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	02/04/2026

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 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** Based on interview and record review, the facility did not immediately inform the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status for 2 of 3 residents (R) reviewed. (R1 and R3).R1 became lethargic and confused and was sent to the emergency department. There is no evidence that representative/emergency contact was updated.R3 had severe abdominal pain, acute leukocytosis with concern of sepsis (life threatening condition) would progress, and was transferred to the emergency department. There is no evidence that representative/emergency contact was updated. The facility policy titled, Change in condition of the Resident, states, Documentation . 4. Notification of responsible party - include date, time, what was conveyed, any comments (each time notified).According to regulation S483.10(g)(14), Even when a resident is mentally competent, his or her designated resident representative or family, as appropriate, should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident.Example 1R1 was admitted to the facility on [DATE] with diagnoses that include diabetes, weakness, proteinuria, heart disease, urinary retention, history of prostate cancer, left leg amputation, and presence of urogenital implants. R1 had a brief interview of mental status (BIMS) score of 15/15 indicating intact cognition.Surveyor reviewed R1's progress notes. Note dated 01/02/26 stated R1 had a change in condition, altered mental status, (weak, tired, confused or drowsy) different than usual, poor food and fluid intake, and a functional decline. On 01/02/26 at 6:05 PM, staff updated the physician that ordered stat labs and push fluids. Staff were unsuccessful in obtaining blood draw after several attempts. Physician was again updated and stated to send R1 to the emergency department if unable to increase fluids or any changes occur. At 10:32 PM, progress notes indicated that staff assessed R1 and noted oxygen saturation was 81%, blood pressure 62/40, and s/he could not keep fluids down. Physician was updated and R1 was sent to the hospital and was diagnosed with septic shock and Fournier's gangrene (rapid progression necrotizing infection). The National Institute of Health explains the rapid progression of the disease can damage tissue at a rate of 1 inch per hour. Both conditions are life threatening. At 10:42 PM, R1 left for the hospital via ambulance. There is no mention that R1's family was notified. On 02/04/26, Surveyor spoke to R1's family member (FM) C who reported being upset that the facility did not provide an update until almost 6:00 AM on 01/03/26. FM C stated that she lives a few hours away and could have been with R1 sooner during R1's time of need. FM C also stated that due to R1's severe condition, all were in agreement to palliative care, which was initiated, and R1 passed away on 01/06/26. FM C stated she received R1's death certificate that identified the primary cause of death was multiple system shut down and secondary cause of death was sepsis.On 02/04/26, Surveyor interviewed Licensed Practical Nurse (LPN) D and asked to explain when family members are updated if residents are sent to the hospital. LPN D stated if residents are (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER Rib Lake Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 650 Pearl St Rib Lake, WI 54470	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their own person (cognitively intact), they offer to call the emergency contact. If residents are not able to communicate, they always update the emergency contact. Surveyor asked LPN D to show in the notes where the documentation is that R1's emergency contact was updated. LPN D looked in multiple areas of R1's electronic health record (EHR) and stated she did not find any notes indicating R1's emergency contact was updated and explained it should have been completed and documented.Example 2R2 was admitted to the facility on [DATE] with diagnoses that include weakness, stroke, diabetes, obstruction/reflux uropathy, and aphasia. R2 had a BIMS assessment completed on 12/11/25 that resulted in a score of 15/15 indicating intact cognition. Surveyor reviewed progress notes that indicated R2 developed severe abdominal pain on 01/05/26, staff updated the physician who ordered labs. Labs showed elevated white blood count. Progress notes on 01/06/26 indicates R1 has severe abdominal pain, acute leukocytosis with a concern to progression of sepsis (life threatening condition). Physician ordered R2 be sent to the emergency department. Surveyor could not find any evidence that R2's emergency contact was updated. R2's face sheet specifically notes to update R2's sibling if R2 goes to the ER. On 01/08/26, progress notes indicate a hospital update that R2 was diagnosed and being treated for a urinary tract infection and will be returning back to the facility. Surveyor attempted to interview R2; however, R2 declined due to not feeling well. Surveyor attempted and was unsuccessful with contacting R2's sibling for verification of notification. On 02/04/26 at 1:20 PM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectation would be for staff to notify emergency contact of resident transfers to the hospital with potential life-threatening concerns. DON B stated she would expect staff to update any activated power of attorney, guardian, and if the resident chooses. If they are not able to choose, or understand for any reason, the emergency contact should be updated and documented in the resident's record. Surveyor asked DON B to show where in R1 and R2's medical record shows evidence that the staff notified emergency contacts for the hospitalization mentioned above. DON B stated she did not see any documentation that families were updated.