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	10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wisconsin Rapids Health Services	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure an allegation of verbal abuse was reported to the State Agency (SA) for 1 resident (R) (R7) of 2 sampled residents.R8 reported to staff on 9/3/25 that Certified Nursing Assistant (CNA)-E yelled at R7 (who was R8's spouse). The facility did not report the allegation of abuse to the SA.Findings include:The facility's Abuse, Neglect, and Exploitation policy, revised 7/15/22, indicates: .IV. Identification of Abuse, Neglect, and Exploitation: .B. Possible indicators of abuse include, but are not limited to: Verbal abuse of a resident overheard or inappropriate verbal conduct overheard .VII. Reporting Response. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services, and to all other required agencies (e. g., law enforcement when applicable) within specified time frames. B. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. B. The Administrator will follow-up with government agencies to report the results of the investigation when final within 5 working days of the incident, as required by State Agencies. On 10/6/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side and dysphagia. A Minimum Data Set (MDS) assessment completed 9/10/25 included a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R7 had moderate cognitive impairment. On 10/6/25, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD). An MDS assessment completed 1/31/22 included a BIMS score of 15 out of 15 which indicated R8 was not cognitively impaired. On 10/6/25, Surveyor reviewed a grievance, reported by R8 and dated 9/3/25, that indicated CNA-E yelled at R7 (who was R8's spouse) on 9/2/25 for getting out of bed. An alarm was activated when R7 was watching TV in a wheelchair and attempted to get the remote. CNA-E entered the room and yelled at R7. The grievance form indicated Nursing Home Administrator (NHA)-A investigated the grievance. Staff had no follow-up or further information and did not confirm or deny the incident. The writer discussed being firm with a resident who puts themself at risk and the perception of coming across as yelling. The form indicated the grievance was resolved on 9/20/25. On 10/6/25 at 1:22 PM, Surveyor interviewed NHA-A who confirmed NHA-A did not report the allegation of abuse to the SA. NHA-A indicated NHA-A knew R7, R8, and CNA-E and felt CNA-E's tone was taken wrong. NHA-A indicated CNA-E is not a soft person and it sounded like CNA-E entered the room with intensity which was perceived as yelling. NHA-A agreed the allegation of abuse should have been reported to the SA.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure an allegation of verbal abuse was thoroughly investigated for 1 resident (R) (R7) of 2 sampled residents.R8 reported to staff on 9/3/25 that Certified Nursing Assistant (CNA)-E yelled at R7 (who was R8's spouse). The facility did not thoroughly investigate the allegation of abuse.Findings include:The facility's Abuse, Neglect, and Exploitation policy, revised 7/15/22, indicates: .IV. Identification of Abuse, Neglect, and Exploitation: .B. Possible indicators of abuse include, but are not limited to: Verbal abuse of a resident overheard or inappropriate verbal conduct overheard .V. Investigation of Alleged Abuse, Neglect, and Exploitation. A. An immediate investigation is warranted when an allegation or suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. VI. Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation.On 10/6/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side and dysphagia. A Minimum Data Set (MDS) assessment completed 9/10/25 included a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R7 had moderate cognitive impairment.On 10/6/25, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD). An MDS assessment completed 1/31/22 included a BIMS score of 15 out of 15 which indicated R8 was not cognitively impaired.On 10/6/25, Surveyor reviewed a grievance, reported by R8 and dated 9/3/25, that indicated CNA-E yelled at R7 (who was R8's spouse) on 9/2/25 for getting out of bed. An alarm went off when R7 was watching TV in a wheelchair and attempted to get the remote. CNA-E entered the room and yelled at R7. The grievance form indicated Nursing Home Administrator (NHA)-A investigated the grievance. Staff had no follow-up or further information and did not confirm or deny the incident. Staff had no comment when the writer discussed being firm with a resident who puts themself at risk and the perception of coming across as yelling. The form indicated the grievance was resolved on 9/20/25. On 10/6/25 at 1:22 PM, Surveyor interviewed NHA-A who confirmed NHA-A did not complete a thorough investigation for the allegation of verbal abuse. NHA-A indicated NHA-A knew R7, R8, and CNA-E and thought CNA-E's tone was taken wrong. NHA-A indiated CNA-E is not a soft person and it sounded like CNA-E entered the room with intensity which was perceived as yelling. NHA-A stated NHA-A talks with staff frequently about checking themselves at the door prior to entering a resident's room. NHA-A agreed the allegation of abuse should have been thoroughly investigated, including resident and staff interviews and staff education.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure 2 residents (R) (R1 and R6) of 2 sampled residents were provided safe and accurate administration of drugs and biologicals. Registered Nurse (RN)-K did not administer R1's Ozempic as ordered. In addition, RN-L documented Ozempic was administered to R1 when it was not administered.During the administration of insulin for R6, RN-C held a lispro injectable pen to R6's skin for less than the recommended 5 to10 seconds.Findings include: The facility's Medication Administration, General Guidelines policy, dated 1/2025, indicates: Medications are administered as prescribed .3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record .2. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (for example, the resident is not in the nursing care center at the scheduled dose time, or an initial dose of antibiotics is needed), the nurse shall document either in the electronic Medication Administration Record or the paper MAR that the dose was withheld, refused, or given at other than the scheduled time and enter an explanatory note. The facility's Medication Administration policy, dated 1/2023, indicates: The correct procedure for injectable pens is to insert the needle into the skin at a 90-degree angle, deliver the dose by pressing the injection button all the way in, keep the injection button pressed all the way in and slowly count to 10 before withdrawing the needle from the skin. 1.On 10/6/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including chronic venous hypertension with ulcer of left lower extremity, type 2 diabetes mellitus, morbid obesity, and chronic kidney disease stage 4. A Minimum Data Set (MDS) assessment completed 9/20/25 included Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 was R1's own decision maker. R1's medication orders included the following: ~ Ozempic Subcutaneous Solution Pen-Injector 2 milligrams (MG)/3 milliliters (ML), inject 0.5 mg subcutaneously once daily every Wednesday for weight loss (Start date: 7/16/25; End date: 8/29/25). ~ Ozempic Subcutaneous Solution Pen-Injector 2MG/3ML, inject 0.5 mg subcutaneously once daily every Wednesday for weight loss (Start date: 9/3/25). R1's Medication Administration Record (MAR) indicated Ozempic 0.5 mg was administered by RN-K on 8/27/25 and by RN-L on 9/3/25. On 10/6/25, Surveyor reviewed a Resident Grievance Form filed by R1 on 9/3/25 that indicated staff did not administer an accurate dose of Ozempic and a dose of Ozempic was not administered as ordered. Follow-up by Director of Nursing (DON)-B indicated staff administered an additional dose of Ozempic after the initial dose had leaked from R1's administration site. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed a Medication Error Report Form, dated 9/3/25, that indicated RN-K administered an Ozempic dose in error. The report was completed by DON-B and indicated the error was discovered on 9/3/25 by RN-L. The provider was notified on 9/4/25. An observation note, documented on 9/10/25 as a late entry by DON-B, indicated R1 and the provider were updated on the Ozempic error. The note indicated the provider advised to give R1 Ozempic as ordered when the facility received the medication from the pharmacy. On 10/6/25 at 10:47 AM, Surveyor interviewed RN-K who indicated RN-K administered R1's Ozempic 0.5 mg pen on 8/27/25. RN-K indicated while administering Ozempic, RN-K noted the medication was leaking down R1's abdomen from the injection site. RN-K then administered an additional 2 clicks of the pen. RN-K did not know the dose of Ozempic that was administered in the 2 clicks of the pen but thought it was comparable to the amount that leaked from the injection site. RN-K did not document a progres note regarding the altered Ozempic dose and did not update the provider or facility administration about the altered dose. RN-K indicated staff later received education regarding medication injection technique, reporting, and what to do if medication is missing. On 10/6/25 at 12:20 PM, Surveyor interviewed DON-B who indicated RN-L verbally informed R1 and DON-B that RN-L did not have Ozempic to administer to R1 on 9/3/25. DON-B discussed Ozempic with R1 who indicated the last time Ozempic was administered, the medication leaked and R1 was administered additional medication. DON-B updated the provider on 9/4/25 but did not enter a provider notification note until 9/10/25 because that was when DON-B completed the staff in-service regarding Ozempic administration, provider notification, and medication ordering. DON-B verified a medication error should have been reported on 8/27/25. DON-B also verified R1's MAR indicated Ozempic was administered on 9/3/25. DON-B thought the Ozempic administration documentation was in error since RN-L verbally communicated to DON-B on 9/3/25 that RN-L did not have the medication to administer. On 10/6/25 at 1:02 PM, Surveyor interviewed RN-L who indicated RN-L did not have R1's Ozempic to administer on 9/3/25. RN-L attempted to reorder the medication, however, it had been ordered from the pharmacy on 9/1/25 by another staff. RN-L thought RN-L documented that the medication was not administered and wrote a progress note. When Surveyor indicated R1's MAR indicated Ozempic was administered by RN-L on 9/3/25, RN-L stated RN-L did not know why Ozempic was documented as administered when RN-L did not administer it. RN-L stated RN-L told DON-B that RN-L did not administer R1's Ozempic on 9/3/25 because R1's Ozempic pen was not available. 2. On 10/6/25, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis, diabetes, chronic obstructive pulmonary disease (COPD), aphasia, and long term use of insulin. An MDS assessment completed 8/14/25 included a BIMS score of 5 out of 15 which indicated R6 had severely impaired cognition. R6 had an order for Lispro sliding scale insulin: 150-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; 401 + give 12 units and notify MD, administered subcutaneously three times daily related to diabetes (Start date: 3/10/25). On 10/6/25 at 10:45 AM, Surveyor observed RN-C insert a needle in a Lispro injectable pen, prime the needle, and dial 8 units of Lispro. RN-C then wiped R6's right abdomen with an alcohol pad, inserted the pen needle at a 90-degree angle, pressed the injection button, and removed the needle from R6's right abdomen in less than 2 seconds. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/6/25 at approximately 10:50 AM, Surveyor interviewed RN-C who indicated RN-C held the pen to R6's right abdomen for 3 seconds. On 10/6/25 at approximately 2:00 PM, Surveyor interviewed DON-B who verified when administering insulin with an injectable pen, the pen should be held to the skin for 10 seconds after pressing the injection button.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure mechanical lifts were in safe operating condition which affected 1 resident (R) (R1) of 2 sanpled residents. R1 required a bariatric lift to transfer to an electric wheelchair. From 9/20/25 to 9/23/25, R1 was unable to transfer out of bed when the facility's bariatric Hoyer lift was out of service. In addition, staff had shared remotes between bariatric lifts for 2 weeks prior and a bariatric EZ stand lift was not in working order.Findings include:The facility's Safe Lifting and Movement of Residents policy, revised 11/28/22, indicates: .9. Mechanical lifts shall be made readily available and accessible to staff 24 hours per day. Back-up battery packs on remote chargers shall be provided as needed so that lifts can be used 24 hours per day .11. Maintenance staff shall perform routine checks and maintenance of equipment used for lifting, consistent with manufacturer's guidance, to ensure it remains in good working order. On 10/6/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including chronic venous hypertension with ulcer of left lower extremity, type 2 diabetes mellitus, chronic obstructive pulmonary disease (COPD), morbid obesity, chronic respiratory failure with hypoxia, and chronic kidney disease stage 4. A Minimum Data Set (MDS) assessment completed 9/20/25 included a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 was not cognitively impaired. A care plan, revised 5/8/23, indicated R1 had limited physical mobility related to activity intolerance, fatigue, impaired balance, limited mobility, arthritis, muscle spasms, lymphedema, obesity, pain, congestive heart failure (CHF), and COPD. The care plan contained an intervention, revised 5/12/25, that indicated R1 required the assistance of 2 staff and a Hoyer lift with an Arjo white 2 XL sling for transfers to R1's electric wheelchair. On 10/6/25 at 12:50 PM, Surveyor interviewed R1 who indicated staff use a bariatric Hoyer lift to transfer R1 to R1's electric wheelchair. R1 indicated R1 does not choose to get out of bed every day; however, there was a 4 day period when R1 couldn't get out of bed if R1 wanted to. R1 stated the bariatric Hoyer lift broke on Saturday (9/20/25) but R1 did not want to get out of bed that day. R1 indicated R1 wanted to get out of bed on 9/21/25 but couldn't because the lift was still broken. R1 indicated staff had been swapping remotes between the bariatric Hoyer lift and bariatric EZ stand lift for approximately 2 weeks because one of the remotes didn't work. R1 spoke with Maintenance Director (MD)-F who had ordered a new remote. R1 stated all of a sudden nothing worked and the facility had a new lift delivered on 9/23/25. On 10/6/25 at 9:26 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who confirmed the bariatric Hoyer lift R1 used for transfers broke on 9/20/25. LPN-D indicated R1 didn't want to get out of bed every day and couldn't recall if R1 wanted to get out of bed during that timeframe. On 10/6/25 at 9:33 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-G who didn't work the weekend the lift broke; however, R1 mentioned to CNA-G that R1 couldn't get out of bed. CNA-G confirmed staff had been swapping out remotes because one of the hand remotes stopped working. On 10/6/25 at 11:57 AM, Surveyor interviewed CNA-H who showed Surveyor a rented bariatric EZ stand lift which did not work. CNA-H indicated the battery must be dead and plugged in the lift. CNA-H indicated CNA-H did not work the weekend when the lift broke but came back to work on 9/22/25 and both lifts were not working. CNA-H indicated staff had been switching remotes between the 2 lifts prior to when the lift broke. CNA-H could not recall if R1 asked to get out of bed during CNA-H's shifts on 9/22/25 and 9/23/25. CNA-H indicated Nursing Home Administrator (NHA)-A was dealing with the lift when CNA-H arrived at work on 9/22/25. NHA-A indicated a new lift would be coming.On 10/6/25 at 10:20 AM, Surveyor interviewed MD-F who indicated the facility rents the bariatric lifts and has some some lifts in house. MD-F indicated MD-F does not do much with rented lifts but occasionally gives them a quick look over. MD-F stated the lookover is not documented on MD-F's spreadsheet for inspections or battery rebuilds. MD-F was aware staff were sharing a remote between lifts and indicated the rented bariatric EZ stand and bariatric Hoyer lift could share a remote. MD-F indicated it doesn't take long to get a remote and was not sure why a new remote did not arrive right away. MD-F verified MD-F was notified that the bariatric Hoyer lift didn't work but could not recall the date. MD-F indicated the rental company came in and swapped the bariatric Hoyer lift. In a subsequent interview at 12:55 PM, MD-F confirmed the issue with the lifts started approximately 2 weeks prior when a remote stopped working. MD-F confirmed NHA-A got involved when the lift stopped working entirely. Surveyor and MD-F then went to the storage room. When Surveyor indicated the rented bariatric EZ stand lift did not work, MD-F tried to turn on the lift. MD-F verified the lift did not work and was not sure why On 10/6/25 at 11:08