STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525212	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wisconsin Rapids Health Services	1350 River Run Dr Wisconsin Rapids, WI 54494

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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** 43361 Based on staff interview and record review the facility did not ensure a physician was notified regarding a change in condition for 1 resident (R) (R1) of 3 sampled residents. R1's medical record indicated R1 refused at least 2 meals per day multiple days in March 2025. The facility did not notify R1's physician of the refusals. Findings include: The facility's Change in Condition of the Resident policy, dated 9/20/22, indicates: When a resident presents with a possible change of condition, after a fall or other possible injury, trauma, or noted changes in mental or physical functioning: 1. Assess the resident's needs for immediate care/medical attention. Provide emergency care as needed .3. Notify resident's physician - use INTERACT Change in Condition. The Interact Version 4.5 tool 2014-2021, Change in Condition: When to report to the Medical Doctor (MD)/Nurse Practitioner (NP)/Physician Assistant (PA) indicates: Symptom or Sign: Appetite, Diminished: No oral intake 2 consecutive meals (immediate notification). Significant decline in food and fluid intake in resident with marginal hydration and nutritional status (non-immediate notification) . On 4/22/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including paraplegia, protein calorie malnutrition, pressure ulcer of sacral region stage 4, pressure ulcer of right heel unstageable, pressure ulcer of left heel unstageable, ileostomy, and monoplegia of upper limb following cerebral infarction affecting the right dominant side. R1's Minimum Data Set (MDS) assessment, dated 2/18/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R1 had moderate cognitive impairment. R1 was hospitalized on [DATE]. R1 was admitted to another facility on Hospice services following discharge from the hospital. R1 had a revised care plan, dated 2/17/25, that indicated R1 was at risk for nutritional status change related to protein-calorie malnutrition, hypertension, hyperlipidemia, tremors, weight loss, pressure areas, depression, poor oral intake, and paraplegia. The care plan contained the following interventions: Eating - Independent. Please cut up foods as needed and set-up (revised 2/17/25); Encourage and assist as needed to consume foods and/or supplements and fluids offered (revised 3/7/24). (continued on next page)

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A note by Advance Practice Nurse Practitioner (APNP)-C, dated 2/7/25, indicated APNP-C saw R1 who was resting in bed. R1 was alert and oriented and denied shortness of breath, chest pain, nausea, vomiting or diarrhea. Nursing staff indicated R1 has not been eating well and had a 13 pound weight loss. APNP-C spoke to R1 about not eating well which R1 confirmed. R1 reported feeling more depressed since R1's spouse does not visit on a daily basis. R1 did not want an increase in any depression medication, however, R1 agreed to try an increase in mirtazapine to help R1's appetite. APNP-C asked the facility's Social Worker to reach out to R1's spouse to see if R1's spouse could visit R1 or do something through telehealth. A discussion was had with the Hospice nurse who indicated R1 did not qualify for Hospice care at that time. A note written by APNP-D, dated 3/3/25, indicated R1 was evaluated that morning. R1's spouse noted increased confusion and requested a capacity evaluation. R1 stated R1's date of birth correctly, but was unable to appropriately answer questions regarding place, time, and situation. APNP-D indicated R1 was not able to make complex medical decisions and agreed with activating R1's Power of Attorney for Healthcare (POAHC). The note indicated an MD would evaluate R1 the following day and indicated R1 complained of depression symptoms A Nutrition/Dietary note, dated 3/19/25, indicated an unstageable deep tissue injury (DTI) on R1's left heel was resolved as 3/19/25. R1 continued with an unstageable DTI on the right heel and had a stage 2 on the right heel. The note indicated to continue with liquid protein 2 times daily (BID) to support wound healing as well as vitamin C and a multi-vitamin injection. R1's meal intake was poor with an average of 0-25%. R1 was offered foods of preference including sandwich's and 2 glasses of chocolate milk with meals. R1 complained of depression symptoms. R1's depression medication was increased and R1 was followed by psych. The note indicated to continue to provide oral intake encouragement. On 3/23/25 at 2:05 PM, a Registered Nurse (RN) messaged the on-call physician via an app the facility uses for physician communication. The note indicated R1 had an acute change in condition and noted R1: refused to drink; had sunken eye sockets; had poor skin turgor; had dry lips; and wouldn't open R1's mouth so the RN could inspect R1's tongue for furrowing. The note indicated the skin along R1's left inner cheek looked like a hanging sheet. R1's mouth was dry and R1 had difficulty or refused to drink from a straw which R1 usually did. R1 was given fluids direct from cup to mouth but only took approximately 5-10 cubic centimeters (cc). The note indicated R1 was very depressed but denied making R1's self intentionally dehydrated. The note asked permission to send R1 to the emergency room (ER) for evaluation and treatment. A change of condition note, dated 3/23/35 at 2:09 PM, indicated nursing staff indicated R1 was unable to draw up fluid through a straw due to dry oral mucosa. R1's lips were chapped and orbital sockets were sunken. R1's eyes were matting shut and R1 had poor skin turgor. R1's Foley catheter output contained medium yellow urine with a brown tint. Charting over last few days indicated R1 had an average output of 700 milliliters (ml) or less. An NP was notified and ordered a stat (emergency) basic metabolic panel (BMP) and complete blood count (CBC) and a bag of normal saline (NS) 75 ml/hour and re-evaluate after administration. The NP also ordered Refresh eye drops as needed (PRN) four times daily (QID). R1's spouse was notified and agreed with the plan of care (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 3/23/25 at 2:43 PM, indicated R1 frequently spilled drinks in bed lately. Nursing staff trialed cups with straws to decrease the likelihood of spilling. On 3/23/25, the writer noted R1 was not drinking and attempted to provide fluids directly, however, R1 cannot drink more than 5-10 cc at a time. R1 was unable to draw up fluid through the straw due to dry oral mucosa. R1's lips were chapped and orbital sockets were sunken. R1's eyes were matting shut and R1 had poor skin turgor. R1's Foley output contained medium yellow urine with a brown tint. Charting over last few days indicated R1 had an average output 700 ml or less. An NP ordered a stat BMP and CBC and a bag of NS 75 ml/hour and to re-evaluate after administration. The NP also ordered Refresh eye drops PRN QID. The NP wanted treatment in the facility at that time, however, an RN was not available until 6:00 PM. The writer contacted the Assistant Director of Nursing (ADON) to see if the concern could be addressed sooner. The NP said it was okay to wait until 6:00 PM if the ADON was unavailable. R1's spouse was notified and agreeable to the plan of care. A progress note, dated 3/23/25 at 6:36 PM, indicated R1 had difficulty swallowing whole pills and requested R1's medication be crushed. The NP agreed to order the appropriate medications crushed as needed. R1 could swallow medication and drink 30 cc of water but stated R1 was unable to drink any more than that A note, dated 3/23/25 at 9:53 PM, indicated R1's lab results were received at 8:20 PM and indicated R1 had a high sodium (NA) level and a low glomerular filtration rate (GFR). R1's physician was notified and sent R1 to the ER. R1's spouse was contacted and agreeable. R1 was transported to the ER via ambulance. When the write attempted to give R1 bedtime (HS) medications, R1 was mostly unresponsive and would not open eyes or mouth when asked. R1 would not open R1's eyes even to painful stimuli. Surveyor reviewed R1's food and fluid intake for March 2025 and noted the following: -On 3/19/25, R1 refused breakfast and lunch and drank 720 ccs of fluid. -On 3/20/25, R1 had refused all meals. R1 refused fluids at 7:30 AM and 11:30 AM. R1 consumed 240 ccs of fluid at 6:00 PM. -On 3/21/25, R1 refused breakfast and lunch. (Of note: R1 refused 5 meals in a row between 3/20/25 and 3/21/25. In addition, there was no fluid intake documented on 3/21/25 (7:30 AM refusal, not applicable (NA) at 11:30 AM, and nothing documented at 6:00 PM.) -On 3/22/25, R1 ate 0-25% for breakfast, refused lunch, and there was no documentation for dinner. R1 consumed 360 ccs of fluid. -On 3/23/25, R1 consumed 480 ccs of fluid at 7:30 AM and 0 ccs at 11:30 AM. R1's change in condition was communicated to an APNP at 2:05 PM on 3/23/25. Surveyor noted that prior to 3/20/25, R1 had 13 other meal refusals including the following dates where R1 also had 2 meal refusals in a row: 3/6/25, 3/10/25, and 3/13/25. R1's medical record did not indicate R1's physician was notified of the meal refusals. Surveyor also noted R1 ate 0-25% of meals provided. With regard to fluids, R1 had only 1 other documented refusal of fluids during the month. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 11:55 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated R1 refused meals regularly. DON-B confirmed R1 had multiple refusals prior to going to the hospital on 3/23/25. DON-B indicated Certified Nursing Assistants (CNAs) should communicate shift to shift and with nurses when they notice things so clinical judgement can then be used based on how the resident presents. On 4/22/25 at 1:08 PM, Surveyor interviewed APNP-D who completed telehealth at the facility on Mondays. APNP-D indicated APNP-D met with R1 for the first time on 3/3/25. APNP-D did an evaluation for capacity because R1's spouse noted increased confusion. APNP-D indicated if a resident refused 5 meals in a row, APNP-D would want to be notified. On 4/22/25 at 1:44 PM, Surveyor interviewed APNP-C via phone. APNP-C indicated APNP-C last saw R1 on 2/7/25 and spoke with R1 about depression and lack of appetite. APNP-C indicated APNP-C is in the building on Fridays to see residents. APNP-C talks with nurses and the DON to see if there are concerns with residents. APNP-C did not recall hearing a concern that R1 refused multiple meals on 3/21/25 (Friday) which was a date that APNP-C would have been at the facility. APNP-C indicated in addition to coming in, APNP-C takes call and covers multiple facilities. APNP-C indicated if APNP-C was notified that R1 refused five meals in a row, APNP-C would have talked with R1 to figure out why. APNP-C indicated APNP-C would order basic lab work to see if R1 was dehydrated or had an infection and might have ordered a speech evaluation pending the findings after talking with R1. If R1's lab work showed dehydration, APNP-C would make a decision based on the severity of the lab work. If intravenous (IV) fluids could be administered in the facility, APNP-C was order IV fluids in the building and re-run lab work or would possibly send R1 to the ER for evaluation if that's what R1's family wanted. APNP-C recalled a conversation with R1 about Hospice services and indicated R1 did not qualify for Hospice services at that time on 2/7/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 2 residents (R) (R3 and R4) of 3 residents observed during the provision of cares. Certified Nursing Assistant (CNA)-G did not complete appropriate hand hygiene during the provision of care for R4. Licensed Practical Nurse (LPN)-E and CNA-F did not wear the appropriate personal protective equipment (PPE) during a transfer for R3 who was on enhanced barrier precautions (EBP). Findings include: The facility's Hand Hygiene policy, dated 11/2/22, indicates: .1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice .The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Hand Hygiene Table: After handling contaminated objects (either soap and water or alcohol-based hand rub (ABHR) is preferred); Before and after handling clean or soiled dressings, linens, etc; After handling items potentially contaminated with blood, body fluids, secretions, or excretions; When, during resident care, moving from a contaminated body site to a clean body site . The facility's Enhanced Barrier Precautions policy, dated 8/8/24, indicates: .a. 4. High-contact resident care activities include: .c: transferring, f. changing briefs or assisting with toileting .8. Additional epidemiologically important multidrug-resistant organisms (MDROs) may include: methicillin-resistant Staphylococcus aureus (MRSA). The facility's Transmission Based Precautions policy, dated 9/24/24, indicates: .10. Contact Precautions: Healthcare personnel caring for residents on contact precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment .F. Contact precautions will be used for residents infected or colonized with MDROs in the following situations: . i. when a resident has wounds, secretions, or excretions that are unable to be covered or contained . 1. On 4/22/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including seizure disorder and malnutrition. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 5:50 AM, Surveyor observed CNA-G provide morning cares for R4. When CNA-G approached R4 to get dressed, CNA-G noted R4 had urinated through R4's clothing and Chux pad. CNA-G completed hand hygiene and donned gloves. CNA-G began removing R4's sheet and Chux pad and also noted R4 had a bowel movement. CNA-G indicated CNA-G did not have wipes or a garbage can nearby. CNA-G walked around the R4's bed and touched R4's bed with soiled gloves. CNA-G then entered R4's bathroom and removed gloves. Without completing hand hygiene, CNA-G donned clean gloves and retrieved wipes. CNA-G then cleansed R4's bottom of stool. With the same soiled gloves, CNA-G fluffed R4's pillow and removed R4's shirt. Throughout the observation, Surveyor observed CNA-G change gloves 4 times without completing hand hygiene between glove changes. Surveyor observed CNA-G wash hands with soap and water once during the care observation and noted CNA-G did not have hand sanitizer available while providing cares. On 4/22/25 at 6:40 AM, Surveyor interviewed CNA-G who acknowledged CNA-G did not complete hand hygiene during glove changes. CNA-G also acknowledged CNA-G touched multiple items in R4's room with soiled gloves. CNA-G also verified there was not hand sanitizer readily available in any of the resident rooms. 2. On 4/22/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including diabetes mellitus, MRSA, and cellulitis. R4's care plan, dated 2/12/25, indicated R4 had venous wounds on the left lower extremity and a MRSA infection/cellulitis in the left lower leg. On 4/22/25 at 5:00 AM, Surveyor observed CNA-G and LPN-E enter R4's room to transfer R4 from bed to toilet with an EZ stand lift. Surveyor observed a sign on R4's door that indicated R4 was on EBP and providers must wear gloves and gowns for the following high-contact resident care activities: Transferring; Changing briefs or assisting with toileting. Surveyor noted a set a drawers to the right of R4's door that contained PPE. A sign on top of the drawers indicated: Contact Precautions: Providers and staff must also: Put on gown before room entry. Discard gown before room exit. Surveyor observed CNA-G and LPN-E don gloves, enter R4's room, and transfer R4 to the toilet. CNA-G and LPN-E remained in R4's room and then transferred R4 from the toilet to R4's wheelchair. When LPN-E exited R4's room, Surveyor interviewed LPN-E and referenced the signage on R4's door. LPN-E indicated LPN-E did not know which sign LPN-E should follow. LPN-E verified LPN-E did not wear a gown during the transfer. CNA-G then exited R4's room. When Surveyor referenced the two signs on R4's door, CNA-G indicated CNA-G thought R4 was on contact precautions. CNA-G acknowledged CNA-G did not wear a gown during the transfer. On 4/22/25 at 11:06 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff should complete hand hygiene when going from dirty to clean and when donning new gloves. Surveyor informed DON-B that hand sanitizer was not accessible for staff in resident rooms. With regard to wearing PPE during a transfer for a resident with EBP and Contact Precautions signs on their door, DON-B indicated staff should have followed the signs and donned a gown for the transfer. DON-B indicated the facility was completing hand hygiene and EBP audits and recognized both of the observations were on the night (NOC) shift, however, the audits were done mostly on the AM and PM shifts.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563 Based on staff and resident representative interview and record review, the facility did not ensure a medical record contained signed COVID-19 vaccination documentation for 1 resident (R) (R2) of 5 sampled residents. R2's medical record did not contain a signed authorization from R2's Power of Attorney for Healthcare (POAHC) for the facility to administer a COVID-19 vaccine. Findings include: The facility's COVID-19 Vaccination policy, dated 9/13/24, indicates: 14. Consent will be signed prior to administration of the COVID-19 vaccine. This information will be retained in the resident's medical record . On 4/22/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD), dysphagia, schizoaffective disorder, and bipolar disorder. On 3/20/25, R2's Minimum Data Set (MDS) assessment, dated 3/20/25, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R2 had moderate cognitive impairment. R2 had an activated POAHC. R2's medical record contained a COVID-19 consent form, dated 2/1/25, that indicated R2's POAHC gave verbal consent for R2 to receive a COVID-19 vaccine. On 4/22/25 at 9:47 AM, Surveyor interviewed Registered Nurse (RN)-H who indicated RN-H called R2' POAHC on 2/1/25 and obtained verbal authorization for R2 to receive a COVID-19 vaccine. RN-H indicated RN-H mailed the authorization form to R2's POAHC with a note to return the signed document to the facility within two weeks. RN-H indicated R2's POAHC had not returned the signed document. RN-H did not document the verbal conversation with R2's POAHC in R2's medical record and indicated RN-H usually documented communications in nursing notes. RN-H indicated RN-H obtained authorization from R2 on 2/14/25 to administer a COVID-19 vaccine. On 4/22/25 at 2:23 PM, Surveyor interviewed R2's POAHC who indicated RN-H called and left a message regarding authorization for vaccines. R2's POAHC indicated they attempted to return RN-H's call but did not get through. R2's POAHC then phoned the former Director of Nursing (DON) and left a message authorizing all vaccines except COVID-19. R2's POAHC indicated R2 authorized COVID-19 vaccination on 2/14/25, however, R2's POAHC had been activated for R2's POAHC to make medical decisions. R2's POAHC indicated they spoke with the former DON who stated there was a miscommunication regarding R2's COVID-19 vaccine and that RN-H would be further educated on the process for the future. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 3:42 PM, Surveyor interviewed DON-B who verified a COVID-19 vaccine was administered to R2. DON-B indicated the facility works off of verbal consents. DON-B verified the language in the facility's policy regarding having a signed consent prior to administration of a COVID-19 vaccine. DON-B was not aware of R2's POAHC and the former DON's conversation. DON-B provided Surveyor with COVID-19 education that was provided to R2.