

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 03/13/2025
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342</p> <p>Based on staff interview and record review, the facility did not make a prompt effort to investigate and resolve a grievance for 1 resident (R) (R1) of 5 sampled residents.</p> <p>A grievance was emailed to the facility on [DATE] that indicated certain medications were not administered to R1 during R1's respite stay. The grievance was not investigated and a resolution was not provided.</p> <p>Findings include:</p> <p>The facility's Grievance Policy, revised 7/2022, indicates: The facility will seek to resolve concerns, complaints, or grievances and provide residents, responsible parties, staff, and others feedback and resolution in a timely manner .</p> <p>On 3/13/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] for a Hospice respite stay and had diagnoses including congestive heart failure, end-stage renal disease, hypothyroidism, and anxiety disorder. R1's Minimum Data Set (MDS) assessment, dated 11/27/24, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R1 had moderate cognitive impairment. R1 was responsible for R1's healthcare decisions and was discharged from the facility on 11/27/24.</p> <p>R1's medical record indicated R1 was administered (as ordered by the physician) levothyroxine (used to treat hypothyroidism) 75 micrograms (mcg) daily, furosemide (a diuretic medication used to treat fluid retention) 40 milligrams (mg) daily, and spironolactone (a diuretic medication used to treat fluid retention) 50 mg daily in addition to other medications during R1's respite stay. R1's medication administration record (MAR) did not indicate any doses were refused or not administered. The MAR indicated Licensed Practical Nurse (LPN)-C, Registered Nurse (RN)-D, and LPN-E were among the nurses who administered medication to R1.</p> <p>On 3/13/25 at 10:03 AM, Surveyor interviewed LPN-C who indicated LPN-C did not recall R1. LPN-C indicated residents on respite stays are usually administered medication provided by the facility's pharmacy, however, sometimes families bring medication.</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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/13/25 at 10:14 AM, Surveyor interviewed RN-D via phone. RN-D recalled R1 and indicated RN-D administered levothyroxine to R1 in the early morning hours when levothyroxine was scheduled to be given. RN-D indicated R1 asked what the medication was for. RN-D indicated the pharmacy delivered medication daily between 10:00 PM and 11:00 PM and 4:30 AM and 6:30 AM. RN-D did not recall concerns with R1's medication supply. RN-D indicated residents on respite stays are usually administered medication provided by the pharmacy. RN-D indicated if medications are brought from a resident's home, the medications might be administered until the pharmacy supply arrives. RN-D also indicated nurses can pull medication from contingency.</p> <p>On 3/13/25 at 10:22 AM, Surveyor interviewed LPN-E via phone. LPN-E indicated R1's name sounded familiar. LPN-E indicated residents on respite stays are usually administered medication provided by the pharmacy. LPN-E indicated if medications are available over-the-counter, nurses can use the facility's stock supply. LPN-E indicated if a resident is prescribed an unusual medication, the resident's family needs to bring in the medication. LPN-E indicated medication can be obtained from contingency if the pharmacy delivery has not yet arrived. LPN-E indicated a family member was upset about a resident not receiving certain medications, however, LPN-E was not sure if the situation involved R1.</p> <p>On 3/13/25 at 11:39 AM, Surveyor interviewed Social Worker (SW)-F who indicated the pharmacy provides medication for respite stay residents.</p> <p>On 3/13/25 at 12:17 PM, Surveyor interviewed Director of Nursing (DON)-B who provided Surveyor with a delivery manifest and invoice from the pharmacy that included information on medications delivered/billed to the facility for R1's respite stay. The documents listed furosemide and levothyroxine and a medication used to treat breathing conditions via a nebulizer. DON-B indicated as far as DON-B could tell, R1's other medications did not come from the pharmacy. DON-B indicated DON-B was not in the facility during R1's respite stay.</p> <p>On 3/13/25, Surveyor reviewed a delivery manifest and invoice from the pharmacy that indicated the facility was charged for fourteen tablets of furosemide and levothyroxine related for R1 with a service date of 11/23/24. No other medications for R1 were listed as received from the pharmacy.</p> <p>On 3/13/25 at 1:18 PM, Surveyor interviewed Hospice Administrator (HA)-G who indicated R1 was admitted to the facility on [DATE] for a Hospice respite stay of five days. HA-G indicated the contract between the Hospice company and the facility allowed for medications to be brought from home for administration at the facility. HA-G indicated Hospice pays the facility an overall rate for care during respite stays which covers any medications administered. HA-G indicated Hospice notes indicated R1's family was upset about the possibility that R1 did not receive certain medications.</p> <p>On 3/13/25, Surveyor reviewed medical records provided by R1's Hospice provider that indicated a family member informed R1's Hospice nurse during a home visit on 11/27/24 that the family member sent six tablets of each of R1's medications with R1 when R1 was admitted to the facility on [DATE]. The family member reported to the Hospice nurse that all six of R1's levothyroxine and furosemide tablets came home with R1 along with three spironolactone tablets. The note indicated the Hospice nurse attempted to call the facility but could only leave a voicemail message for SW-F. The note indicated the Hospice nurse also emailed SW-F on the same date regarding the medication concerns.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/13/25 at 2:10 PM, Surveyor interviewed DON-B who indicated the facility could not find any indication that R1's medications were at the facility. DON-B indicated the facility did not have documentation that R1 brought medication from home or left with medications when R1 discharged home. When asked where R1's administered medications came from, DON-B stated, I don't know.</p> <p>On 3/13/25 at 2:15 PM, Surveyor interviewed SW-F who verified SW-F received an email from R1's Hospice nurse. SW-F indicated SW-F would have followed-up with nursing staff but could not find documentation that that occurred. SW-F verified the facility should have used the grievance process for the emailed concerns.</p> <p>On 3/13/25, Surveyor reviewed the email sent from the Hospice nurse to SW-F on 11/27/24. The email indicated the Hospice nurse attempted to call SW-F but was unable to get through. The Hospice nurse asked for a call back due to medication concerns and indicated R1 returned home from respite care that day. The email indicated a family member sent six tablets plus an extra of each of R1's medications, however, R1 returned home with medication that should have been administered during R1's stay. The email indicated six tablets of one medication were sent home and six tablets of another medication were sent home, however, staff ordered fourteen tablets from the pharmacy.</p> <p>On 3/13/25 at 2:43 PM, Surveyor interviewed SW-F who indicated SW-F contacted Hospice staff via phone to let them know R1's medications came from the pharmacy. When asked how SW-F knew R1's administered medications came from the pharmacy, SW-F indicated nurses told SW-F. SW-F verified a thorough investigation was not completed and the facility's grievance process was not followed.</p>		