

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525212	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Wisconsin Rapids Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 River Run Dr Wisconsin Rapids, WI 54494	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45943</p> <p>Based on observation, staff and resident interview, and record review, the facility did not ensure 3 residents (R) (R2, R7 and R9) of 12 sampled residents received necessary and timely assistance with activities of daily living (ADLs).</p> <p>R2 was dependent on staff for bathing. R2 did not receive a shower as scheduled.</p> <p>R7 had an order for weekly diabetic nail care. The facility did not provide consistent nail care and/or revise R7's order to provide nail care more frequently.</p> <p>During an observation on 6/27/24, staff did not respond to R9's call light and request to get out of bed in a timely manner.</p> <p>Findings include:</p> <p>The facility's Nail Care Policy, reviewed/revise on 4/20/23, indicates: . 1. Monitoring of resident nails will be conducted on admission and readmission to determine the resident's nail condition, needs, and preferences for nail care, if possible. 2. Identify conditions that increase the risk for foot or nail problems, such as diabetes .3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule. Nail care will be provided between scheduled occasions as the need arises.</p> <p>The facility's Call lights: Accessibility and Timely Response policy, reviewed/revise on 7/26/22, indicates: . 10. All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified .f. If assistance is needed with a procedure, summon help by using the call light. Stay with the resident until help arrives.</p> <p>1. On 6/27/24, Surveyor reviewed R2's medical record. R2 had diagnoses including congestive heart failure (CHF), chronic obstructive pulmonary disorder (COPD), lymphedema, and chronic venous hypertension with ulcer to left lower extremity. R2's Minimum Data Set (MDS) assessment, dated 4/21/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R2 had intact cognition. R2 required a Hoyer lift for transfers and the assistance of 2 staff.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/27/24 at 10:09 AM, Surveyor interviewed R2 who stated R2 was supposed to receive a shower every Tuesday.</p> <p>Surveyor reviewed documentation which indicated R2 was scheduled to receive a shower on the Tuesday PM shift. Surveyor noted R2 received showers on 5/31/24, 6/11/24, and 6/25/24. From 5/31/24 to 6/11/24, R1 did not receive a shower for 11 days. From 6/11/24 to 6/25/24, R1 did not receive a shower for 14 days. R1 should have received showers on 6/4/24 and 6/18/24.</p> <p>On 5/27/24 at 3:58 PM, Surveyor interviewed Director of Nursing (DON)-B via phone who verified blanks on the documentation report indicated a shower wasn't provided for R1. DON-B stated residents should receive a weekly shower or bath.</p> <p>30571</p> <p>2. On 6/27/24, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes mellitus with diabetic neuropathy, long term use of insulin, and long term use of oral hypoglycemic drugs. R7's Quarterly MDS assessment, dated 4/16/24, had a BIMS score of 9 out of 15 which indicated R7 had moderately impaired cognition.</p> <p>R7's self-care performance deficit care plan, initiated on 1/10/24, indicated R7 required the assistance of 1 staff for personal hygiene. R7's care plan did not contain an intervention for nail care.</p> <p>R7 had an order for diabetic nail care weekly by nurse one time a day every Saturday for diabetes mellitus, dated 1/13/24.</p> <p>On 6/27/24, Surveyor interviewed R7 in R7's room. Surveyor noted R7's nails were long, extended beyond R7's fingertips, and did not appear to have been recently cut.</p> <p>On 6/27/24 at 2:45 PM, Surveyor interviewed Registered Nurse (RN)-G who was was unsure how to determine when R7's nails were last cut. When asked if nail care was documented in a resident's medical record, RN-G stated RN-G had not documented nail care, but nail care might be documented on a resident's Treatment Administration Record (TAR). Surveyor reviewed R7's June 2024 TAR which indicated R7 received nail care on 6/1/24, 6/15/24 and 6/22/24 (which was 5 days prior). During the interview with RN-G, R7 returned from an off-site appointment. When Surveyor showed RN-G R7's nails, RN-G confirmed R7's nails needed to be cut and stated RN-G would cut them.</p> <p>3. On 6/27/24, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] following a hospital stay and had diagnoses including malignant neoplasm of rectum, bacterial intestinal infections, and unspecified atrial fibrillation. An MDS assessment had not yet been completed.</p> <p>On 6/27/24 at 11:03 AM, Surveyor noted R9's call light was activated.</p> <p>On 6/27/24 at 11:09 AM, Surveyor noted R9's call light was still activated. Surveyor interviewed R9 who stated R9 was admitted to the facility the day prior and said R9's call light had been on for approximately 10 minutes. R9 stated R9 wanted to get out of bed, but knew staff were busy.</p> <p>On 6/27/24 at 11:22, Surveyor observed staff enter R9's room and state, I'll get the nurse. We're going to transfer you.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/27/24 at 11:27 AM, Surveyor noted R9's call light was still activated. Surveyor again interviewed R9 who stated the staff who answered R9's call light earlier wasn't sure how to transfer R9 and had to check.</p> <p>On 6/27/24 at 11:29 AM, staff entered R9's room and closed the door. At 11:32 AM, Certified Nursing Assistant (CNA)-I entered R9's room with a gait belt.</p> <p>On 6/27/24 at 11:37 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-I. When Surveyor asked about the call light response time for R9, CNA-I said prior to responding to R9's call light CNA-I provided care for another resident which took a long time and stated, I can only do so much. CNA-I stated CNA-I didn't want to get R9 up before determining if R9 was evaluated by therapy.</p> <p>On 6/27/24 at 2:30 PM, Surveyor interviewed Regional Consultant (RC)-L who indicated the facility's policy doesn't contain an appropriate call light response time but stated a response time of 26 minutes was excessive.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342</p> <p>Based on observation, staff and resident interview, and record review, the facility did not ensure necessary care and services were provided to promote healing and/or prevent pressure injuries from worsening/developing for 2 residents (R) (R1 and R7) of 3 sampled residents.</p> <p>During an observation on 6/27/24, Registered Nurse (RN)-F did not perform appropriate hand hygiene during wound care for R1 and Surveyor noted care planned pressure relieving measures were not in place. In addition, R1's medical record did not contain appropriate wound assessment documentation and timely response to newly opened areas.</p> <p>R7 had a history of a pressure injury on the left heel. R7's care plan contained an intervention to float/elevate R7's heels. The intervention was not consistently implemented.</p> <p>Findings include:</p> <p>The facility's Pressure Injuries and Non Pressure Injuries policy, with a review date of 7/20/22 indicates: This center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently develop a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity .Manage friction and Shear .Protect elbows and heels as appropriate .</p> <p>The facility's Hand Hygiene policy, with a review date of 11/2/22, indicates: All staff will perform proper hand hygiene procedures to prevent the spread of infection. A Hand Hygiene Table attached to the policy indicated staff should perform hand hygiene in the following situations: After handling contaminated objects; Before applying and after removing personal protective equipment (PPE), including gloves; Before and after handling clean or soiled dressings; After handling items potentially contaminated with blood, body fluids, secretions or excretions; and When moving from a contaminated body site to a clean body site during resident care.</p> <p>On 6/27/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including left pubis fracture, protein-calorie malnutrition, and diabetes mellitus. R1's Minimum Data Set (MDS) assessment, dated 6/5/24, stated R1's Brief Interview for Mental Status (BIMS) score was 14 out of 15 which indicated R1 had little to no cognitive impairment. R1's MDS further indicated R1 was at risk for pressure injuries (PIs) and had three stage 3 PIs (full-thickness loss of skin, in which fat tissue is visible) and two stage 4 PIs (skin loss damage to the muscle and bone, and sometimes to tendons and joints) which were not present upon admission. In addition, R1's MDS indicated R1 required substantial/maximum assistance for mobility including rolling from left to right. R1's medical record indicated R1's court-appointed guardian was responsible for R1's healthcare decisions.</p> <p>R1's medical record contained an Admission Evaluation, dated 4/11/24, that indicated upon admission R1 had a laceration on R1's scalp, a blister on R1's buttocks, and red, spongy heels, and stated, .Buttocks has blisters, some intact and some not. Blanchable redness noted.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's care plan included the following:</p> <ul style="list-style-type: none"> ~ At risk for infection related to wounds .Enhanced barrier precautions when performing high-contact care activities. ~ R1 has potential/actual impairment to skin integrity .Skin-Float/elevate heels .Heel lift boots. <p>R1's nursing notes contained the following:</p> <ul style="list-style-type: none"> ~ A note, dated 4/17/24, indicated: Blisters not intact. Open wound weeping slight tannish white sanguinous (bloody) fluid. No odor noted. On-call notified. Updated care plan. EBP (enhanced barrier precautions). ~ A note, dated 4/24/24, indicated: Wound is open and draining light brown serous fluid. Maceration along some of wound edging. Malodorous. Notified NP (Nurse Practitioner). Requesting wound MD (Medical Doctor) referral. ~ A note, dated 4/26/24, indicated: Wound MD did initial wound care assessment. ~ A note, dated 4/29/24, indicated: R1 is on follow-up for doxycycline (used to treat infection) 100 mg (milligrams) twice daily for 10 days for wound infection. R1 has a DTI (deep tissue injury) on R1's buttocks. R1 stated with prolonged sitting, it becomes sore. Area is purple in color. ~ A note, dated 5/9/24, indicated: Late Entry. R1 has red hard area on left trochanter (outer hip) approximately 6.5 (length) by 3.5 cm (centimeters) (width). Notified oncoming nurse. Placed on 24 hour board for wounds. ~ A note, dated 5/15/24, indicated: Asking for an air mattress for R1 because R1 is starting to get a red spot on R1's left hip. ~ A note, dated 5/21/24, indicated: Noticed new wound on R1's left hip. R1 had redness but now has a black area in the center of the area. ~ A note, dated 5/23/24, indicated: R1 is on follow-up for antibiotic Levaquin (used to treat infection) 750 mg daily for 14 days for coccyx wound. <p>R1's medical record indicated R1 received treatments to the right heel, left ankle, and left foot which indicated: Wash with Dakins 0.25 %, place collagen on base of wounds then place petroleum gauze over wounds, foam donut over heel, cover with ABD pad, wrap with Kerlix and secure with tape one time a day for wound care. R1's medical record also indicated R1's left hip and coccyx open areas were treated with a wound vac that was changed on Mondays, Wednesdays and Fridays.</p> <p>A Skin Review assessment, dated 4/18/24, indicated R1's coccyx had an open area with redness. The assessment did not contain measurements or a description of the open area.</p> <p>A wound MD note, dated 4/26/24, indicated R1 had an unstageable DTI on the coccyx that measured 4.2 cm by 4.5 cm with an unmeasurable depth.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/27/24 at 11:05 AM, Surveyor interviewed R1 who stated R1's wounds were painful. When asked how often R1 was repositioned by staff, R1 stated often but was unable to recall when the R1 was last repositioned.</p> <p>On 6/27/24 at 11:14 AM, Surveyor observed RN-F provide wound care to R1's heels. During wound care, Surveyor observed RN-F remove blankets from R1's feet with gloved hands. Surveyor observed gripper socks on R1's feet, but no heel lift boots. Surveyor observed RN-F use scissors to cut open the dressing on R1's right foot and remove dead skin from the edges of R1's right heel that contained a dry scab. With the same gloved hands, RN-F cleansed the area, applied collagen to the scabbed area, and cut petroleum gauze with the soiled scissors. RN-F then applied the gauze, removed the soiled dressing from under R1's right heel, and cut the foam dressing with the scissors. RN-F applied the foam dressing, put an ABD pad over the area, and wrapped R1's right foot with Kerlix. RN-F cut the Kerlix with the scissors, secured the Kerlix with tape, and dated the dressing. With the same gloved hands and soiled scissors, RN-F cut open the dressing on R1's left foot. Surveyor observed a small open area on R1's left lateral foot and a dark spot which appeared to be a DTI on R1's left lateral ankle. With the same gloved hands, RN-F cleansed the area and applied collagen to the open area on R1's lateral foot. With the same soiled scissors, RN-F cut and applied petroleum gauze and cut and applied a foam dressing to R1's lateral foot. RN-F then applied petroleum gauze and a foam dressing to R1's ankle, placed an ABD pad over both areas, and wrapped R1's left foot with Kerlix. RN-F removed the soiled dressing from R1's bed, secured the Kerlix on R1's left foot with tape, and dated the dressing. RN-F put gripper and heel lift boots on R1's feet and verified the heel boots should have been in place by previous staff who cared for R1. With the same gloved hands, RN-F closed R1's door and unfastened R1's brief to check the function of R1's wound vac and the dressings on R1's left hip and buttocks. RN-F then assisted R1 onto R1's right side, verified R1's wound vac dressing was intact and functioning, and placed a pillow between R1's knees. RN-F verified R1's comfort, covered R1 with blankets, and placed R1's call light within reach. RN-F then disposed of used supplies, lowered R1's bed, put clean supplies on R1's desk, and removed RN-F's PPE, including gloves. Without performing hand hygiene, RN-F took clean clothes handed to RN-F by laundry staff, put the clothes in R1's closet, picked up the scissors used during wound care, and put the scissors on a cart in the hallway, and performed hand hygiene prior to sanitizing the scissors.</p> <p>On 6/27/24 at 11:34 AM, Surveyor interviewed RN-F who verified RN-F should have changed gloves and performed hand hygiene between dressing changes and when moving from soiled to clean parts of the dressing change. RN-F also verified RN-F should have immediately performed hand hygiene following glove and PPE removal. RN-F stated there was usually hand sanitizer on R1's desk. RN-F verified R1's heel lift boots should always be in place.</p> <p>On 6/27/24 at 11:44 AM, Surveyor interviewed Director of Nursing (DON)-B via phone. Following a discussion of the above observation, DON-B stated DON-B expected staff to follow wound protocol, including dirty to clean glove changes with hand hygiene every time and between every wound. DON-B verified R1 should always have heel boots in place.</p> <p>On 6/27/24, Surveyor reviewed R1's most recent wound clinic note, dated 6/26/24, which indicated R1 had stage 4 pressure injuries on the coccyx/sacrum and left hip. The coccyx/sacrum area measured 3.2 cm by 2.2 cm by 2.5 cm (depth). The left hip measured 3.2 cm by 2.1 cm by 3.1 cm. Both areas were debrided during the visit and had muscle involvement.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/27/24 at 3:04 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who stated ADON-C tried to figure out with the wound clinic MD why R1's wounds deteriorated so fast. When asked what ADON-C and the wound clinic MD concluded, ADON-C stated the MD believed the cause was pressure-related. ADON-C stated ADON-C wished staff had better documentation to provide a clearer picture of what happened between when R1's blisters opened and the DTI was discovered. ADON-C stated the facility did not start weekly assessments of R1's PIs until R1 saw the wound MD on 4/26/24. ADON-C verified the facility should have conducted a more thorough assessment on 4/17/24 when the open areas were discovered so the wound MD could have been consulted sooner.</p> <p>30571</p> <p>2. On 6/27/24, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including non-pressure chronic ulcer of left heel and mid-foot, type 2 diabetes mellitus, and muscle weakness. R7's Quarterly MDS assessment, dated 4/16/24, stated R7 had a BIMS score of 9 out of 15 which indicated R7 had moderately impaired cognition. The MDS assessment also indicated R7 required partial to moderate assistance for rolling side to side, had an unhealed stage 4 PI, and had pressure reducing devices for bed and chair.</p> <p>R7's limited physical mobility care plan, initiated on 1/10/24, contained an intervention for the assistance of two staff with bed mobility.</p> <p>R7's history of impairment to skin integrity to left heel (present on admission), initiated on 1/10/24, contained interventions to float/elevate heels and use heel lift boots (both initiated on 1/10/24).</p> <p>R7's medical record indicated the following:</p> <ul style="list-style-type: none"> ~ R7 had a stage 3 full-thickness pressure injury on the left heel on 4/13/24. ~ A note on 4/22/24 indicated staff used pillows to float R7's heels per R7's request. ~ R7 completed a course of antibiotics for the left heel PI on 4/30/24. ~ A wound assessment, dated 5/17/24, indicated R7's behavior complicated R7's wound healing. ~ R7 had the following wound recommendations: float heels in bed, pressure off-loading boots, dated 5/17/24. ~ R7 had an order for skin prep to left heel once daily for prevention, dated 5/23/24. ~ A weekly tracker, dated 5/24/24, indicated R7's left heel PI was healed. ~ An orders/admin note, dated 6/8/24, indicated R7 had an order for heel poseys or booties and to float heels every shift for wound health. <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/27/24 at 12:11 PM, Surveyor observed R7 in bed and noted R7 had a pillow under R7's left leg that was vertical to the leg. Surveyor noted R7 was not wearing heel boots(ies) or poseys, R7's heels were in direct contact with the mattress, and R7's feet were against the footboard of the bed. When asked if R7 wore heel boots, R7 stated, I told them to get rid of the boots. R7 stated when the physician asked R7 why R7 wouldn't wear the boots, R7 stated the boots had a strap that scraped R7's skin. During the interview, Certified Nursing Assistant (CNA)-H entered the room to help R7 get ready for an off-site appointment. CNA-H verified R7's heels were in contact with the mattress, R7's feet were in contact with the footboard, and R7 was not wearing heel boots(ies) or poseys.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563</p> <p>Based on staff interview and record, the facility did not ensure 2 residents (R) (R3 and R5) of 3 sampled residents received the necessary care and treatment for respiratory therapy.</p> <p>The facility provided R3 with respiratory therapy via continuous positive airway pressure (CPAP) without a physician's order. In addition, R3 was ordered to have bilevel positive airway pressure (BiPAP), but the facility did not obtain the appropriate equipment.</p> <p>R5 had a physician's order for CPAP therapy. R5 did not have a care plan that addressed R5's need for and use of CPAP therapy.</p> <p>Findings include:</p> <p>The facility's CPAP Therapy policy, dated 6/24/22, indicates: Continuous Positive Airway Pressure is used to treat obstructive sleep apnea . Policy Explanation and Compliance Guidelines: 1) Verify physician orders .</p> <p>1. On 6/27/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypoxia, and obstructive sleep apnea. R3's Minimum Data Set (MDS) assessment, dated 4/26/24, stated R3's Brief Interview for Mental Status (BIMS) score was 15 out of 15 which indicated R3 had intact cognition.</p> <p>R3's medical record contained the following physician's order:</p> <p>~ 4/21/24: May use BiPAP 20/10 settings. Can use oxygen 2 liters in interim at bedtime (until BiPAP is here). Two times a day. Check oxygen saturation level while on oxygen.</p> <p>R3's physician orders did not include an order for CPAP therapy. R3's care plan did not indicate R3 needed or used CPAP therapy.</p> <p>On 6/27/24 at 12:43 PM, Surveyor interviewed Director of Nursing (DON)-B via phone who verified the facility accepted residents with orders for BiPAP therapy. DON-B stated the facility could obtain BiPAP equipment from Respiratory Therapy Company (RTC)-K.</p> <p>On 6/27/24 at 12:43 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who verified R3 received CPAP therapy but did not have a physician's order for CPAP therapy. ADON-C verified R3's care plan should contain reference to R3's need for and use of CPAP therapy.</p> <p>On 6/27/24 at 2:59 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified a physician's order should be obtained and a care plan should be implemented prior to treating a resident with CPAP therapy.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Wisconsin Rapids Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 River Run Dr Wisconsin Rapids, WI 54494	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/27/24 at 3:10 PM, Surveyor interviewed Respiratory Therapy Company Staff (RTCS)-M via phone. RTC-M stated RTC-K did not have record that the facility contacted RTC-K to obtain BiPAP equipment for R3.</p> <p>2. On 6/27/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including obstructive sleep apnea. R5's MDS assessment, dated 5/31/24, stated R5's BIMS score was 14 out of 15 which indicated R5 had intact cognition. R5's medical record indicated R5 was responsible for R5's healthcare decisions.</p> <p>R5's medical record contained a physician's order for CPAP therapy. R5 did not have a care plan that addressed R5's need for or use of CPAP therapy.</p> <p>On 6/27/24 at 12:43 PM, Surveyor interviewed ADON-C who verified a resident with a CPAP order should have a care plan to address the use of CPAP therapy.</p> <p>On 6/27/24 at 2:59 PM, Surveyor interviewed NHA-A who verified a resident with an order for CPAP therapy should have a care plan that addresses CPAP therapy.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45943</p> <p>Based on observation, staff interview, and record review, the facility did not ensure food was stored in a sanitary manner and labeled/dated appropriately. This practice had the potential to affect multiple residents residing in the facility.</p> <p>Staff did not date items with open or expiration dates and did not ensure food was stored in a sanitary manner.</p> <p>Staff did not ensure supplement shakes were dated when removed from the freezer and thawed.</p> <p>Findings include:</p> <p>Undated and Unlabeled Items/Sanitary Storage:</p> <p>The Food and Drug Administration (FDA) Food Code 2022 documents at ,d+[DATE].18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition (A): A food specified in ,d+[DATE].17 (A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in ,d+[DATE].17 (A) except time that the product is frozen; (2) Is in a container or package that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in , d+[DATE].17(A).</p> <p>During a tour of the facility's kitchenettes that began on [DATE] at 1:02 PM, Surveyor and Dietary Aide (DA)-E observed the following undated and/or expired food in the refrigerator/freezers:</p> <p>Cedar Ridge Kitchenette:</p> <ul style="list-style-type: none"> ~ An unlabeled and undated container of fruit punch <p>Bear Creek Kitchenette:</p> <ul style="list-style-type: none"> ~ Two protein drinks with expiration dates of [DATE] ~ One container of lemonade, 1 container of cranberry juice, 2 containers of white milk, and 1 container of chocolate milk that were not dated with preparation or open dates ~ Three containers of orange sherbet with use by dates of [DATE] <p>Deer Trails Kitchenette:</p> <ul style="list-style-type: none"> ~ A container of dill dip with an expiration date [DATE] ~ A container of cranberry almond chicken salad with an expiration date of [DATE] ~ An unlabeled and undated container of what appeared to be cranberry drink <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>~ A unlabeled and undated pitcher of tan liquid with a sediment ring on the inside of the pitcher</p> <p>~ An unlabeled container of 3 rotten cucumbers</p> <p>On [DATE] at 1:20 PM, Surveyor interviewed DA-E who stated the refrigerator on the Deer Trails unit was disorganized and needed to be cleaned. DA-E stated kitchen staff were responsible for dating items and cleaning the refrigerator. DA-E stated DA-E was not sure who the miscellaneous food items belonged to. DA-E verified and discarded the above listed items.</p> <p>On [DATE] at 1:28 PM, Surveyor interviewed Dietary Director (DD)-D who stated dietary aides are responsible for cleaning unit refrigerators, however, DD-D cleaned the refrigerators last week. DD-D verified beverage pitchers should be labeled and dated when they are filled and should be used within 7 days. DD-D stated unit refrigerators may be used for resident food and the items should be labeled, dated, and kept for 7 days. DD-D stated kitchen staff participated in meetings regarding food labeling and indicated kitchen staff only keep juice in unit refrigerators.</p> <p>2. On [DATE] at 9:04 AM, Surveyor observed Licensed Practical Nurse (LPN)-J in the hallway on the Cedar Ridge unit with a medication cart. Surveyor observed 2 thawed and undated 4 ounce Sysco Imperial vanilla shakes on the top of the cart. Instructions on the shake cartons indicated to store the shakes frozen, thaw under refrigeration, and use within 14 days of thawing.</p> <p>LPN-J verified the shakes weren't dated when removed from the freezer and stated the shakes were delivered to the unit on [DATE].</p> <p>On [DATE] at 1:28 PM, Surveyor interviewed Dietary Director (DD)-D who stated supplements are kept frozen until needed, dated 10 days from when they are removed from the freezer, and delivered to the units by dietary staff unless nurses pull the shakes from the cooler and don't date them. DD-D stated supplements can be frozen for ,d+[DATE] months before use.</p>		