STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525329	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rib Lake Health Services	650 Pearl St Rib Lake, WI 54470

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30570 Based on record review and interview, the facility did not revise resident care plans to reflect residents' current needs and to provide the needed direction to staff in providing necessary care and services. The facility practice affected 2 of 4 residents care plans reviewed (R3 and R4). R3's care plan directs staff with intervention on toileting schedule when R3 is fully incontinent and requires checking for incontinence, providing incontinent care and/or changing or brief if warranted. R4's care plan directs staff to remove her Hoyer sling when in wheelchair when current interventions include leaving R3's sling in place when up in her wheelchair for her safety. This is evidenced by: Surveyor requested and reviewed the facility policy titled Comprehensive Care Plan dated as most recently revised 9/23/2022. The policy in part read: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered plan for each resident . Policy Explanation and Compliance Guidelines: The comprehensive care plan will describe at minimum, the following: ~The services which are to be provided . ~Resident specific interventions . The comprehensive care plan will be reviewed and revised as appropriate by the interdisciplinary team after each comprehensive and quarterly MDS assessment, and as needed with changes in condition. Surveyor reviewed R3's record and noted the following: (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3 most recent significant change in status Minimum Data Set (MDS) assessment completed 10/29/24 indicated R3 is always incontinent of bowel and frequently incontinent of bladder. R3's most recent Bowel/Bladder assessment dated [DATE] indicated Bladder: How long has resident been incontinent .Incontinent longer than a month, less than a year How often is resident wet .once or more per shift Resident is wet during .day and night time Amount of urine .Large Medications affecting elimination: antipsychotics Continent of stool .no Factors contributing to fecal incontinence .diarrhea, diet R3's care plan included: Focus: Urinary Incontinence r/t (related to) functional incontinence. Goal: will have no complications due to incontinence. Date initiated: 10/29/201 Revision on: 12/04/2023 Target date: 5/07/2025 Interventions/Tasks: ~Remind and assist as needed with toileting at routine times such as upon arising in am, before and after meals, activities, therapy and at bedtime. On 1/22/25 at 12:17 PM, Surveyor spoke with Director of Nursing (DON) B about R3's care plan for her incontinence care needs. DON B expressed R3 is always incontinent of bowel and bladder and a toileting schedule is no longer appropriate for R3. R3's care plan should have been revised with an intervention indicating she is to be checked/changed and provided incontinence care as needed every 2-3 hours and was not revised. Surveyor asked DON B about the facility process for revising resident plans of care. DON B expressed Registered Nurse/Resident Care Management Director (RCMD) E leads the facility process of MDS assessment and care plan development/revision. RCMD E works from home. DON B provided Surveyor with RCMD E's phone number. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 1:17 PM, Surveyor spoke with RCMD E via phone. RCMD E expressed during the MDS assessment process and with any resident change in status such as therapy recommendation the IDT (interdisciplinary team) meets to discuss and revise residents' care plans. R3's significant change in status MDS was done when hospice services were added. The bladder assessment was done as part of the assessment which showed R3 is incontinent of bowel and bladder. R3's care plan should have been updated to include she should be checked/changed and provided incontinent care every 2-3 hours as a toileting schedule is no longer appropriate. Example 2 Surveyor reviewed R4's most recent MDS which was a quarterly completed 12/01/24. The MDS indicated R4 understands, is understood and is cognitively intact. R3 is dependent on staff for transfer. Surveyor reviewed R4's comprehensive care plan and noted: Focus: urinary incontinence r/t impaired mobility. Goal: Will be free from skin breakdown Date Initiated: 11/04/2022 Date Revised: 6/15/2023 Target Date: 6/04/2025 Intervention: Remove sling from under resident when in bed or w/c (wheelchair). Surveyor observed R4 throughout the survey with her sling from her mechanical lift under her in her wheelchair. On 1/22/25 at 11:50 AM, Surveyor spoke with R4 about her sling observed under her in her wheelchair. R4 explained the sling is used with a lift to move her from bed to wheelchair and back. R4 expressed sometimes staff leave it under her in her wheelchair and sometimes staff remove it. R4 further expressed she is not sure why sometimes it is under her and sometimes it is not stating maybe cause it is sent to laundry. On 1/22/25 at 12:17 PM, Surveyor spoke with DON B about R4's care plan for her Hoyer sling. DON B expressed R4 needs her sling to remain under her when she is up in her wheelchair for safety reasons. It would be unsafe to remove the sling under R4 when she is up in her wheelchair and place it under R4 when she is in her wheelchair. The sling needs to remain in place for R4's safety. R4's care plan should have been revised indicating she requires her sling to remain under her for her safety and it was not revised. On 1/22/25 at 1:17 PM, Surveyor spoke with RCMD E about R4's care plan for her hoyer sling. RCMD E expressed R4 needs her sling to remain under her when she is up in her wheelchair for both her safety and staff safety. R4's care plan should have been revised indicating she requires her sling to remain under her for her safety and it was not revised.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30570 Based on observation, record review and interview, the facility did not provide the necessary activities of daily living (ADLs) services for residents dependent on staff for care. The facility practice affected 1 of 4 residents reviewed for ADLs (R3). This is evidenced by: Surveyor requested and reviewed the facility policy tilted Perineal Care dated as most recently revised 4/04/2023. The policy in part read: Policy: It is the practice of this facility to provide perineal care to all incontinent residents .as needed to promote cleanliness and comfort . Policy Explanation and Compliance Guidelines: ~Gather supplies needed. ~Place water proof pad underneath resident. ~Reposition resident in supine position and continue with perineal care. Surveyor reviewed R3's record and noted the following: R3's most recent significant change in status Minimum Data Set (MDS) assessment completed 10/29/24 indicated R3 sometimes understands, sometimes is understood and has severe cognitive impairment. R3 does not reject care. R3 requires maximum assist for bed mobility and is dependent on staff for transfer. R3 is always incontinent of bowel and frequently incontinent of bladder. R3's diagnoses include memory deficit from known intra-cranial hemorrhage, hemiplegia and hemiparesis affecting right side. R3 has range of motion limitations of 1 upper and 1 lower extremity. R3's most recent Bowel/Bladder assessment dated [DATE] indicated Bladder: How long has resident been incontinent .Incontinent longer than a month, less than a year How often is resident wet .once or more per shift Resident is wet during .day and night time Amount of urine .Large Medications affecting elimination: antipsychotics (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continent of stool .no Factors contributing to fecal incontinence .diarrhea, diet R3's care plan included: Focus: Urinary Incontinence r/t (related to) functional incontinence. Goal: will have no complications due to incontinence. Date initiated: 10/29/201 Revision on: 12/04/2023 Target date: 5/07/2025 Interventions/Tasks: ~Remind and assist as needed with toileting at routine times such as upon arising in am, before and after meals, activities, therapy and at bedtime. On 1/22/25 at 8:18 AM, Surveyor observed R3 up in her wheelchair in her room. R3 remained up in her wheelchair until 9:49 AM when Certified Nursing Assistants (CNA) C and D entered R3's room. On 1/22/25 at 9:47 AM prior to care observation, Surveyor spoke with CNA C about R3's routine and care provided by CNAs. CNA C indicted she cares for R3 routinely. R3 had gotten up per her usual around 6:20-6:30 AM this morning. R3 is dependent on staff for all care needs and is dependent on 2 staff via a Hoyer lift for transfers. CNA C expressed it is usual to check and change R3 as needed after meals, around this time each day. On 1/22/25 at 9:49 AM, CNA C and D entered R3's room and reclined R3 in her wheelchair. CNA C and D lowered R3's pants in front and checked her brief in the front for incontinence. CNA C and D expressed the strip in front of R3's brief indicated she was dry. CNA C and D pulled R3's pants up and inclined R3 in her chair. R3 was not transferred from her wheelchair to bed to allow for supine positioning to fully check R3 for incontinence. R3 remained up in her wheelchair and was not provided incontinent care or changing of her brief as warranted. Surveyor asked CNA C and D if the observed incontinence check is normal procedure. CNA C expressed staff check R3's brief in her chair; if the strip in front indicates she is wet she is transferred to her bed and provided incontinence care and changing of brief. On 1/22/25 at 12:17 PM, Surveyor spoke with Director of Nursing (DON) B about the observation. DON B expressed the manner of checking R3's brief for incontinence, as observed, is not sufficient to check R3 fully for incontinence. R3 should be transferred to bed and checked and changed with incontinent care as needed every 2-3 hours. Surveyor asked DON B about R3's intervention for toileting. DON B expressed R3 is always incontinent of bowel and bladder and a toileting schedule is no longer appropriate for R3. R3's care plan should have been revised with an intervention indicating she is to be checked/changed and provided incontinence care as needed every 2-3 hours.

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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. 30570 Based on observation, record review and interview, the facility did not provide the necessary services for residents at risk for pressure injuries or residents with actual pressure injuries. The facility practice affected 1 of 4 residents reviewed (R3). R3 was not provided repositioning from her wheelchair to off-load pressure from 6:30 AM until Surveyor concluded observation at 12:10 PM. This is evidenced by: Surveyor requested and reviewed the facility policy titled Pressure Injury and Non-pressure Injuries dated as most recently revised 7/20/22. The policy in part read: Policy: This center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put measures in place intended to achieve the goal of prevention of pressure injuries in our residents. Friction and Shearing: Friction is the mechanical force exerted on skin that is dragged across any surface. Policy Explanation and Compliance Guidelines: ~Complete the Braden Scale to assess risk of developing PI (pressure injury) . ~Care Planning: A comprehensive skin integrity care plan is based on resident history, review of skin assessments, Braden scoring .Consider the area of risk .Communicate risk factors and interventions to direct staff: Moisture: address cause of moisture . Activity: If a resident is chair bound . ~Schedule repositioning in the plan ~Develop turning/repositioning schedule based on resident needs and risk factors. Friction and Shear: ~Use lifting aides to move patient (slip sheet/lift sheet .) Surveyor reviewed R3's record and noted the following: (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's most recent significant change in status Minimum Data Set (MDS) assessment completed 10/29/24 indicated R3 sometimes understands, sometimes is understood and has severe cognitive impairment. R3 does not reject care. R3 requires maximum assist for bed mobility and is dependent on staff for transfer. R3 is at risk for the development of pressure injuries. R3's most recent Braden Scale for Predicting Pressure Score Risk dated 10/30/24 noted R3 scored a 13 which indicates R3 is at moderate risk for the development of pressure injuries. R3's risk factors include: Sensory Perception: Slightly limited: responds to verbal commands but can not always communicate discomfort or the need to be turned or has some sensory impairment Moisture: Occasionally moist: skin is occasionally moist . Activity: Chair fast: ability to walk severely limited or non-existent. Can not bear own weight and/or must be assisted to chair or wheel chair, Mobility: Very limited: makes occasional slight changes in body .unable to make frequent or significant changes independently. Nutrition: Probably inadequate . Friction and Shear: Problem: requires moderate to maximum assistance in moving .Complete lifting without sliding . R3's care plan included: Focus: At risk for alteration in skin integrity related to: contractures, diabetes, impaired mobility, incontinence, end of life, post CVA (stroke). Goal: minimize skin breakdown. Date initiated: 11/01/14 Target date: 5/07/2025. Interventions/Tasks: ~Encourage to reposition as needed; use assistive devices as needed. On 1/22/25 at 8:18 AM, Surveyor observed R3 up in her wheelchair in her room. R3 remained up in her wheelchair until 9:49 AM when Certified Nursing Assistants (CNA) C and D entered R3's room. On 1/22/25 at 9:47 AM prior to care observation, Surveyor spoke with CNA C about R3's routine and care provided by CNAs. CNA C indicted she cares for R3 routinely. R3 had gotten up per her usual around 6:20-6:30 AM this morning. R3 is dependent on staff for all care needs and is dependent on 2 staff via a Hoyer lift for transfers. CNA C expressed it is usual to check and change R3 as needed after meals, around this time each day. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 9:49 AM, Surveyor observed R3 up in her wheelchair in her room. CNA C and D entered R3's room and reclined R3 in her wheelchair. CNA C and D lowered R3's pants in front and checked her brief in the front for incontinence. CNA C and D expressed the strip in front of R3's brief indicated she was dry. CNA C and D pulled R3's pants up and inclined R3 in her chair. R3 was not transferred from her wheelchair and pressure was not off-loaded for R3. R3 remained up in her wheelchair until Surveyor concluded observation at 12:10 PM when Surveyor observed R3 in her room, in her wheelchair, with her lunch tray on bedside table in front of R3. On 1/22/25 at 12:17 PM, Surveyor spoke with Director of Nursing (DON) B about the observation. DON B expressed R3 should be transferred to bed to off-load pressure. The manner of reclining and incline of R3 in her wheelchair as observed could cause friction/shearing of R3's skin. R3 is at risk for pressure injuries. R3 is not able to reposition self in her wheelchair. Surveyor discussed R3's care planned interventions that indicated R3 should be repositioned as needed. DON B expressed R3 should be repositioned to prevent pressure injuries from developing.