care planning. Resident's goals may change throughout their nursing home stay and are reviewed quarterly at care conferences.Care conferences for each resident are held annually, change of condition, or other times specified by the IDT or family/resident.Example 1R6 was admitted to the facility on [DATE]. R6's current diagnoses include paraplegia, neuromuscular dysfunction and malignant neoplasm of left kidney. MDS with the assessment reference date (ARD) of 07/22/25 an annual assessment documented a Brief Interview Mental Status (BIMS) score of 10/15, meaning R6 had moderate cognitive impairment.Review of R6's medical record documented MDS assessments were completed with the ARD of 07/16/24 an annual assessment. The IDT care conference meeting met with R6 on 08/29/24.Review of MDS with the ARD of 09/27/24 a significant change in status assessment, 12/16/24, 02/03/25, and 05/01/25 quarterly review assessments and 07/22/25 an annual assessment. R6's medical record did not document R6 was invited or declined a care conference meeting for each MDS. On 08/18/25 at 3:49 PM, Surveyor interviewed R6 about attending care conferences. R6 stated they have not been asked to go to care conferences.Example 2R2 was admitted to the facility on [DATE]. R2's current diagnoses include cystitis, osteoarthritis, chronic pain, nutritional anemia, pressure ulcer of other site, bladder-neck obstruction, disease of intestine, reduced mobility, and insomnia.MDS with ARD of 10/15/24 an annual assessment, 01/09/25 and 04/08/25 quarterly assessments were completed. R2's medical record did not document R2 or resident representative was invited or participated with the care conference meetings for each MDS.Example 3R3 was admitted to the facility on [DATE]. R3's current diagnoses include Alzheimer's disease, dementia, dysphagia, atrial fibrillation, anxiety disorder, adjustment disorder with depressed mood, and benign prostatic hyperplasia.Review of MDS with the ARD of 08/20/24, 02/07/25, 05/06/25, and 07/30/25 quarterly assessments were completed. R3's medical record did not document R3 or resident representative was invited or participated with the care conference meetings for each MDS. Example 4R48 was admitted to the facility on [DATE]. R48's current diagnoses include coronary artery disease, renal insufficiency, and diabetes mellitus.Review of MDS with the ARD of 11/16/24 and 12/12/24 are 5 day assessments, 06/10/25 and 08/15/25 are quarterly assessments completed. R48's medical record did not document R48 or resident representative was invited or participated with the care conference meetings for each MDS. On 08/20/25 at 10:49 AM, Surveyor interviewed Director of Nursing (DON) B, Manager of Nursing Services (MN) Y, and Nursing Home Administrator (NHA) A about care conference meetings involving residents and their representative. DON B stated the care conference meetings are conducted with the resident with the annual assessment. MN Y stated the facility had just started doing in person care conferences. On 08/20/25 at 11:11 AM, Surveyor interviewed Social Worker (SW) H about residents being invited to care conferences. SW H stated invites are for annual, change of condition and admissions. They always have done in person. They have not invited everyone since COVID for quarterly assessments. They don't invite residents on quarterly care conferences. Surveyor asked for documentation of invitations and if residents declined. SW H stated they don't consistently document when invited and declined.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable disease and infections. This had the potential to affect all 119 residents in the facility.-Clean linens were not covered in the facility's laundry room where dirty fans were blowing on the linens. Findings:The facility's policy titled Processing of Laundry and Linens, reads in part, . Linens stored in the laundry will be on covered carts. Clean linens will not be stored in areas that contain environmental contamination (air conditioners, chairs, etc.) . On 08/21/25 at 9:16 AM, Surveyor observed an uncovered cart containing clean laundry in clean laundry area. This area had large fans with fuzzy, dirty debris blowing directly down onto the clean, uncovered laundry in a cart. On 08/21/25 at 9:19 AM, Surveyor interviewed Laundry Team Coordinator CC, who stated the clean laundry should have been covered, the fans are dirty and should not be blowing directly on clean laundry. Laundry Team Coordinator CC stated the laundry was just put in there that day and she didn't know why it wasn't covered.On 08/21/25 at 9:24 AM, Surveyor interviewed Environmental Services Manager (ESM), C. ESM C verbalized understanding and stated the expectation would be that the clean laundry would be covered and agrees the fans need to be cleaned and should not be blowing on the clean laundry.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not complete the proper discharge process for 5 of 5 residents (R) reviewed for discharge. (R124, R6, R2, R43, R126) R124 transferred out of the facility and did not receive written discharge documentation.R6 was transferred to the hospital on [DATE] and 01/17/25 did not receive written notice of transfer or bed hold reserve payment notice.R2 was transferred to the hospital on [DATE] and did not receive written notice of transfer or bed hold reserve payment notice.R43 was not given a notice of transfer when sent to the hospital on 6/22/25.The ombudsman was not notified of R126's discharge. According to federal regulation 483.15(c)(3), resident/representative needs to be provided with a written Notice of Transfer (and/or discharge as appropriate) in a manner they could understand, and which meets all the notice requirements. Example 1 R124 was admitted to the facility on [DATE] with diagnoses including stroke, diabetes, and heart failure. R124 was discharged to the hospital on [DATE]. R124's Minimum Data Set (MDS) assessment, dated 06/06/25, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated moderate cognitive impairment. R124 requires set up help for eating and is dependent on staff for bed mobility, transfers, and toileting hygiene. Surveyor reviewed R124's electronic health record (EHR) and found a progress note dated 08/06/25 at 8:25 AM, stating CNA entered room to assist R124 with AM cares. R124 complained of difficulty breathing. Oxygen saturation was in the 60's, nurse placed on oxygen, called 911, and sent R124 to the emergency room for further evaluation. Family was called and updated. R124 was transferred to the hospital via ambulance; however, there was no written notice of transfer. On 08/20/25 at 1:12 PM, Surveyor interviewed Nurse Manager (NM) G and asked for the written transfer notice for R124's hospitalization on 06/06/25. NM G stated they have not been using a transfer form in writing for the residents for hospital transfers. NM G stated they will develop one and use it going forward. Example 2 R6 was admitted to the facility on [DATE]. R6's current diagnoses include paraplegia, neuromuscular dysfunction and malignant neoplasm of left kidney. R6 was transferred to the hospital and was admitted to the hospital on [DATE] for a change in condition and on 01/17/25 for surgical procedure. Review of R6's medical record documented a bed hold notice for 07/24/24 and 01/21/25 that was signed by Social Worker (SW). The notices were not signed by R6 and was not documented the notice was given to R6. R6's medical record did not document a written reason for transfer/discharge notice was given to R6. (continued on next page)

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	525132	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Central Health Care	2400 Marshall Street, Ste A Wausau, WI 54403

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/18/25 at 3:49 PM, Surveyor interviewed R6 about receiving written notice of bed hold and reason for transfer. R6 stated have been hospitalized many times and does not recall receiving bed hold notice and only verbally told and understood why going to hospital and needed to go. Example 3 R2 was admitted to the facility on [DATE]. R2's current diagnoses include cystitis, osteoarthritis, chronic pain, nutritional anemia, pressure ulcer of other site, bladder-neck obstruction, disease of intestine, reduced mobility, and insomnia. R2 was transferred to the hospital and was admitted to the hospital on [DATE] for a change of condition. Review of R2's medical record documented a bed hold notice dated 06/30/25 was signed by SW. The notice was not signed by R2 or R2's representative and did not document the notice was given to R2 or R2's representative. R2's medical record did not document a written reason for transfer/discharge notice was given to R2 or R2's representative. On 08/20/25 at 10:49 AM, Surveyor interviewed Director of Nursing (DON) B and Manager of Nursing (MN) Y about written notice of transfer and bed hold notices. MN Y stated will get the information from Social Worker (SW) H. On 08/20/25 at 12:00 PM, SW H provided Surveyor with bed hold notices for R6 and R2 with SW H's signature. On 08/20/25 at 1:25 PM, Surveyor interviewed DON B about the notice of transfer was not given to Surveyor only the bed hold notice. DON B asked what is contained in the notice of transfer and stated the notice probably was not given. Surveyor requested a copy of the facility's policy for notice of transfer. DON B stated there is no policy. Example 4 R43 was transferred to the hospital on [DATE]. On 08/18/25, Surveyor reviewed bedhold notice in R43's electronic record. Surveyor noted the bedhold notice was signed by the facility's social worker (SW) and was unable to find evidence R43 or R43's representative had been notified of the bedhold notice. Surveyor was not able to locate a notice of transfer provided to R43 or his representative in R43's record. On 08/19/25 at 8:15 AM, Surveyor interviewed SW V. SW V reported for residents receiving Medicaid (MA), MA will automatically hold a resident's bed for 15 days. The facility did not provide bedhold notice to R43 or his representative as he receives MA and his bed was automatically held for 15 days. SW V stated if R43's hospital admission would have extended past the 15 days, the facility would have updated R43 or his representative to see what they would like to do. SW V stated R43 would likely not have been able to pay for a bedhold after 15 days, so they would have discharged R43 but (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	allowed him to re-admit. Staff interviews indicated the facility was not completing notice of transfer agreements. Example 5 R126 was admitted to the facility on [DATE], for short-term rehab after surgical repair for right hip fracture. Appropriate discharge planning in place for resident to return to an assisted living facility on 07/17/25. R126 was discharged on 07/17/25. Progress note on 07/17/25, stated in part that R126 was discharged following completion of her rehabilitation program at the facility. Discharge summary completed and signed by resident. No notification to ombudsman of discharge. 0n 08/20/25 at 1:09 PM, Surveyor interviewed Executive Assistant (EA) N. EA N stated they only notify the ombudsman for hospitalizations or emergency room visits.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility did not maintain a safe and sanitary environment in which food is prepared and distributed. This had the potential to affect 45 residents who eat on the second floor of the north wing out of 119 residents that reside in the facility.Facility staff did not conduct appropriate hand hygiene and were observed touching foods with contaminated gloved hands. Findings include:Facility's policy titled, Safe Food Handling and Sanitation Policy revised 5/31/2023, states in part, 4. General Procedure.Hands will be washed with warm water, per WI food code . Examples of when hands must be washed: .Any change in task from dirty to clean . touching face or hair.Facility's policy titled, Hand Hygiene revised 8/8/2024, reads in part, 4.1.1 Staff must perform hand hygiene (even if gloves are used): .4.1.1.4 After removing personal protective equipment (e.g., gloves.) 4.2. All staff shall use the hand-hygiene techniques, as set forth in the following procedure: . 4.2.4 Before applying gloves.On 08/19/2025 at 12:04 PM, Surveyor observed Dietary Aide (DA) BB wash hands and apply gloves. With gloved hands, DA BB touched bread bag to set on counter, opened refrigerator door, touching handles, took out container of butter, opened drawer and took out utensils, opened bread bag and with same gloved hands, took out 2 pieces of bread and held them while buttering before placing on griddle. DA BB then opened cheese container, and with same gloved hands, touched two pieces of cheese and placed on bread. DA BB then opened drawer and grabbed spatula. Surveyor observed DA BB wiping her face with gloved hands and then went back into fridge to take out a container of oatmeal, dish it up, put on covers and place in microwave. DA BB then touched surface of microwave. After taking out plates and serving utensils to dish up residents' food, and handing dishes to staff to serve, DA BB then removed her gloves, did not wash her hands, took grilled cheese off the griddle with spatula and plated. DA BB then applied new gloves without washing her hands. On 08/19/2025 at 12:22 PM, Surveyor interviewed DA BB about touching foods after touching unsanitary surfaces. DA BB reported she wasn't told that she had to change gloves after touching surfaces and then touching resident food directly. Surveyor asked DA BB if she was to wash her hands before applying new gloves. DA BB reported yes and stated she did not wash her hands after removing or before applying gloves and should have done so. On 08/20/2025 at 12:50 PM, Surveyor interviewed Dietary Manager (DM) AA who reported the expectation of staff is that they wash their hands before applying gloves, after removing gloves, and that hand hygiene preformed and gloves would be changed after touching face and/or touching contaminated surfaces and before directly touching residents' food.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not immediately report to the physician on call for a change in respiratory patterns and gastrointestinal (GI) issues for 1 out of 12 residents (R) (R105) reviewed for change in condition. -Facility did not notify physician on call for the numerous events of Respiratory Therapist (RT) F manually bagging R105 during respiratory distress for long periods of time. -Facility did not notify physician on call for the numerous times R105 had no Bowel Movement (BM) and signs of abdomen distention. Findings include:Surveyor reviewed the facility protocol titled Notification of Change, last reviewed on 07/23/25, which states in part, The nurse will immediately notify the residents physician for the following:-A significant change in residents physical, mental, or psychosocial status (that is deterioration in the health, mental, or psychosocial status in either life threatening conditions or clinical complication).-A need to alter treatment significantly (that is a need to discontinue or change an existing form of treatment due to adverse consequences or to commence a new form of treatment) . R105 was admitted to the facility on [DATE] with diagnoses in part, acute respiratory failure with hypoxia, multiple sclerosis, quadriplegia, interstitial emphysema, encounter for attention to gastrostomy, retention of urine, dependence on respirator [ventilator] status, dysphagia, pneumothorax bilateral, constipation, unspecified, and contracture, unspecified joint of the hand and lower leg. R105's minimum data set (MDS) assessment confirmed R105 is totally dependent on staff for all cares.Surveyor reviewed R105's care plan, which states in part, *ADL Care plan last reviewed on 06/12/25:-Toileting assist x1 dependent, undergarments size and type medium. *Nutritional Status care plan last reviewed on 06/12/25:-Has noted allergy to nuts- do not provide nut or foods that may contain.-Monitor tube feeding tolerance and adjust as needed.-Monitor weight trends, discuss nutritional approaches with IDT and resident/guardian as needed.-Weight as ordered, monitor labs as needed, report significant weight changes to RD and MD, provide tube feeding and water flushes as ordered. *Respiratory care plan last reviewed 06/12/25:-Monitor respiratory status with assessments, ventilator management, pulse oximeter as needed, suctioning, bronchodilator therapy and O2 therapy as needed, maintain trach with daily prn trach care and tube changes as needed.Surveyor did not find a Bowel and Bladder care plan. Previous one referred to following standards of care and was discontinued on 03/09/25. CNA care plan:- Toileting assist x1 dependent, undergarments size and type medium.Surveyor reviewed physician orders:-On 03/22/23, Bisacodyl suppository 10mg, give rectal for constipation as needed.-On 03/22/23, Miralax 17gram/dose, give 17 grams for constipation through gastric tube as needed.-On 06/18/25, Peg tube feeding formula Jevity 1.2 at 45mls/hr continuous every 4 hours.-On 03/22/23, Peg tube feeding residual gastric contents every 4 hours then re-instill.-On 06/27/23, Miralax 17 gram/dose, give 16 grams for constipation daily. -On 06/11/25, Docusate sodium liquid 50mg/5ml, give 10ml's three times a day through gastric tube for constipation.-On 11/19/24, NPO.-On 01/27/25, Morphine concentrate 100mg/5ml, give 0.4ml (8mg) sublingual for dyspnea and pain three times a day.-On 06/08/25, Morphine concentrate 100mg/5ml, give 0.4ml (8mg) sublingual for dyspnea as needed.-On 07/08/25, Rectal decompression using 30 fr foley, lubricate and insert as far as possible. Place patient on side for 15-30min, massage stomach, repositioning halfway through. Continue until flatus stops or slows down as needed.-On 07/23/25, Metoclopramide hcl 10mg give 10mg three times a day through gastric tube for gastric motility.-On 07/30/25. Simethicone liquid 125mg via gastric tube three times a day for gas and bloating.Surveyor reviewed R105's Bowel Movement (BM) list:-On 07/18/24-07/22/24: No BM documented.-On 07/23/24-07/26/24: No BM documented.-On 08/13/24-08/16/24: No BM documented.-On 08/21/24-08/24/24: No BM documented.-On 09/06/24-09/09/24: No BM documented.-On 09/09/24-09/13/24: No BM documented.-On 10/04/24-10/06/24: No BM documented.-On 10/09/24-10/13/24: No BM documented.-On 10/19/24-10/21/24: No BM (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented.-On 10/25/24-10/28/24: No BM documented.-On 10/30/24-11/02/24: No BM documented.-On 11/09/24-11/11/24: No BM documented.-On 11/21/24-11/26/24: No BM documented.-On 12/19/24-12/21/24: No BM documented.-On 03/17/25-03/20/25: No BM documented.-On 04/01/25-04/03/25: No BM documented.-On 04/05/25-04/08/25: No BM documented.-On 04/09/25-04/11/25: No BM documented.-On 06/05/25-06/07/25: No BM documented.-On 06/30/25-07/02/25: No BM documented.The MD was not notified on the above incidents when R105 did not have a bowel movement. Surveyor reviewed progress notes, which state in part: On 11/12/24 at 11:48 AM, Resident's ventilator has been alarming on and off since start of the shift at 0600. Resident has required frequent suctioning. Also have removed resident from ventilator and manually bagged 2 different times. 2nd time RT and other staff with resident for about 30 minutes. Resident was clamping down breathing so hard that vent was reading circuit disconnect, even though circuit was intact. RN provided morphine. Resident has complaints of abdominal discomfort and appears somewhat bloated/distended. RN manager also assisting with assessing stomach. Resident eventually calmed down and able to place back on ventilator. Breathing appears to be comfortable and achieving adequate tidal volumes. No further needs.Facility did not notify physician on call of R105's respiratory change during ventilation that required 30 minutes of manual bagging. -On 12/22/24 at 3:46 AM, Vent alarming, writer went to check. Vt 50-80, writer suctioned for moderate amounts of pale yellow. Vt still not returning to baseline. Writer manual vented resident for several minutes. attempted to put back on vent, resident didn't respond. Writer informed RN and RN gave breathing medicine. Writer again manually ventilated. Resident was boosted in bed and resident was placed back on vent with Vt and Vte at baseline. Total time was 30 minutes. Facility did not notify physician on call of R105's respiratory change during ventilation that required 30 minutes of manual bagging. -On 01/18/25 at 3:44 PM, Recorded as Late Entry on 01/31/2025 12:40] 01/18/2025 at 3:44 PM, called to residents room shortly after neb tx was given 30min ago. resident had bronchospasms, very diminished breath sounds, purple in the face. took resident off and bagged until bagging became easier, suctioned small to moderate yellow to clear secretions, breath sounds clear throughout at this point. placed resident back on vent, good return VT/MV. resident comfortable at this point. Respiratory Therapy RT.Facility did not notify physician on call of R105's respiratory change during ventilation that required unknown time of manual bagging or change in lung sounds and respiratory status. -On 01/24/25 at 6:02 PM, Resident had 2 episodes today of being asynchronous with the ventilator. The first episode lasted about 45 minutes. Writer provided suction, cuff adjustment, manual ventilation with Ambu bag, prn albuterol. RT manager assisted and RN provided morphine. Eventually resident was able to synch with vent. RT manager did note suction catheter was more challenging to pass at one point. Readjusted tube and this seemed to resolve the issue. Resident had 2nd episode following his shower. Provided scheduled nebulizer and replaced trach ties. Did deflate cuff and suctioned large amounts of oral secretions. Reinflated cuff and placed washcloth under wye adaptor. Ventilation seems adequate at this time.Facility did not notify physician on call of R105's respiratory change during ventilation that required unknown time of manual bagging or change in lung sounds and respiratory status. -On 01/27/25 at 4:37 PM, Resident vent alarm was alarming overhead. Writer went in to find vent alarming low tidal volume. Writer started by suctioning resident which yielded moderate amount of pale-yellow secretions. Vent was still alarming low tidal volume, so writer adjusted trach tube/trach ties with still no luck. Writer started to bag resident. RN and RN manager came in and helped by giving breathing meds. Resident was still not syncing with vent. After 20 minutes of bagging with no luck, writer called RT manager to help. RT manager took over bagging while writer suctioned. Resident was placed back on vent but still had low tidal volumes and vent started to alarm circuit disconnect. RT manager and writer looked but saw no disconnect. Suctioned again and catheter was not able to pass. Listened to lung sounds which were diminished with little air movement going through. Writer started up scheduled albuterol nebulizer to hopefully open up airways. VS after treatment on RA were O2 94/ HR 73/ RR 18. Tidal volumes continued to be low. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Kept bagging resident while trying to suction and catheter still was not passing. RT manager decided to try to change trach tube with writer assisting. After new trach tube was placed, resident was placed back on vent and shortly after vent started alarming low tidal volume again. Began bagging again. RT manager went to get nurse to possibly get x-ray. RN came in to help while getting more VS. Resident was put on 3L of O2 because could not get saturations above 90. RN gave another dose on meds to resident and about 5 minutes later, tidal volumes were back up to 600s and resident was resting comfortably. Will continue to monitor. Total time was 1 hour and 20 minutes.Facility did not notify physician on call of R105's respiratory change during ventilation that required 1 hour and 20 minutes of manual bagging or change in lung sounds and respiratory status. -On 04/28/25 at 5:47 PM, Resident had 2 episodes late afternoon with being found out of synch with ventilator. Writer suctioned trach, provided oral suction, deflated and reinflated cuff, and provided manual ventilation for periods of time. This seemed to resolve his discomfort. No further intervention needed at this time, resting comfortably of ventilator.Facility did not notify physician on call of R105's respiratory change during ventilation that required unknown time of manual bagging or change in lung sounds and respiratory status. -On 05/10/25 at 11:07 AM, Responded to resident's ventilator alarming. Resident attempting to talk and in attempts to do this, was cutting off the ventilator. Deflated cuff and resident asked where his wife was. Writer informed resident that she was unsure. RN also in room to assist and found resident to have bounding heartbeat that seemed irregular. PRN morphine given by RN. After short period of time, HR went back to a normal rhythm. Resident did require manual ventilation for short period of time as well. Eventually settled back into [NAME] with ventilator. No further needs.Facility did not notify physician on call of R105's respiratory change during ventilation that required unknown time of manual bagging or change in heart sounds and respiratory status. -On 05/10/25 at 12:48 PM, Reassessed resident at 1115 and found him to be pale in color. Resident not responsive to resident's attempts to arouse him. Suctioned large amount of white secretions. Pulse oximeter applied to ear and found SpO2 86%, HR to be in 130-140 range. Called RN to room. At this point ventilator started alarming low VTE, min vent, and circuit disconnect. Circuit completely intact. Resident removed from ventilator and manually ventilated. 2nd RN came to assist, obtained albuterol which was given via in-line ventilator circuit. HR came down to 110-120, SpO2 98%. Once treatment was done, SpO2 dropped to 70s and HR went back into 130s. Initiated manual ventilation again. Also used trach tube obturator to verify trach placement, which was appropriate placement. Did several attempts of placing back on ventilator and each time resident not in synch with vent. Started 2nd albuterol treatment and after about 2-3 minutes of treatment, SpO2 dropped to 77%. Manual ventilation started again. After short period of time, resident placed back on vent and able to ventilate appropriately. Stable at this time. Left on 4 L O2, SpO2 98%, HR 115. Checked resident frequently and each time HR was lower. At 1240 oxygen turned off. SpO2 98%, HR 78. Assessed again at 1300 and SpO2 96%, HR 77, RR 18.Facility did not notify physician on call of R105's respiratory change during ventilation that required unknown time of manual bagging or change in heart/lung sounds and respiratory status. -On 05/10/25 at 6:00 PM, TACHYCARDIC EVENT:10:40- Writer responded to RT request to assess resident's HR. Apical and radial pulses palpated and found to be bounding, rapid, and Irregular. Continued for approximately 10 minutes. Abruptly, residents HR returned to normal rhythm and rate. Writer had given PRN MS04 0.2ml about 10 minutes prior. RN from neighboring unit assisted with assessment and plan of care.11:20- RT alerted writer that resident's HR was elevated after hooking him up to ear sat. HR in the 140's, O2 sat maintaining in high 90's on manual ventilation as resident was not syncing with ventilator. Heart sounds auscultated and in normal rhythm. BP 146/88. Pupils pinpoint and not responsive to light. Tongue slightly protruding from mouth. Eyes closed, non-responsive to voice. No indication that resident was in distress.11:40- Scheduled MS04 0.4ml administered. HRR ranging 110-120 on manual ventilation. Pupils 2-3mm, non-responsive to light. Skin returning to normal color. No indication that resident was in distress.12:10- Resident synced with the ventilator, remained on 3Loxygen. O2 sats continue in high 90's. HRR ranging in low (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	100's. No indication that resident was in distress.12:30- HRR ranging in the 80's. No signs of distress, lying in bed appearing comfortable with eyes closed.12:50- Oxygen removed. HRR ranging in the 70's. No signs of distress, lying in bed appearing comfortable with eyes closed.Resident remained stable rest of shift. Responsive to voice and environment by opening his eyes per his usual.Facility did not notify physician on call of R105's significant respiratory change during ventilation that required unknown time of manual bagging or change in heart/lung sounds and respiratory status. -On 05/26/25 at 5:31 PM, Resident had 3 episodes of being asynchronous with ventilator today. Each time resident required manual ventilation in order to settle back on to ventilator. Resident appears to have increased discomfort due to his neck sore. RN and RT worked together to assess and change dressing to back and side of neck today.Facility did not notify physician on call of R105's significant respiratory change during ventilation that required unknown time of manual bagging or change in heart/lung sounds and respiratory status. -On 05/29/25 at 2:30 AM, Writer responded to resident's vent alarming overhead for low tidal volume, low minute ventilation. He has required inline suction frequently the last few days to maintain tidal volumes above 300mL. His saturation with ear probe registered at 83% on RA. Writer saline lavage and suctioned resident, with difficulty passing closed-suction catheter past end of tracheostomy tube. Writer completely deflated resident's cuff, attempting to pass suction catheter again, with moderate but successful difficulty. Thick clear secretions were yielded; however, resident's color turned to purple. Writer removed resident from ventilator and bagged on flush supplemental oxygen for 2 minutes, returning to 99% SpO2, then on room air while still being bagged for 3 more minutes, resulting with a saturation of 94%. RN administered morphine to relieve desynchrony with ventilator. Writer inspected resident's trach ties to discover that his tracheostomy tube was sticking out from his neck 3/4. History has shown that this leads to vent desynchrony when his trach tube is not flush with his neck. Despite the fact that resident is being treated for a wound under his trach ties, tightening them was necessary to preserve resident's breathing. Writer adjusted resident's trach ties ensuring trach was centered with stoma. Writer placed resident back on ventilator and inflated his cuff with saline to attain an adequate tidal volume and peak flow. Resident was also boosted in bed to alleviate any stress on his diaphragm. He is now resting comfortably.Facility did not notify physician on call of R105's significant respiratory change during ventilation that required unknown time of manual bagging or change in heart/lung sounds and respiratory status until 06/04/25. -On 06/04/25 at 6:38 PM, MD in for rounds today and updated on resident's respiratory status and increased spasms. N.O received for clonazepam BID. reviewed labs and decreased Magnesium to once daily. Writer called and left message for guardian for starting clonazepam. waiting for return call. -On 06/09/25 at 1:30 PM, Resident having episode this morning starting around 10am and lasted for 45min. resident was bagged with O2 due to skin purple in color, suctioned moderate amounts of yellow secretions. would be placed back on vent but would still not have good values on vent. continue bagging thru another episode of discoloration, purple of the face. After doing 3 rounds of bagging, and being placed back on vent, resident then turned pale white in the face requiring more bagging, but not before O2 saturation bottomed out into the 77-83% range. during bagging pink hue returned to face, resident placed back on the vent with 3L O2 added bleed in with saturation at 94%. resident now [NAME] in the low 300s for VT, MV >5lpm.Facility did not notify physician on call of R105's significant respiratory change during ventilation that required unknown time but more than 45 minutes of manual bagging in one episode or change in heart/lung sounds and respiratory status. -On 07/07/25 at 11:02 AM, Resident seems to be having unsettled morning, PRN meds given for breathing as well as bagging for several minutes. VS stable during but Vt drops to 50-150ml needing extra support from writer. Over the weekend it was reported that resident needed to be bagged several times.Facility did not notify physician on call of R105's significant respiratory change during ventilation that required unknown time of manual bagging or change in heart/lung sounds and respiratory status. -On 07/07/25 at 4:57 PM, [resident name] has been having some episodes of increased muscle tensing which is interfering with adequate ventilation and the (continued on next page)

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	525132	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Central Health Care	2400 Marshall Street, Ste A Wausau, WI 54403

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	respiratory therapists are needed to bag him for several minutes. He is being given prn morphine at these times. RT feels the episodes are increasing and staff will be keeping note in case this is indicative of a change. -On 07/08/25 at 1:54 AM, alerted to residents room, return Vt low, suctioned a few times with bagging, after 5 min of manual bagging volumes increased. -On 07/08/25 at 12:11 PM, Resident having difficulty breathing following being changed and repositioned by CNAs. Resident required manual ventilation for several minutes. Suctioned large amounts of pale yellow secretions and copious clear oral secretions. Attempted to placed resident back on ventilator 2 different times after manual ventilation and he would become agitated and out of synch with vent. After 3rd time of manual ventilation, resident relaxed and fell asleep. Placed back on vent and ventilation returned to acceptable tidal volumes. RN also provided resident with prn morphine.Facility did not notify physician on call of R105's significant respiratory change during ventilation that required unknown time of manual bagging or change in heart/lung sounds and respiratory status. -On 07/08/25 at 12:46 PM, Responded to vent alarming again. Resident not achieving adequate tidal volumes. RT manager assisted writer with manual ventilation while writer suctioned trach tube. Suction large white secretions. Provided manual ventilation for several minutes. Placed resident back on vent and tidal volumes consistently high 300 to low 400s. Will continue to monitor.Facility did not notify physician on call of R105's significant respiratory change during ventilation that required unknown time of manual bagging or change in heart/lung sounds and respiratory status. -On 07/14/25 at 7:41 PM, lab results and KUB and chest x-ray with no significant changes noted from previous labs/tests. Labs taken d/t increased edema to right arm, edema in left elbow upper arm (left forearm is contracted and typically curled above his chest), 3+ edema to BLE. Tolerating tube feeding well. Abdomen appears bloated. Continues to have urinary retention and currently has 280cc in bladder. Bowel sounds active. Had large bowel movement early this a.m. Lung sounds has some wetness, however, nothing, unusual for this resident. He does have increased secretions in what sounds tracheal and at times will have secretions pool in his posterior throat/mouth. We will ask our in house provider to take a closer look. VS 97.4-64-18, b/p= 130/73, oxygen sat = 95%, 1 lpm via trach & vent.Facility did not notify physician on call of R105's abdomen appearing bloated. -On 07/22/25 at 1:51 PM, Resident had multiple episodes of not syncing with vent today. Suctioning, bagging, morphine, and repositioning trach were all tried. The only time resident looked comfortable and was syncing with vent was when resident got tired out and was asleep. Writer spent about 1 hour in the morning and 1 hour after lunch trying to get resident to sync. Resident is currently in room, sleeping. VSS HR 63/ RR 18/ O2 98.Facility did not notify physician on call of R105's significant respiratory change during ventilation that required 1 hour each episode of manual bagging or change in heart/lung sounds and respiratory status. -On 07/29/25 at 10:04 PM, entered room for vent alarm, resident bearing down having difficulties obtaining appropriate VT / MV. resident was bagged and suctioned but no improvement, catheter hard to pass due to residents anatomy when bearing down, residents head was slightly lowered and tube readjusted without pulling, resident then relaxed and was able to get appropriate volumes.Facility did not notify physician on call of R105's significant respiratory change during ventilation that required unknown time of manual bagging or change in heart/lung sounds and respiratory status. -On 07/30/25 at 5:05 PM, Resident de-stated to 85% increased to 4lpm, Sp02 rose to 97% will continue on 4lpm.Facility did not notify physician on call of R105's significant respiratory change. -On 08/18/25 at 3:00 PM, Resident resting in bed, appears calm and had 2 very large bowel movements. Earlier today had significant respiratory distress. Resident has history of bearing down and stressful resistance against vent. he typically recovers with suctioning, calm approach, mso4, bagging at times. He required greater time today. He appears to have recovered well.A chest x-ray has been completed to rule out respiratory factors. A KUB was also completed as resident does have history of bowel complications as well. Resident has been having bowel movements regularly. -On 08/18/25 at 4:30 PM, RT note, late entry-- resident having difficulty synching with the vent, having obstruction passing suction catheter, bad return volumes on ventilator, paradoxal breathing on the right side of chest and (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no breath sounds. resident spasming causing possible bronchospasm as well and throat muscles causing bend in tube which could be why catheter is hard to pass. first suctioning was performed, did not produced any large amounts which would cause the vent values, next trach was changed in effort to bypass obstruction. this was only temporary and resident able to bend tube causing lesser volumes. Albuterol treatment was given to relax bronchials and had no affect, finally after repositioning resident and bagging for an additional 20min, resident was able to be placed back on vent where normal chest excursion returned to bilateral as well as Vt in high 400's to 500. resident more comfortable at this time and resting.Surveyor reviewed notes from communication to provider on 08/18/25, which state in part: .-On 08/18/25 at 1:04 PM, Provider is notified. Resident has been having problems syncing with the vent. Request CXR. RT and nursing in room bagging.-On 08/18/25 at 1:11 PM, Resident has been given PRN and scheduled at 12:40 PM, nurse is thinking may need to give extra dose, can you possibly come talk with nurse.-On 08/18/25 at 1:43 PM, Provider ordered stat KUB due to abdominal distention along with STAT CXR.-On 08/18/25 at 11:43 PM, Provider ordered hold tube feeding and flushes x 24 hours now. Start PIV and infuse 75ml/hr. Daily KUB.Facility did not notify physician on call of R105's significant respiratory change with assessment of paradoxal breathing during ventilation that required 2.5 hours of manual bagging R105 until 1:04 PM which is an hour after manually bagging began. Interviews/ObservationsOn 08/18/25 at 12:06 PM, Surveyor observed R105's call light going off rainbow colored. Surveyor observed Registered Nurse (RN) W enter R105's room in a rush.On 08/18/25 at 12:08 PM, Surveyor observed Respiratory Therapist (RT) F enter R105's room; R105 was in respiratory distress. Surveyor observed alarms sounding and flashing in R105's room. RT F began manually bagging R105. Surveyor entered R105's room to observe respiratory distress and RT F working with R105 in room manually bagging. Surveyor observed many attempts from RT F in manually bagging R105 and trying to reconnect R105 to ventilator. RT F was conversing with RN W in room on what each one thought was going on while manually bagging R105. On 08/18/25 at 12:31 PM, Surveyor observed RT F look around for finger oximeter and then placed on R105's finger. O2 sats were 91% and heart rate 34. RT F continued to manually bag R105 and stated, That is not accurate reading. You must make sure the lines on the screen on the side are flowing consistently for it to be accurate. RT F continued assessing oximeter reading and manually bagging R105.On 08/18/25 at 12:58 PM, RN W called for backup to help manually bag R105 while RT F stepped out to supply room. RN X arrived, placed EBP PPE on and entered room. RT F exited room for more supplies. On 08/18/25 at 12:59 PM, Surveyor heard another staff member in hallway state, I am going to call the doctor now.On 08/18/25 at 1:10 PM, Surveyor observed RT F exit R105's room and report to Surveyor that a chest x-ray needs to be ordered right away. RT F reported that R105 is stable at this moment but during assessment RT F assessed paradoxical in rise and fall of R105's chest. RT F reported to Surveyor that for now we have to wait for chest x-ray and is going to exit and continue down RT F's to do list. Surveyor observed RT F and RN exit R105's room. On 08/18/25 at 1:47 PM, Surveyor observed ventilator settings going off for R105. RT F, RN W, and Physician Assistant (PA) U entered R105's room. PA U assessed R105's lungs, heart, and BM sounds. PA U ordered chest x-ray and a KUD of the abdominal to see if R105 is full of BM. PA U stated, I understand [R105] has issues fighting ventilator when trying to have a BM. Let's order a KUD to make sure this isn't causing [R105] respiratory issues. On 08/18/25 at 2:09 PM, Surveyor observed R105 get back to regular peep, tidal volume on ventilator. Staff repositioned R105. RT F reported to Surveyor that x-ray will be at facility around 2:45 PM/2:50 PM. Concerns of possible Pneumothorax or infection. Surveyor observed RT F exit room while waiting on x-ray. RT F reported that R105 was back to baseline on ventilator breathing and ok for now.On 08/19/25 at 2:57 PM, Surveyor interviewed RT F and asked RT F at what point does RT F contact the physician on call for manually bagging R105. RT F reported to Surveyor that RT F does not notify physician on call and RT F thought nursing staff oversees this with any changes. RT F reported again that RT F does not report to physician on call unless absolutely needing to and that physician on call trusts RT F's (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	judgement to make decisions without physician on call's input. RT F reported to Surveyor that RT F does not have a policy or parameters in place for how long RT F manually bags R105 for, before notifying the physician on call. RT F reported that RT F just continues to manually bag until R105 becomes in sync with ventilator and is stable. On 08/19/25 at 3:22 PM, Surveyor interviewed Nurse Manager G and asked Nurse Manager G what the expectation is for staff to notify physician on call of changes per residents. Nurse Manager G reported that any significant change needs to be reported to physician on call within 15-30 minutes of significant change in status. Surveyor asked Nurse Manager G how often R105 should have BMs. Nurse Manager G reported to Surveyor that R105 should be having BMs every day since being tube fed, and if not, staff need to report this finding to physician on call, especially since R105 has had bowel issues in the past that effect R105's respiratory status and fighting the ventilator. Surveyor asked Nurse Manager G if Nurse Manager G has a policy in place explaining the steps in manually bagging a resident and for how long manually bagging precedes before notifying the physician on call. Nurse Manager G reported to Surveyor that reporting regardless of the change should be completed within 15-30mins of the significant change. Nurse Manager G reported to Surveyor that RT F, RN W, and/or RN X should have notified physician on call within 15-30 minutes of RT F manually bagging R105 on 08/18/25. Nurse Manager G stated, Staff should not be going that long without notifying physician while manually bagging.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that the PASRR (Pre-admission Screen and Resident Review) Level I screen for 1 of 1 resident (R82) reviewed was conducted accurately for having mental illness or developmental disability.R82's PASRR Level I screen was not completed accurately, resulting in the screen not being submitted to the appropriate agency for further review. Findings Include:The Pre-admission Screen and Resident Review (PASRR) Level 1, revised in 7/2017, states the following: Federal law requires that all persons requesting admission to a nursing facility must be screened to determine the presence of a major mental illness and/or developmental disability. If on the Level 1 a resident is marked for Yes in section A, under Current Diagnosis, then the Level I must be referred to PASRR Contractor for a Level II Screen.R82 was admitted to the facility on [DATE] and has diagnosis of Post Traumatic Stress Disorder (PTSD), depression, alcohol abuse, seizures. R82 has a BIMS of 8/15, meaning moderate cognitive impairment, and a POA for healthcare.R82's Minimum Data Set (MDS) admission assessment, dated 10/19/20, indicated an active diagnosis of PTSD 16100. At time of MDS assessment, R82's BIM score was 15.R82's PASRR Level I Screen, completed on 10/12/20, Section A, part 1 (Current Diagnosis), indicated NO for person having a major mental disorder. No Level II Screen was done.R82's recent care plan, dated 06/11/25, with a target date of 09/30/25, states: Psychosocial Well-Being - I have a Dx of PTSD related to my military service in Vietnam. I am aware of my Dx, have done counseling in the past. I decline discussing my sx or dx further at this time. Approach includes: CNA: Be aware I have a Dx of PTSD. Report to nursing changes in mood, routine, responses to environment, approach or interactions. Identify potential sx such as appearing to feel unsafe, withdrawal, uncharacteristic responses to environment, approach.Surveyor reviewed R82's History and Physical and Hospital Discharge summary, dated [DATE], which indicated a Past Medical History of PTSD and Depression. In reference to the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, PTSD is recognized as a major mental illness.On 08/20/25 at 7:52 AM, Surveyor interviewed Social Worker (SW) H and asked if a PASRR Level I screening was done for a resident with a diagnosis of PTSD, would Section A, be answered as a yes for major mental illness. SW H stated, Yes, it would. Surveyor asked SW H if a Level II screening would be done on a resident admitted with a diagnosis of PTSD. SW H stated, Yes. SW H confirmed R82 had a diagnosis of PTSD upon admission to the facility based off hospital discharge summary and history and physical done 10/12/20. SW H confirmed the Level I was completed inaccurately, and a Level II screen was not done.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure 2 of 24 residents (R) reviewed (R18, R19) were provided the necessary services to maintain personal hygiene.-The facility did not develop and implement interventions in accordance with R18's needs related to toileting and repositioning.-The facility did not implement interventions in accordance with R19's assessed needs related to toileting and repositioning.Findings include:R18 was admitted to the facility on [DATE].The Minimum Data Set (MDS) shows a Brief Interview for Mental Status (BIMS) score of 3/15 which indicates R18 is severely cognitively impaired.Facility document titled, Bowel and Bladder Standards of Practice, created on 12/13/24, reads in part: Prompt, offer or assist with toileting with rounding.Facility document titled, Skin Care Standards of Practice, created on 12/13/24, reads in part: Know if your resident has or is at risk of a pressure injury.Keep skin and linens clean, dry, free of wastes, moisture, and drainage.R18's care plan includes a problem of alteration in skin integrity related to decreased mobility and bowel and bladder incontinence with an approach of follow skin standards of care created on 02/27/25.R18's care plan includes a problem containing frequent incontinence of bladder and bowel with an approach of follow bowel and bladder standards of care created on 02/27/25R18's care plan includes a problem of resident specific direct care staff interventions for activities of daily living (ADLs) with an approach of prompted repositioning and assist of 2 for toileting created on 02/27/25. No frequency listed for toileting.Progress note on 08/17/2025 indicated R18 has Moisture Associated Skin Damage (MASD) to left gluteal area, and a reddened groin.On 08/19/25 at 10:19 AM, Surveyor observed R18 sitting in same chair and position since prior to breakfast.On 08/19/25 at 11:08 AM, Surveyor interviewed Certified Nursing Assistant (CNA) O. CNA O stated usually they try to toilet/reposition residents at a minimum of every 2 hours. CNA O confirmed resident was toileted at 10:19 AM. CNA O stated that night shift had gotten R18 up before 6:00 AM and this was the first time R18 was toileted/repositioned on AM shift. CNA O also stated CNA O would try to take R18 to the bathroom one more time before end of CNA O's shift between 1:30 PM and 2:00 PM. Surveyor requested to observe the next toileting.On 08/19/25 at 1:53 PM, Surveyor observed CNA O and CNA P toilet R18. Surveyor observed open/macerated area to buttocks. Red spot comparable in size to a pencil eraser. CNA O stated they have cream that gets applied to R18's bottom. Surveyor observed no cream applied after toileting hygiene completed. R18 assisted back to geri-recliner.On 08/20/25 at 7:35 AM, Surveyor interviewed CNA R. CNA R stated residents are toileted/offered toileting when they get up in the morning and before and after meals. CNA R also stated there are care cards inside each resident's closet door and the nurses update them as needed.On 08/20/25 at 7:40 AM Surveyor interviewed CNA Q. CNA Q stated staff toilet residents every 2 hours or as close as they can to that. CNA Q stated they do rounds and either lay residents down to be changed if they don't use the toilet, or assist residents to the toilet. CNA Q stated they do a check/change on some residents. CNA Q also stated there are care cards inside each resident's closet door or in electronic charting program and they update the nurse with anything different/new.On 08/20/25 at 7:42 AM, Surveyor interviewed Licensed Practical Nurse (LPN) T. LPN T stated that each resident has a toileting care plan, and the expectation is for the CNAs to follow them. LPN T also stated LPN T would expect that if a CNA was falling short on time, they would get LPN T, and LPN T would either find help or provide help. LPN T stated due to some resident's dementia, they may only go to the bathroom once per shift. LPN T stated each care plan is different. LPN T also stated the general rule for toileting is before and after meals and before bedtime. LPN T stated each resident has a care profile in their room/closet and they include everything a CNA would need to know to take care of that resident. LPN T stated the nurses update the care profiles and replace them with new ones as needed. On 08/20/25 at 10:30 AM, Surveyor interviewed Unit Manager (UM) L. UM L stated the CNAs perform routine rounding for toileting which includes when resident (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gets up in the morning, before and after meals, before bed, and several times at night. UM L stated they do not have actual time frames they use. UM L stated each resident falls into a category for toileting. Independent residents can toilet themselves when needed. Prompted residents are encouraged or prompted to use the toilet at routine round times. Dependent residents are toileted by staff at routine rounding times. UM L was unsure if this is listed on the care profiles for CNAs. Surveyor reviewed care profile for R18. No indication of independent, prompted, or dependent list. Care profile indicates R18 requires assist of 2 for transfers with stand aide, and toileting of 1 assist.Example 2R19 was admitted to the facility on [DATE].MDS shows BIMS score of 9/15 which indicates R19 is moderately cognitively impaired.R19's care plan includes a problem of alteration in skin integrity requiring staff assistance with repositioning with an approach of follow skin standards of care and see CNA care card plan for interventions, created on 02/27/25.R19's care plan includes a problem of risk for alteration in elimination pattern related to decreased mobility and dementia with an approach of follow bowel and bladder standards of care and see CNA care card plan for resident specific interventions, created on 02/27/25R19's care plan includes a problem of resident specific direct care staff interventions for ADLs with an approach of dependent for repositioning, bed mobility, and toileting assist of 2 when asleep and assist of 1 when awake.On 08/19/25 at 7:45 AM, Surveyor observed R19 in bed.On 08/19/25 at 10:54 AM, Surveyor observed R19 remained in bed. On 08/19/25 at 11:06 AM, Surveyor interviewed CNA P. CNA P reported CNA P likes to take residents to the bathroom before and after breakfast and before and after lunch. CNA P stated R19 is sometimes wide awake in the morning, and sometimes R19 is up during the night then likes to sleep in. CNA P stated the last time R19 was changed/repositioned was at 9:00 AM.On 08/19/25, Surveyor observed R19's room from 10:54 AM to 12:36 PM.On 08/19/25 at 12:36 PM, Surveyor observed CNAs O and P enter R19's room to begin cares.Surveyor reviewed resident care profile which indicated assist of 1/dependent, 2 assist at night. No other specific interventions listed.On 08/20/25 at 7:38 AM, Surveyor interviewed R19. R19 stated R19 does not use the bathroom and wears a brief. R19 stated R19 just eliminates in the brief and when staff has time, they come change it. R19 stated it depends who is working on how long of a wait it is. R19 stated R19 only gets changed when in bed. R19 stated once being up in the recliner, R19 usually stays there for several hours.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility did not provide care and treatment by professional standards of practice to maintain a resident's highest practicable level of physical well-being. The facility did not ensure a resident received gastrointestinal (GI) assessments and treatment promptly for bowel issues for 1 of 24 residents (R) reviewed. (R105)Surveyor reviewed the facility protocol titled Bladder and Bowel Management, last reviewed on 08/06/25, which states in part, .Bowel Management-Each shift to review EMR documentation an devaluate need for interventions. If no BM by AM Day 2: Offer/encourage prune juice and increase fluid intake. If not effective by PM Day 2: Offer oral laxative per MD order. If not effective by AM Day 3: Check for stool in rectum, give suppository or enema per MD order. If constipation persists: Evaluate possible contributing factors and initiate interventions. And consult with MD for possible stool softener, etc.R105 was admitted to the facility on [DATE] with diagnoses in part, acute respiratory failure with hypoxia, multiple sclerosis, quadriplegia, interstitial emphysema, encounter for attention to gastrostomy, retention of urine, dependence on respirator [ventilator] status, dysphagia, pneumothorax bilateral, constipation, unspecified, and contracture, unspecified joint of the hand and lower leg. R105's minimum data set (MDS) assessment confirmed R105 is totally dependent on staff for all cares.Surveyor reviewed R105's care plan, states in part, *ADL Care plan last reviewed on 06/12/25:-Toileting assist x1 dependent, undergarments size and type medium. *Respiratory care plan last reviewed 06/12/25:-Monitor respiratory status with assessments, ventilator management, pulse oximeter as needed, suctioning, bronchodilator therapy and O2 therapy as needed, maintain trach with daily prn trach care and tube changes as needed.Surveyor did not find a bowel and bladder care plan. The previous one referred to following standards of care and was discontinued on 03/09/25. CNA care plan:- Toileting assist x1 dependent, undergarments size and type medium.Surveyor reviewed physician orders:-On 03/22/23, Bisacodyl suppository 10mg, give rectal for constipation as needed.-On 03/22/23, Miralax 17gram/dose, give 17 grams for constipation through gastric tube as needed.-On 06/18/25, Peg tube feeding formula Jevity 1.2 at 45mls/hr continuous every 4 hours.-On 03/22/23, Peg tube feeding residual gastric contents every 4 hours then re-instill.-On 06/27/23, Miralax 17 gram/dose, give 16 grams for constipation daily. -On 06/11/25, Docusate sodium liquid 50mg/5ml, give 10ml's three times a day through gastric tube for constipation.-On 11/19/24, NPO.-On 01/27/25, Morphine concentrate 100mg/5ml, give 0.4ml (8mg) sublingual for dyspnea and pain three times a day.-On 06/08/25, Morphine concentrate 100mg/5ml, give 0.4ml (8mg) sublingual for dyspnea as needed.-On 07/08/25, Rectal decompression using 30 fr foley, lubricate and insert as far as possible. Place patient on side for 15-30min, massage stomach, repositioning halfway through. Continue until flatus stops or slows down as needed.-On 07/23/25, Metoclopramide hcl 10mg give 10mg three times a day through gastric tube for gastric motility.-On 07/30/25. Simethicone liquid 125mg via gastric tube three times a day for gas and bloating.Surveyor reviewed R105's Bowel Movement (BM) list:-On 07/18/24-07/22/24: No BM documented.-On 07/23/24-07/26/24: No BM documented. -On 08/13/24-08/16/24: No BM documented. -On 08/21/24-08/24/24: No BM documented.-On 09/06/24-09/09/24: No BM documented. -On 09/09/24-09/13/24: No BM documented. -On 10/04/24-10/06/24: No BM documented. Surveyor did not find a GI assessment completed with tube feeding administration.-On 10/09/24-10/13/24: No BM documented. -On 10/19/24-10/21/24: No BM documented. -On 10/25/24-10/28/24: No BM documented. -On 10/30/24-11/02/24: No BM documented. -On 11/09/24-11/11/24: No BM documented. -On 11/21/24-11/26/24: No BM documented. -On 12/19/24-12/21/24: No BM documented. Surveyor did not find a GI assessment completed with tube feeding administration.-On 03/17/25-03/20/25: No BM documented. Surveyor did not find a GI assessment completed with tube feeding administration. -On 04/01/25-04/03/25: No BM documented.Surveyor did not find a GI (continued on next page)

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	525132	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Central Health Care	2400 Marshall Street, Ste A Wausau, WI 54403

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment completed with tube feeding administration. -On 04/05/25-04/08/25: No BM documented. -On 04/09/25-04/11/25: No BM documented. -On 06/05/25-06/07/25: No BM documented. -On 06/30/25-07/02/25: No BM documented.Surveyor reviewed progress notes, which state in part: -On 07/08/25 at 1:18 PM, Received order for chest x-ray via flat plate due to abdominal distension. Resident did have a large BM on night shift. Abdomen has hypoactive bowel sounds, abdomen distended, not soft to palpation.Facility did not initiate a bowel care plan or implement any new interventions for routine bowel regimen. -On 07/08/25 at 5:53 PM, Resident had breathing episode this afternoon that lasted 1.5 hours. Resident required manual ventilation almost entire time. Each time writer attempted to place resident back on ventilator, his tidal volumes would drop low and he would get gray in color. RN, RN manager, and RT manager all observed at different points during episode. Resident finally settled in after RN placed rectal tube. Abdominal x-ray was also completed during this time. Resident appears comfortable at this time.Facility did not initiate a bowel care plan or implement any new interventions for routine bowel regimen. -On 07/08/25 at 8:47 PM, ABD Xray reads, Colonic ileus. -On 07/08/25 at 10:40 PM, [Recorded as Late Entry on 07/09/2025 00:34]Results for abdominal xray received and send to provider. Patient has a colonic ileus. New order received for patient to be NPO and start IV 0.9 normal saline 1000ml at 100ml/hr; give MOM 30ml x 1 dose, give suppository x1, and to repeat KUB after fluids are done infusing and patient has had bowel movements.Facility did not initiate a bowel care plan or implement any new interventions for routine bowel regimen. -On 07/09/25, Nurse Practitioner note: ***Chief Complaint***Abdominal distention with ventilator desynchrony***Subjective***[AGE] years old male, is seen today for an acute care visit. Over the last 24 hours, he has experienced worsening abdominal distention associated with further increase in ventilator dyssynchrony. He has been having loose bowel movements. Abdominal imaging suggested ileus. His examination shows a distended abdomen, but he does have faint bowel sounds. There is otherwise no change in his mental status.Previously, the patient was seen on 05/28/2025 for worsening spastic episodes and contractions requiring breakthrough dosing of morphine. He has a history of chronic hypoxemic respGASTROINTESTINAL-abdomen distended, but does not appear tender he does have faint bowel sound***Assessment and Plan**** Paralytic ileus *: Patient experiencing worsening abdominal distention associated with ventilator desynchrony. Has been having loose bowel movements. Abdominal imaging suggested ileus. Examination shows distended abdomen with faint bowel sounds present. Will plan to repeat abdominal x-ray imaging today to make sure he does not progress to potential obstruction. Due to his inability to tolerate oral intake will be placed on continuous maintenance IV fluids for the next 48 hours as well. In addition we will check labs today including CBC, BMP, lipase and also lactic acid. His lactic acid is elevated we sent to the emergency department for CT scan imaging of the abdomen pelvis. In the interim if he does have absent bowel sounds or worsening respiratory failure or abdominal distention will also be sent to the emergency room. Will continue with her aggressive bowel regimen IV fluids and bowel rest with daily imaging in the meantime Facility did not initiate a bowel care plan or implement any new interventions for routine bowel regimen. -On 07/09/25 at 11:31 AM, ABD Xray reads Mild intestinal ileus.Facility did not initiate a bowel care plan or implement any new interventions for routine bowel regimen. -On 07/10/25 at 5:40 PM, GI: Has had 2 large and 1 small BM today. Bowel movements are loose, liquid. Bowel sounds remain hypoactive, abdomen is distended. Tube feeding has been restarted at a rate of 30ml/hr continuously. Will be increased if able to tolerate.Facility did not initiate a bowel care plan or implement any new interventions for routine bowel regimen. -On 07/11/25 at 4:50 AM, GI: Patient continues to have hypoactive bowel sounds in all 4 quadrants. Patient has not had any bowel movements nor urine output from 1800 to current time. TF held x1 for positive residual. Does not appear to be in any pain and sleeping all night long.Facility did not initiate a bowel care plan or implement any new interventions for routine bowel regimen. -On 07/11/25 at 9:08 AM, GI: Has been tolerating tube feeding at a rate of 30ml per hour. Had 5ml residuals. Bowel sounds remain hypoactive but are improving. Abdomen is less distended today. Has (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f/u KUB this morning.Facility did not initiate a bowel care plan or implement any new interventions for routine bowel regimen. -On 07/14/25 at 7:41 PM, lab results and KUB and chest x-ray with no significant changes noted from previous labs/tests. Labs taken d/t increased edema to right arm, edema in left elbow upper arm (left forearm is contracted and typically curled above his chest), 3+ edema to BLE. Tolerating tube feeding well. Abdomen appears bloated. Continues to have urinary retention and currently has 280cc in bladder. Bowel sounds active. Had large bowel movement early this a.m. Lung sounds has some wetness, however, nothing, unusual for this resident. He does have increased secretions in what sounds tracheal and at times will have secretions pool in his posterior throat/mouth. We will ask our in house provider to take a closer look. VS 97.4-64-18, b/p= 130/73, oxygen sat = 95%, 1 lpm via trach & vent.On 07/17/25 at 4:00 PM, afebrile today. Redness to thigh, trunk comes and goes and is redder at times and lesser at others. No signs of distress today. No bm. Cont to have pitting edema to BLLE and to right arm/hand and distended abdomen. Bowel sounds present. Voiding - foley cath patent.Surveyor did not find a GI assessment completed with tube feeding administration. Facility did not initiate a bowel care plan or implement any new interventions for routine bowel regimen. -On 07/21/25, documented dated 07/16/2025***Chief Complaint***This morning he is awake and alert. His abdomen remains distended but soft compared to the week prior, and he has been having bowel movements.Previously, the patient was seen on 07/09/2025 for abdominal distention with ventilator desynchrony. Abdominal imaging at that time suggested ileus, which appears to have improved with treatment.***Physical Examination***GASTROINTESTINAL-abdomen distended but soft, bowel sounds present***Assessment and Plan**** Paralytic ileus *: Patient's abdominal distention has improved compared to last week. Abdomen remains distended but soft, and patient is having bowel movements. Recent blood work was normal. Will continue with current management including bowel regimen. In addition today we will add in Reglan to see if he can get his bowels moving a little bit more***Follow-up***Facility did not initiate a bowel care plan or implement any new non-pharmacological interventions for routine bowel regimen. -On 08/18/25 at 3:00 PM, Resident resting in bed, appears calm and had 2 very large bowel movements. Earlier today had significant respiratory distress. Resident has history of bearing down and stressful resistance against vent. he typically recovers with suctioning, calm approach, mso4, bagging at times. He required greater time today. He appears to have recovered well.A chest x-ray has been completed to rule out respiratory factors. A KUB was also completed as resident does have history of bowel complications as well. Resident has been having bowel movements regularly.Facility did not initiate a bowel care plan or implement any new interventions for routine bowel regimen affecting respiratory status on ventilator. -On 08/18/25 at 6:46 PM, ABD Xray reads Colonic ileus.Facility did not initiate a bowel care plan or implement any new interventions for routine bowel regimen. -On 08/19/25 at 1:40 AM, KUB and chest xray results received and send on HUCU. Chest x-ray negative. Kub showed colonic ileus, new orders to hold tube feeding and flushes for 24hrs, give IV 0.9NS at 75ml/hr, CBC and BMP in the morning. PIV 22g inserted to right hand, and fluids initiated per order. Resident tolerated well.Interviews/ObservationsOn 08/18/25 at 12:06 PM, Surveyor observed R105's call light going off rainbow colored. Surveyor observed Registered Nurse (RN) W enter R105's room in a rush.On 08/18/25 at 12:08 PM, Surveyor observed Respiratory Therapist (RT) F enter R105's room; R105 was in respiratory distress. Surveyor observed alarms sounding and flashing in R105's room. RT F asked RN W if R105 is constipated, or when was R105's last BM. RN W reported that RN W did now know when last BM was. RT F stated to Surveyor, I know that if [R105] doesn't have a BM for a while he tends to bear down like his body is trying to have a BM and [R105] tends to fight the ventilator. RT F reported to Surveyor that these episodes are becoming increasingly frequent. On 08/18/25 at 1:10 PM, Surveyor observed RT F exit R105's room, and RT F reported to Surveyor that a chest x-ray needs to be ordered right away. On 08/18/25 at 1:47 PM, Surveyor observed ventilator settings going off for R105. RT F, RN W, and Physician Assistant (PA) U entered R105's room. PA U assessed R105's lungs, heart, and BM sounds. PA U ordered chest x-ray and a KUD of the abdominal to see if R105 is (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	full of BM. PA U stated, I understand [R105] has issues fighting ventilator when trying to have a BM. Let's order a KUD to make sure this isn't causing [R105] respiratory issues. On 08/19/25 at 3:22 PM, Surveyor interviewed Nurse Manager G and asked Nurse Manager G how often R105 should have BMs. Nurse Manager G reported to Surveyor that R105 should be having BMs every day since being tube fed, and if not, staff need to report this finding to physician on call, especially since R105 has had bowel issues in the past that effect R105's respiratory status and fighting the ventilator. Surveyor asked Nurse Manager G what expectation is for having a care plan set in place for R105 for bowel management. Nurse Manager G reported that R105 does not have a BM regimen care plan and R105 should have one in place since R105 was admitted with constipation issues. Surveyor asked Nurse Manager G if there was any direction on nursing staff administering the rectal tube to decrease gas in the abdomen for R105 to possibly decrease the extra work R105 is producing when needing to have a BM. Nurse Manager G reported to Surveyor that the order just says use rectal tube decompression as needed with no other parameters. Nurse Manager G reported that Nurse Manager G should notify physician and get that order clarified for better use with R105.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility did not ensure a resident with limited range of motion (ROM) received the appropriate treatment and services to maintain or prevent further reduction in ROM for 1 of 3 residents (R). (R13)-R13's restorative plan was not implemented. R13 did not receive right hand splint for 10 of the last 19 days. The facility policy, titled Restorative Nursing, dated 01/11/23, states: . Programs are to be planned, scheduled, and documented in the medical record.Team member will complete the Restorative Program as indicated in the Comprehensive Care Plan. Documentation will be completed in Matrix. R13 was admitted to the facility on [DATE], with diagnoses that include stroke with one sided paralysis, Parkinson's disease, encephalopathy, epilepsy, and COPD. R13 had a Brief Interview for Mental Status (BIMS) on 07/15/25 indicating severe cognitive impairment. Minimum Data Set (MDS) assessment, dated 07/21/25, indicates R13 has impaired range of motion (ROM) to all extremities. R13 is dependent on staff for all bed mobility, transfers, toileting hygiene, and eating.On 08/18/25 at 12:15 PM, Surveyor observed R13 in reclining high back wheelchair. Fingers curled tight to both hands and right hand was held tight against R13's chest. No brace or cloth was placed in either hand.Between 08/18/25 through 08/20/25, Surveyor made numerous spot observations, and on 08/20/25 made a continuous observation from 7:00 AM to 12:30 PM, and found R13 had no brace applied to right hand, and no staff attempted to apply the brace. R13's care plan with a revision date of 07/22/25 indicates: Resident requires splint/brace assistance to right hand up to 7 days. Nursing will apply gentle passive ROM to right hand then [NAME] Palm Guard splint into right hand in AM and removal at HS, up to 7 days per week. CHART TIME IT TOOK TO DO ROM, APPLY BRACE AND REMOVE BRACE.Surveyor reviewed care instructions in R13's closet. The care instructions made no mention of hand brace application or removal. Surveyor requested proof that R13 received right hand splint. Staff provided print out for August 2025. 10 of the last 19 days, entries note that it is unanswered or not performed.On 08/20/25 at 8:43 AM, Surveyor interviewed Certified Nursing Assistant DD who was assigned to R13 on that day. Surveyor asked how they are informed of resident's restorative needs. CNA DD replied that it is in the care plan, and the nurses let them know. Surveyor asked to demonstrate where it is documented when completed. CNA DD demonstrated on facility computer: noted under care assessment, under restorative, shows ROM for nurses to complete. Surveyor asked CNA DD to show how CNA DD signs it out, and CNA DD said they cannot because the nurses are to complete it. On 08/20/2025 at 9:32 AM, Surveyor interviewed Licensed Practical Nurse (LPN) EE who reported there is no resident on my unit that the nurses complete ROM for. The CNAs assigned to each resident are responsible to ensure the restorative is completed. Surveyor asked if there is supposed to be a hand splint on R13. LPN EE showed Surveyor a therapy order written on 06/30/22 and verified R13 is supposed to have a right-hand splint on. On 08/20/2025 at 9:32 AM, Surveyor interviewed CNA FF and CNA GG who reported CNAs or nurses can do ROM. R13 should have something in her hands all the time because her hands are so tight, and fingers dig in. R13 has a right-hand splint that goes on during the day and off at night. Sometimes this gets missed because we switch units a lot. We know who needs restorative because it pops up in blue in the computer if something is undone.On 08/20/2025 at 12:33 PM, Surveyor interviewed Director of Nursing (DON) B and Nurse Manager (NM) G was present. Surveyor explained R13's care plan identifies R13 is to receive a splint on right hand on during the day and off at night. None was noted during multiple periodic and continuous checks. Surveyor showed R13's splint sign out sheet for the month of August 2025, R13 did not receive right hand splint for 10 of the last 19 days. DON B asked NM G if they were aware the staff was not completing this. NM G stated they were not aware and would address the issue.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure residents (R) with indwelling Foley catheters received care and treatment consistent with professional standards of practice to prevent complications or urinary tract infections from the catheter, for 1 of 3 residents (R), (R2) reviewed with a Foley catheter.This is evidenced by:Facility policy titled Urinary Catheters revised date 08/06/25, read in part.General Care. Follow enhanced barrier precautions, perform handy hygiene before and after.Emptying of Bag.Disinfect the drainage port with an alcohol-based wipe after each use.R2 was admitted to the facility on [DATE]. R2's current diagnoses include cystitis, bladder-neck obstruction, disease of intestine, and reduced mobility. Minimum Data Set (MDS) dated [DATE] a significant change assessment documented R2's Brief Interview of Mental Status (BIMS) score of 6/15 meaning severe cognitive impairment. R2 is dependent on staff for toilet hygiene and has a urinary catheter.R2 had a hospital admission on [DATE] with diagnoses of urinary tract infection (UTI) and septic shock. On 08/15/25, R2 was seen by urology and was placed on an antibiotic for UTI. On 08/20/2025 at 8:16 AM, Surveyor observed Certified Nursing Assistant (CNA) Z provide R2's morning cares. CNA Z sanitized hands, applied gown and gloves, and entered room. CNA Z gathered basin water, washcloth and soap. CNA Z picked up the fall mat from the floor to move the mat to the side. CNA Z removed pillows between R2's legs and under left arm. CNA Z completed R2's upper body cares. With the same gloves, CNA Z washed R2's groin and penis. CNA did not complete cleaning of the urinary catheter tubing. CNA Z rolled R2 to the right side and washed buttocks. CNA Z called for a nurse to look at buttock wound and to apply cream. CNA Z did not remove gloves and sanitize hands after peri care. CNA Z applied R2's sock and went to the bathroom to get a urinal and alcohol wipes. CNA Z place the urinal directly on the floor. With the same contaminated gloves, CNA Z removed the catheter port from catheter bag, wiped the port with an alcohol wipe and emptied the urine into the urinal. With the same alcohol wipe, CNA Z cleaned the catheter port and placed the port back into the catheter bag holder. CNA Z measured urine to be 475 cc yellow urine and emptied the urine into toilet and rinsed urinal. CNA Z removed gloves and washed hands. CNA Z rinsed hands, turned the faucet off with clean hands and then sanitized hands. On 08/20/25 at 9:10 AM, Surveyor interviewed CNA Z about hand hygiene after providing peri care. CNA Z stated should have removed gloves and sanitized hands after peri care. Surveyor asked CNA Z if a barrier should have been placed under the urinal when placed on floor and emptying the catheter bag. CNA Z stated a barrier should have been placed under the urinal on the floor. Surveyor asked when cleaning the catheter port with an alcohol wipe is it appropriate to use the same alcohol wipe to clean the port after emptying. CNA Z stated had not been trained to use another wipe to clean the port and it is okay to use the same alcohol wipe. On 08/21/25 at 11:40 AM, Surveyor interviewed Director of Nursing (DON) B and Manager of Nursing (MN) Y about catheter care and hand hygiene practices during cares. DON B stated expectation of hand hygiene after peri care, use of barrier, and a clean alcohol wipe to be used after emptying catheter bag.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure standards of practice were followed for verification of gastrostomy placement before medication administration for 1 of 3 residents (R) reviewed for tube feeding. (R105) Registered Nurse (RN) E did not check placement of the G-tube (A G-tube is a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) according to professional standards of practice prior to administering medications. Findings include:Surveyor reviewed the facility protocol titled Enteral Feeding, last reviewed on 10/15/21, which states in part, .2.2. Assessment- Checking Feeding Tube Placement: Feeding tubes require initial and ongoing verification to minimize complications. -The position of a gastric feeding tube must be checked:-Prior to each feed.-Before each medication administration.-Before putting anything doe the tube. Gastrostomy Tube (GT)-Correct placement of the feeding tube should be confirmed by:-Checking insertion site at the abdominal wall/-Observing the patient for abdominal pain or discomfort.-Obtaining a gastric aspirate. Checking placement:-Obtain equipment: 60 ml catheter tip, changed every 24 hours, and gloves.-Put tip of the 60 ml syringe into your feeding tube with the plunger in the down position.-Gently pull back on the plunger. You should see stomach fluid(residual) go into your syringe. Gastric aspirate is clear, off white, or grassy green.-Re-instill aspirate. R105 was admitted to the facility on [DATE] with diagnoses in part, acute respiratory failure with hypoxia, multiple sclerosis, quadriplegia, interstitial emphysema, encounter for attention to gastrostomy, retention of urine, dependence on respirator [ventilator] status, dysphagia, pneumothorax bilateral, constipation, unspecified, and contracture, unspecified joint of the hand and lower leg. R105's minimum data set (MDS) assessment confirmed R105 is totally dependent on staff for all cares.Surveyor reviewed R105's care plan, which states in part, *Nutritional Status care plan last reviewed on 06/12/25:-Has noted allergy to nuts- do not provide nut or foods that may contain.-Monitor tube feeding tolerance and adjust as needed.-Monitor weight trends, discuss nutritional approaches with IDT and resident/guardian as needed.-Weight as ordered, monitor labs as needed, report significant weight changes to RD and MD, provide tube feeding and water flushes as ordered.Surveyor reviewed physician orders:-On 06/18/25, Peg tube feeding formula Jevity 1.2 at 45mls/hr continuous every 4 hours.-On 03/22/23, Peg tube feeding residual gastric contents every 4 hours then re-instill.-On 11/19/24, NPO.-On 07/23/25, Metoclopramide hcl 10mg give 10mg three times a day through gastric tube for gastric motility.-On 07/30/25. Simethicone liquid 125mg via gastric tube three times a day for gas and bloating.Interviews/ObservationsOn 08/19/25 at 2:15 PM, Surveyor observed RN E enter R105's room with 4 different liquid medicine cups. Surveyor asked RN E what RN E was doing. RN E reported to Surveyor that RN E needs to administer these medications to R105 via gastric tube. RN E took 60ml syringe of water and pushed through R105's G-tube. Surveyor observed R105 grimace and squint eyes. RN E administered medications and then flushed again with another 60ml syringe of water. RN E exited R105's room. Surveyor did not observe RN E check for tube placement or gastric residuals per facility policy.On 08/19/25 at 3:02 PM, Surveyor interviewed RN E and asked what RN E's process is prior to administering medications through G-Tube. RN E reported to Surveyor that RN E flushed G-Tube with 60 ml of water first, then administered medications and then flushed again with 60ml when all done. Surveyor asked RN E if RN E knows that the facility policy states, To verify tube placement with G-Tube, the G-Tube must be checked prior to each feed, and before each medication. RN E reported to Surveyor that RN E did not realize verifying placement was a must before administering medications. RN E apologized to Surveyor that RN E did not perform this task.On 08/19/25 at 3:22 PM, Surveyor interviewed Nurse Manager G and asked Nurse Manager G's expectation for Tube Feeding (TF) procedure and if expectation is for nursing staff to check residuals (continued on next page)

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	525132	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Central Health Care	2400 Marshall Street, Ste A Wausau, WI 54403

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	before administering medications or providing feedings. Nurse Manager G reported to Surveyor that all nurses are trained in verifying placement of G-tube by aspirating gastric contents and checking residuals before administering medications or jevity. Nurse Manager G reported that RN E should have checked resident's residuals before administering medications. Surveyor requested the TF policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility did not provide sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 24 residents (R1) reviewed. The facility did not ensure Registered Nurse (RN) E completed training before working on the ventilator unit where R1 resides.R1 was admitted on [DATE] and then readmitted on [DATE], with diagnoses in part: acute and chronic respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, pneumonia, cerebral vascular accident with advance brain injury, Alzheimer's disease unspecified, chronic obstructive pulmonary disorder, hypertensive heart disease with heart failure, chronic diastolic (congestive) heart failure, and persistent vegetative state. R1's respiratory care plan, dated 06/24/25, states,- Maintain patent airway, and adequate ventilation.- Maintain good pulmonary hygiene, keep O2 sats >90%.- Monitor respiratory status with assessments, ventilator management, with use of pulse oximetry, bronchodilator therapy and oxygen therapy as needed.- Suctioning as needed, daily and prn trach care, scheduled and prn trach tube changes.Interviews and Observations On 08/19/25 at 1:15 PM, Surveyor observed Certified Nurse Assistant (CNA) D enter R1's room. R1 was sleeping soundly on ventilator. Surveyor observed tan colored secretions running down R1's edge of mouth and chin. CNA D wiped R1's mouth and continued cares on R1. When CNA D completed cares, CNA D exited R1's room and walked down the hall to next resident.Surveyor never observed CNA D report the secretions coming down R1's mouth unto chin. On 08/19/25 at 1:51 PM, Surveyor interviewed CNA D and asked what CNA D's process is when CNA D sees extra secretions coming out of R1's mouth down chin. CNA D reported to Surveyor that CNAs are trained to suction with visual secretions around lips and outside of mouth. CNA D reported to Surveyor that CNA D didn't feel R1 needed suctioning so just wiped secretions out of R1's mouth. Surveyor asked CNA D does CNA D report the secretions to a nurse at all. CNA D reported that CNA D should have reported this to the nurse on duty but didn't think much of the secretions coming out of R1's mouth. On 08/19/25 at 2:01 PM, Surveyor interviewed RN E and asked if R1 had secretions dripping down face, and CNA D observed this, what would RN E's expectation be. RN E reported to Surveyor that RN E would want CNA D to report this to RN E. Surveyor asked if RN E would then go suction R1's secretions out. RN E reported to Surveyor that RN E would not suction as RN E does not feel comfortable with suctioning. RN E would then call Respiratory Therapist (RT) to come suction. Surveyor asked RN E did RN E receive any training on ventilator and suctioning. RN E reported that RN E did not receive training on this unit and so RN E would not be suctioning R1 if need be. On 08/20/25 at 2:18 PM, Surveyor interviewed Respiratory Therapist (RT) F and asked RT F who trains staff on ventilator unit for ventilator usage and suctioning. Surveyor asked RT F how often the staff is trained. RT F reported to Surveyor that RT F trains all new staff upon hire and annually on ventilator and trach cares. Surveyor asked RT F is its common practice for an RN such as RN E to not be comfortable suctioning a resident on trach and ventilator and to not have the training completed prior to working on the ventilator unit. RT F reported that all nurses are to be trained before they work on the ventilator unit. Surveyor asked RT F if RN E has received ventilator and suctioning training. RT F reported to Surveyor that RT F cannot recall if RN E has received training or not. On 08/20/25 at 2:21 PM, Surveyor interviewed Nurse Manager G and asked how often staff are trained on the vent unit for ventilator and suctioning. Nurse Manager G reported to Surveyor that staff are trained upon hire and annually. Surveyor asked for RN E's training on the ventilator unit. Nurse Manager G reported to Surveyor that Nurse Manger G will gather RN E's training.On 08/20/25 at 3:01 PM, Surveyor received RN E's training from Nurse Manager G. Nurse Manager G reported to Surveyor that RN E did not complete the ventilator and suctioning training (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	before working on the ventilator unit. Nurse Manager G reported the training should have been completed before RN E worked the ventilator unit for her first shift.