

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER North Shore Healthcare at Marshfield		STREET ADDRESS, CITY, STATE, ZIP CODE 814 W 14th St Marshfield, WI 54449	
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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on staff and resident interview and record review, the facility did not ensure 1 resident (R) (R9) of 1 sampled resident was provided restorative services to maintain physical abilities. Therapy developed a restorative program for R9 that indicated R9 should walk daily. The restorative program was not implemented. Findings include: The facility's Activities of Daily Living (ADLs) policy, dated 7/26/22, indicates: The facility will provide a maintenance and restorative program as applicable to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment. R9 had diagnoses including osteoarthritis, history of thrombosis and embolism, and mild cognitive impairment. R9's Minimum Data Set (MDS) assessment, dated 5/8/26, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. The MDS assessment indicated R9 had no refusals of care and did not participate in a restorative program. On 6/1/26 at 10:40 AM, Surveyor interviewed R9 who indicated they needed more help with ADLs now and it had been a while since they walked with staff. An ADL care plan, dated 5/15/26, did not indicate R9 had a restorative program. Surveyor reviewed R9's behavior monitoring for the last 30 days which did not indicate R9 rejected care. A physical therapy discharge note, dated 5/12/26 and written by Physical Therapist (PT)-H, indicated R9 made minimal improvement with bed mobility and transfers but improved significantly with ambulation with a front-wheeled walker. Therapy had communicated a walking program to nursing staff. On 6/3/26 at 11:27 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-G who was not sure if R9 had a restorative program and needed to check R9's care plan. On 6/3/26 at 11:39 AM, Surveyor interviewed PT-H who had developed a restorative program for R9. PT-H provided a Therapy Plan of Care-Interdisciplinary Team (IDT) Recommendations form for R9, dated 4/27/26, that indicated to reinstate R9's walking program with a two-wheeled walker, wheelchair following and contact guard assist to walk from cone-to-cone daily. The form indicated R9 required minimal to moderate assistance to stand. On 6/3/26 at 1:31 PM, Surveyor interviewed CNA-I who stated R9 was not on a restorative program at that time. On 6/3/26 at 1:33 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R9 had started a restorative program; however, DON-B could not find the restorative program in R9's medical record or Treatment Administration Record (TAR). DON-B stated DON-B would enter the restorative program in R9's medical record to ensure the program was started.		

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 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 staff and resident interview and record review, the facility did not ensure treatments were provided as ordered for 1 resident (R) (R7) of 4 sampled residents. R7 had a non-pressure chronic ulcer of the right foot and peripheral artery disease of the right leg. R7's Treatment Administration Record (TAR) contained multiple missing entries for treatments in March and May of 2026. Findings include: The facility's Pressure Injuries and Non-Pressure Injuries policy, revised 7/20/22, indicates: For those residents admitted with, or who subsequently develop a pressure injury or impaired skin integrity, they will receive care, treatment, and services that promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. R7 was admitted to the facility on [DATE] and had diagnoses including non-pressure chronic ulcer of the right foot and peripheral artery disease of the right leg. R7's Minimum Data Set (MDS) assessment, dated 5/18/26, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderately impaired cognition. Surveyor reviewed R7's TAR which contained the following orders: ~ Right third toe: Cleanse and apply Xeroform to wound bed and cover with bordered 2x2 dressing every other day. Once daily. Discontinue when healed (started 5/20/26). (Of note: R7's TAR indicated the order was not completed on 5/22/26.) ~ Vancomycin 1% topical solution, apply to right ankle/inner shin topically once daily for wound care. Use 1/4-inch strip gauze with vancomycin solution wet to damp dressing over Endoform leaving Endoform in place. Cover with 2x2 gauze (started 4/25/26; discontinued 5/7/26; restarted 5/16/26). (Of note: R7's TAR indicated the order was not completed on 5/3/26 and 5/22/26.) ~ Apply ace wrap to right lower extremity after wound care. Ace wrap can come off at bedtime. Two times daily for wound care, scheduled for early morning and bedtime (HS) (started 3/6/26; discontinued 3/15/26; restarted 3/15/26; discontinued 5/8/26). (Of note: R7's TAR indicated the order was not completed on 3/13/26 (EM) and 5/3/26 (EM).) ~ Monitor wound to right great toe for increased redness/pain/abnormal drainage/odor twice daily. If symptoms are present, progress note to be completed with findings (started 3/24/26). (Of note: R7's TAR indicated the order was not completed on 5/3/26, 5/22/26, and 5/28/26.) On 6/3/26 at 3:09 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed the above dates in R7's TAR were blank. DON-B indicated blank dates in a resident's TAR means the order/treatment wasn't completed or documented. DON-B indicated if a resident refuses a treatment, the TAR should contain code 2 and the staff's initials. On 6/3/26 at 3:42 PM, Surveyor interviewed Registered Nurse (RN)-M who worked on 5/3/26 and was unsure why R7's TAR indicated treatments weren't completed. RN-M indicated when the TAR is blank, it appears the treatment wasn't completed. RN-M stated if R7 refused or had an appointment, the nurse should initial the TAR and document in a progress note why the treatment wasn't completed.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, staff and resident interview, and record review, the facility did not ensure 1 resident (R) (R8) of 4 sampled residents received the necessary care and services to prevent pressure injuries from developing and/or promote healing. R8 had a pressure injury on the right heel. During an observation of wound care, Licensed Practical Nurse (LPN)-J used soiled scissors to cut gauze that was directly applied to the pressure injury on R8's right heel. Findings include: The facility's Pressure Injuries and Non-Pressure Injuries policy, revised 7/20/22, indicates: For those residents admitted with, or who subsequently develop a pressure injury or impaired skin integrity, they will receive care, treatment, and services that promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. R8 had diagnoses including diabetes and heart failure. R8's Minimum Data Set (MDS) assessment, dated 4/15/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The MDS assessment indicated R8 had a stage 2 pressure injury. On 6/1/26 at 2:10 PM, Surveyor interviewed R8 who indicated they had 2 wounds on their feet and went to the wound clinic regularly. R8 stated facility staff provided daily wound care. R8's medical record contained the following orders from the wound clinic: ~ Alternate tobramycin and vancomycin onto wound gauze, then ABD dressing, then Kerlix, Tubigrips, Circaid wraps, and HeelMedix to right heel with follow-up in 1 week (dated 4/28/26) ~ Continue current wound care and always ensure HeelMedix to right heel except when transferring (dated 5/5/26) On 6/2/26 at 9:19 AM, Surveyor interviewed R8 who indicated their wounds were healing. Surveyor observed a boot on R8's right foot and Circaid wraps on both legs. R8 had no concerns with wound care and stated they hadn't missed any treatments. On 6/3/26 at 10:06 AM, Surveyor observed LPN-J and Director of Nursing (DON)-B don gowns, enter R8's room, cleanse the bedside table, and place wound care items on the table. LPN-J and DON-B completed hand hygiene and donned gloves. LPN-J removed scissors from a pencil pouch that contained various items and opened a package of sterile gauze. LPN-J cut 2 pieces of gauze with the scissors, put the gauze in vancomycin solution, and put the scissors back in the pouch. LPN-J removed R8's right leg wraps, retrieved the scissors, and cut/removed Kerlix from R8's right leg/ankle. LPN-J removed gloves, completed hand hygiene, donned clean gloves, and cleansed the right heel wound with a 4x4 gauze and wound cleanser. LPN-J removed gloves, completed hand hygiene, donned clean gloves, and put a strip of vancomycin soaked gauze on the right heel pressure injury. LPN-J put an ABD pad over the gauze and wrapped R8's heel/foot/ankle with Kerlix. LPN-J applied a leg wrap and HeelMedix following wound care. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/26 at approximately 10:25 AM, Surveyor interviewed LPN-J who was not sure if the scissors used during wound care were cleaned prior to cutting the sterile gauze. On 6/3/26 at approximately 10:25 AM, Surveyor interviewed DON-B who indicated the best practice is to clean scissors after using them and indicated it was uncertain if the scissors were cleaned prior to use. DON-B stated DON-B would educate staff about cleaning scissors before use during wound care.		

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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. 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 3 residents (R) (R3, R7, and R35) of 10 residents observed during medication administration. Medication Technician (MT)-D did not complete hand hygiene prior to or after administering medication to R3, R7, and R35. Findings include: The facility's Hand Hygiene policy, dated 11/2/22, indicates: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors .2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table: Between resident contacts; Before preparing or handling medication. During observations of medication administration on 6/2/26 that began at 11:06 AM, Surveyor noted MT-D did not complete hand hygiene before or after oral medication administration for R3, R7, and R35. On 6/2/26 at 1:02 PM, Surveyor interviewed MT-D who indicated MT-D usually completes hand hygiene when leaving a resident's room. On 6/2/26 at 1:09 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed staff should complete hand hygiene before and after medication administration between residents.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure influenza vaccines were offered and/or administered for 2 residents (R) (R41 and R5) of 5 sampled residents. Findings include: The facility's Influenza Policy, revised 9/5/25, indicates: It is the policy of this facility to minimize the risk of acquiring, transmitting, or experiencing complications from influenza by offering our residents, staff, and volunteer workers annual immunization against influenza .9. The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal .1. R41 was admitted to the facility on [DATE] and had diagnoses including post-surgical digestive care and morbid obesity. R41's Minimum Data Set (MDS) assessment, dated 2/6/26, stated R41 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. R41 made their own medical decisions. Surveyor observed an undated signed consent form that indicated R41 wished to receive the influenza vaccine. R41's medical record did not indicate the vaccine was administered. (See interview under example 2.)2. R5 was admitted to the facility on [DATE] and had a diagnosis of vascular dementia. R5's MDS assessment, dated 5/26/26, stated R5 had a BIMS score of 7 out of 15, indicating severely impaired cognition. R5 had an activated Power of Attorney (POA) to assist with medical decisions. R5's medical record did not indicate R5 was offered or administered an influenza vaccine. On 6/3/26 at 1:05 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated Infection Preventionist (IP)-C was responsible for immunization consents and administration of vaccines. On 6/3/26 at 1:49 PM, Surveyor interviewed IP-C who indicated IP-C offered and educated residents on receiving influenza, COVID-19, and pneumococcal vaccines. IP-C indicated IP-C did not have completed consent or declination forms for the influenza vaccine for R41 or R5. On 6/4/26 at 3:48 PM, Nursing Home Administrator (NHA)-A verified via email the facility did not have completed consent or declination forms or education regarding the benefits or potential side effects of the influenza vaccine for R41 or R5.		