STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Tomahawk Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 720 E Kings Rd Tomahawk, WI 54487	

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure each resident received adequate supervision and assistance devices to prevent elopement or falls for 2 of 3 residents reviewed (R23, R5).R23 has a history of elopement attempts on and was assessed to be at risk for wandering and elopement. R23 wears a Wanderguard that alerts staff to her attempts to elope. On 02/24/26, R23 exited the facility without staff knowledge and without the Wanderguard alarm sounding. R23 was found by a citizen approximately 0.7 miles from the facility with approximately 1 inch of snow on top of her head. Police were called and were able to determine resident was from the facility.The facility's failure to provide adequate supervision created a finding of immediate jeopardy that began on 02/24/26. Director of Nursing (DON) B was notified of the immediate jeopardy on 03/19/26 at 3:10 PM. The immediate jeopardy was removed on 3/19/26 however, the deficient practice continues at a scope/severity of D as the facility continues to implement its action plan and as evidenced by the following examples:Facility did not follow R5's care plan related to appropriate footwear to prevent falls and is at risk for wandering and eloping and no Wanderguard in place.Findings include: Example 1 The facility policy titled, Elopement/Unsafe Wandering last revised on 08/09/22, includes, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.Alarms are not a replacement for necessary supervision. R23 was admitted to the facility on [DATE] with diagnoses of early onset Alzheimer's disease, aphasia, generalized anxiety disorder, severe dementia with mood disturbance, major depressive disorder, and personal history of stroke without residual deficits. R23 was initially admitted to the secured Memory Care Unit (MCU) A Wanderguard trial was performed and successful on 06/27/24, and R23 was moved off of the secured unit and on to the East Wing. R23's care plan prior to the incident reads in part: Focus of potential for elopement related to dementia with interventions of allowing resident to vent feelings and/or frustration as needed, calmly redirect to an appropriate area, encourage socialization with others and provide recreational programming, and engage in activities/tasks to keep occupied (6/21/24). Focus of at risk for changes in mood related to anxiety and major depressive disorder with interventions of assess for physical/environmental changes that may precipitate change in mood (06/24/24). Focus of at risk for behavior symptoms (wandering, repeated movements, rejection of care) related to Alzheimer's Disease with interventions of redirect as able, offer meaningful activity, offer food or drink, use consistent approaches when giving care (08/28/24), redirection, reapproach as resident allows (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(09/23/24). Upon admission, R23 had a Brief Interview for Mental Status (BIMS) score of 3/15, which indicates severe cognitive impairment. R23's current BIMS dated 12/22/25, R23 had a BIMS score of 00, indicating severe cognitive impairment. Wandering risk assessments indicated R23 was a moderate risk for wandering for all assessments except 06/14/25 and the one completed on 02/24/26 (day of incident). On those two dates, R23's risk assessments indicated R23 was a high risk for wandering. R23's care plan prior to the elopement incident on 02/24/26 reads in part: Focus of potential for elopement related to dementia with interventions of allowing resident to vent feelings and/or frustration as needed, calmly redirect to an appropriate area, encourage socialization with others and provide recreational programming, and engage in activities/tasks to keep occupied (6/21/24). Focus of at risk for changes in mood related to anxiety and major depressive disorder with interventions of assess for physical/environmental changes that may precipitate change in mood (06/24/24). Focus of at risk for behavior symptoms (wandering, repeated movements, rejection of care) related to Alzheimer's Disease with interventions of redirect as able, offer meaningful activity, offer food or drink, use consistent approaches when giving care (08/28/24), redirection, reapproach as resident allows (09/23/24). The progress notes in R23's medical record stated R23 had two previous incidents of elopement from facility. On 10/9/24, R23 exited the building and was walking toward the park. Alarm did not sound upon R23 exiting the facility. On 10/10/24 following the elopement, behavior monitoring was revised for wandering and repeated movements of residents. R23's care plan interventions were added to redirect as able, offer meaningful activity, and offer food or drink. Surveyor did not find any documentation indicating if the Wanderguard or the door alarm was not functioning. On 02/15/25 at 1:00 PM, R23 exited the building and was seen by staff walking quickly down a nearby street. Surveyor did not find any documentation of changes/interventions after the elopement on 2/15/25 On 7/11/24 at 2:01 PM, progress note stated R23 gave the Wanderguard bracelet to a nurse. The Wanderguard looked as though it had been cut off. R23's care plan states: Date initiated 8/8/24. Revision 1/26/26. [R23] will accept care and medications as prescribed. Staff will check placement of code alert on resident's wrist q shift On 11/2/24 at 8:22 AM, R23's Wanderguard was inoperable. Progress note in R23's medical record states the charge nurse would be notified. No documentation noted until 3:41 PM, that the Wanderguard was functioning properly. Surveyor did find any documentation for follow-up to confirm what the facility did with R23's Wanderguard if anything. On 11/29/24 at 4:35 PM, progress note states the call light system was not working. At 5:23 PM, the progress note states the call light system/alarm system was not working. R23 was the only resident wearing a Wanderguard. The Wanderguard was in place and checked every shift. The alarms on all of the facility exit doors are checked daily by maintenance and this is logged when checked. The call light system and door alarm system are tied to the same sound board, which was not working at this time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/20/25 at 10:14 PM, the progress note states R23's Wanderguard was inoperable. Surveyor could not find documentation following up on this statement of R23's Wanderguard not functioning nor what the facility did to correct this. On 1/19/26, night shift documented that R23's Wanderguard was not functioning. No documentation was found about whether Wanderguard was replaced or not. According to documentation received by the state agency, on 02/24/26 at approximately 1:04 PM, police were informed of an elderly female outside of a thrift store who was covered in snow and was wandering around and looked to be in distress. PO C observed R23 standing in the middle of the parking lot wearing a white coat and mittens with about an inch of snow on the top of R23's head. PO C pulled up next to R23 and asked if R23 was ok. PO C exited the and car saw R23 had R23's first name stitched on R23's coat. PO C asked again if R23 was ok and R23 showed PO C R23's mittens. R23 did not respond to PO C's questions. PO C guided R23 to the squad car and asked R23 to sit in the rear seat to warm up. PO C did not locate any identification on R23. PO C did locate a plastic band that appeared to be a sensor maybe from a nursing home to alert when R23 left the building and PO C asked dispatch to contact the nursing homes in the city and to call for an ambulance in case of this being a medical emergency. PO C then tracked R23's footprints in the snow and it appeared that R23 came from the south on the sidewalk on North 4th St. (North 4th St. is the main thoroughfare through Tomahawk with traffic consisting of passenger vehicles, buses, and semi traffic.) Dispatch then stated R23 had walked away from the facility, and staff did not notice that R23 had left the building. The ambulance and PO C then took R23 to the facility so they could obtain R23's paperwork for the hospital. PO C spoke to the nurse on duty. The nurse on duty stated R23 had dressed R23's self and walked out without them knowing. The facility stated R23 had done this in the past and they did not know why the alarm did not sound when R23 left. Hospital discharge summary indicated R23 was disoriented but physically unharmed. A progress note in R23's medical record stated R23 returned to facility on 2/24/26 at 2:24 PM. Wanderguard was discontinued, and R23's room was changed to the Memory Care Unit (MCU). MCU is a secure unit, and the residents in the MCU do not have Wanderguards. Later interviews will show that there are times when the MCU door does not close and does not signal staff that the door is ajar. R23's care plan post incident included in part: Intervention added to elopement care plan of at high risk for elopement updated on (02/24/26). Revision 2/25/26 states [R23] will accept care and medications as prescribed through next review date. Staff will check placement of code alert on resident's [R23] wrist every shift. Resident [R23] resides on MCU for long-term care updated on (3/19/26). On 2/24/26, R23 was wearing a Wanderguard bracelet, but the facility was unsure if it was functioning at this time. The door box alarm had been marked as functioning; however, it was discovered that the signal strength for the alarm to detect the bracelet was not set sensitive/strong enough. All of the facility exit doors are equipped with Wanderguard boxes. DON B provided Surveyor with a facility timeline of incident on 02/24/26 from their investigation. The document was titled, Elopement 2/24/26 Summary. The summary includes the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1:00 PM-1:07 PM, R23 left facility without Wanderguard system alarming. Of note - The police report shows that the call was received at 1:04 p.m. To travel .7 miles in 4 minutes, a person would have to go 10.5 miles per hour. 1:15 PM: Police Department notified facility of elopement. 1:20 PM: R23 transported to emergency room (ER) via Emergency Medical Services (EMS). 1:35 PM: Left voicemail for Power of Attorney (POA). 1:38 PM: Secondary POA updated. 1:45 PM: Notified [NAME] President of Success (VPS) for further instruction. 1:55 PM: Provider was notified. 2:05 PM: ER called facility with report for R23. 1410: R23's room was changed to the Memory Care Unit. 2:24 PM: R23 arrived back at facility. 2:25 PM: Skin, pain, psychosocial, and wandering assessments were completed. 3:00 PM: R23 was placed on additional 1:1 monitoring. On 2/24/26, an email was sent to the facility's Wanderguard system provider for assistance with the door alarm system. Of note-this has been an ongoing problem. The first elopement on 10/9/24 states the alarm did not sound upon R23's exit from the facility. The second elopement on 2/15/25, the alarm did not sound, and facility staff did not see resident until they noticed R23 walking down a nearby street. The facility investigation notes included in part: Upon this notification, staff were interviewed about the time R23 was last seen in the facility and R23's psychosocial status during the timeframes to which she R23 was seen. Per Therapy Director (TD) E, R23 was in the therapy department working with another resident at 12:50 PM. Staff report that they believe R23 became upset because a cup in R23's refrigerator was thrown away, but R23 did not make any suggestion of leaving the facility. Assistant Director of Nursing (ADON) J was interviewed as ADON J's office directly faces the front entry door, which R23 has exited in the past. ADON J stated that ADON J was in ADON J's office until 1300 with the office door open and did not see R23 exit the facility. No other staff witnessed R23 exiting the facility prior to the report of the elopement. From the interviews with the staff present, it can be determined that R23 left the facility between 1300-1307 and was located at 1315. Staff were interviewed if the Wanderguard door alarm system alerted at all in the last 2 hours prior to R23 leaving the facility and they deny hearing it sound. From the information gathered and maintenance checks of the system, the facility believes there was a fault in the system, which didn't alarm, allowing R23 to leave facility without alerting staff to R23's departure. The Wanderguards are tested by having a Wangerguard close to the door and opening the door to make sure that an alarm sounds. Surveyor found no documentation the facility interviewed any other staff or residents to determine which door R23 may have gone out if not the front door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor traveled several routes from facility to the thrift store and was able to determine the 0.7-mile distance indicated at minimum, a 12–14-minute walk. This facility is located about 280 feet from the Wisconsin River. The road where the facility is located is also one of the main routes to the elementary, middle school, high school, and a day care center. A technician arrived at the facility on 2/26/26 and Surveyor reviewed the information from that visit, and it stated: The technician inspected equipment, and everything appeared to be okay and functioning. Voltage was correct at 12.4 volts. The tech contacted tech support and explained the issue who stated it may be the specific tag used. Tech continued to do more testing and was able to duplicate what may have occurred simply by cupping the tag against the far side of his body away from the antenna, and it let him go through the door without setting off the alarm. This was tested several times with the same result. Tech then recontacted tech support and was walked through how to turn up the detection field to create a larger field for tag detection. Tech was able to expand the field, and it then started to detect the tag even while cupped in hand away from the antenna. Maintenance director asked for a quote to replace the Wanderguard system. Surveyor reviewed the log named, Daily check operation of door monitors and patient wandering system. The log indicates the alarm systems passed the check on 02/24/26 (the day of the incident). The alarm system sounds on the sound board near the nurse's station and Wanderguard alarms at the box on the door that it sets off. Surveyor requested a policy specific to the Wanderguard system. [NAME] President of Success (VPS) I stated the facility did not have one. Surveyor reviewed staff education completed after the incident. The education titled, Elopement/Unsafe Wandering, was initiated on 02/25/26 with some staff reviewing that day, continued with more staff between 02/25/26 and start of survey, and the rest of the staff being contacted by phone after surveyors entered the facility for survey. On 3/17/26 at 2:37 PM, Surveyor interviewed R23's Power of Attorney (POA) G and asked about R23's wandering/elopement. POA G stated that R23 removes the Wanderguard and places it under her armpit or in her shoe. POA G stated POA G has told this to the facility staff, but they do not listen. On 03/18/26 at 9:37 AM, Surveyor was at the nurse's station speaking with Certified Nursing Assistant (CNA) M. CNA M turned toward the Memory Care Unit (MCU) door and asked another staff member to close the door as CNA M could see a gap and a resident approaching the door. The other staff member closed the door. Surveyor asked why the door did not shut all the way. CNA M stated there is a latch at the top of the door that stops the door from closing if you open both doors at the same time. CNA M also said there is usually an alarm that sounds but it did not this time. CNA M stated that if it is bumped just right, it will not sound. On 03/18/26 at 9:40 AM, Surveyor observed R45 walking through the hall and entering the East wing. Housekeeper L approached R45 and redirected R45 toward the nurse's station where CNA M confirmed R45 lives on the MCU. R45 was then assisted back to the MCU by CNA M. On 03/18/26 at 11:54 AM, Surveyor interviewed RP D. RP D stated RP D arrived at the thrift store to meet RP D's spouse. RP D noticed R23 walking around in the parking lot, but other people were coming and going and didn't think much of it at first thinking maybe R23 was with them. RP D stated (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RP D went to the back of the building to assist someone with something, and RP D returned to see R23 was now walking around, and no one was with R23. RP D noticed an inch or more of snow on R23's head and called the police. RP D stated R23 was wearing a white windbreaker type coat and mittens. RP D stated R23 had tennis shoes and no hat. RP D stated 5 minutes or more passed from when RP D first observed R23 walking before calling the police. RP D checked the call log on RP D's cellphone and found RP D called PO C at 12:56 PM. On 03/19/26 at 7:09 AM, Surveyor interviewed Therapy Director (TD) E. TD E stated on the day of the incident, R23 was slightly agitated that morning. TD E tried to work with R23, and R23 was getting more agitated, so TD E stopped. TD E stated TD E last saw R23 at the nurse's desk but is not sure of the time. TD E stated it should be in the notes from that day. TD E stated R23 did not have R23's coat or mittens on at the time TD E last saw R23. On 03/19/26 at 7:19 AM, Surveyor interviewed CNA F. CNA F was working on the day of the incident. CNA F stated CNA F remembers last seeing R23 around lunch time between 12:30 PM-1:00 PM. CNA F remembers R23 was fixated on flowers and was observed taking them back and forth between R23's room and the dining room. CNA F stated R23 was then cleaning the hallway. CNA F stated the alarm did not sound. CNA F was first aware of R23 being gone when the phone call came in asking if they had any missing residents. CNA F stated all the staff went around and did a check, and R23 was the only one missing. On 03/19/26 at 8:27 AM, Surveyor interviewed Licensed Practical Nurse (LPN) H. LPN H was working from the day of the incident. LPN H stated that day R23 was agitated and angry. LPN H last saw R23 walking with another resident down toward therapy but could not recall what time that was. LPN H stated R23 did not have R23's coat and mittens on at that time. LPN H did not hear an alarm and was first made aware R23 was missing when the police called to inform the facility. On 03/19/26 at 3:17 PM, Surveyor interviewed Director of Nursing (DON) B and Maintenance Director (MD) K entered the room. DON B asked MD K if all door alarms were working correctly. MD K stated the only one not working the way it should is the [NAME] Hall door. MD K stated MD K was waiting to find out what parts were compatible. Surveyor found no documentation as to how long the [NAME] Hall door has not been working. Currently the facility does not have any residents who wear Wanderguards. The facility's failure to provide adequate supervision for residents at risk for elopement/wandering and ensure door alarms were sounding properly created a reasonable likelihood for serious harm thus leading to the finding of immediate jeopardy. The facility removed the immediate jeopardy on 3/19/26, when it completed the following: Affected resident R23 did not experience any negative outcome from the on the elopement on 2/24/26. R23's care plan was reviewed and updated on 2/24/26 to include interventions to prevent further eolopements. There has been no further elopements since 2/24/26. Wandering risk assessment completed for residents currently residing in facility 3/19/26. There were 18 residents at moderate risk and 3 residents at high risk for elopement. Care plans for these residents were reviewed to ensure interventions are in place to prevent elopement risk. There are no current residents identifed with a Wanderguard signaling device. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/19/26, DON/designee initiated staff re-education on recognizing behavior changes and elopement/unsafe wandering policy. On 3/19/26, DON/designee initiated licensed nurse and maintenance director staff re-education on checking Wanderguards and checking for functionality. On 3/19/26, DON/designee initiated staff re-education on residents at risk for elopement plan of care which indicates interventions to de-escalate exit seeking behaviors and provide increase supervision. Employees will have education completed prior to their next scheduled shift. On 3/19/26, Medical Director, VPS, on DON reviewed policy on Elopement/Unsafe Wandering, with no changes made. ADHOC QAPI completed 3/19/26 to discuss root cause analysis and action plan. Attendees were DON, Medical Director, and VPS. ED/designee to complete audits on staff to determine if resident at risk for elopement are being monitored/supervised 4 x weekly for a period of 12 weeks. ED/designee to complete random audits of Wanderguard functionality and Wanderguard system check 2 x weekly for a period of 12 weeks. Results of these audits will be reviewed by QAPI for patterns, trends of concerns, further education, or process improvement needs. Frequency and continuation of audits will be adjusted at this time. The deficient practice continues at a scope/severity level of D as the facility continues to implement their action plan and as evidenced by the examples for R5. Example 2 R5 was admitted to the facility on [DATE] and has diagnoses that include post-traumatic stress disorder (PTSD), unspecified dementia with behavioral disturbance, wandering, repeated falls, and noncompliance with medical treatment and regimen due to unspecified reasons. R5 has a Brief Interview for Mental Status (BIMS) score of 4/15, which means severe cognition impairment. R5 has a legal representative for health care decision making. R5's Minimum Data Set (MDS) assessment, dated 04/24/2025, indicated no wandering behaviors. MDS (quarterly) dated 07/05/2025, indicated no wandering behaviors. MDS (quarterly) dated 10/27/2025, indicated wandering behaviors occurred 1-3 days during look back period. R5's care plan, last revised 12/09/2025, with target date of 04/21/2026, states: At risk for falls due to dementia, receiving anxiety meds, Dx (diagnosis) of wandering. Interventions include.ensure shoes have proper grip. R5's care plan, last revised 01/26/2026, with target date 04/21/2026, states: At risk for behavior symptoms (.repeated movements, wandering, abusive behaviors.) related to unspecified dementia, generalized anxiety disorder, post-traumatic stress disorder (PTSD), wandering. Interventions include (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	under wandering: redirection, offer meaningful activity, offer 1:1 conversation as able and as resident allows. On 03/05/2026, R5 was evaluated by provider for routine psychiatric care. Provider documentation states in part: Patient also demonstrates yelling and screaming, wandering, abusive language. impulse control impaired.On 03/17/2026 at 12:04 PM, R5 was observed sitting in dining room wearing no shoes and socks that did not have grippers. R5 did not have Wanderguard bracelet (devices worn by residents to notify staff via alarm sound of residents attempting to elope from facility) in place. On 03/17/2026, at different intervals, Surveyor observed R5 ambulating in hallway between his room, and the dining room. R5 occasionally stopped at nurses' station to talk with staff. The nurse's station was located near front entrance of facility. R5 did not have a Wanderguard device in place. On 03/17/2026 at 2:00 PM, during interview with DON B, Surveyor asked if any residents in the facility were requiring use of the Wanderguard system. DON B stated there were no residents utilizing the Wanderguard system at that time. On 03/18/2026, R5 was observed lying on a couch in common area, which was located near front entrance of facility. Door to facility entrance/exit was approximately 20 feet distance from couch R5 was lying on. R5 did not have a Wanderguard in place. Resident was not in direct observation of facility staff. R5's medical record included the following incidents of R5 attempting to elope from the facility: 05/04/2025 at 3:40 PM, This RN saw resident [R5] outside front door talking to another resident. On 07/04/2025 at 11:10 AM, Resident [R5] attempted to walk away from facility due to not being given a lighter to smoke a cigarette. On 07/07/2025, Resident [R5] was seen walking down the driveway but did not get to the sidewalk. On 03/19/2026 at 9:39 AM, Surveyor asked certified nursing assistant (CNA) F if R5 wore a Wanderguard bracelet to alert staff to attempts at elopement. CNA F stated R5 did not wear a Wanderguard. Surveyor asked CNA F how staff monitor R5's whereabouts at all times and CNA F stated they do 30-minute checks on R5 and document on a check list kept at the nurses' station. CNA F stated R5 likes to go outside to check the mail because he is looking for a letter from his wife. The mailbox is located outside of the facility. CNA F stated front desk staff are usually there to keep an eye on R5. CNA F stated R5 has been found across the street at times. The street CNA F refers to is a public transportation street in front of facility with vehicles observed driving back and forth.On 03/19/2026 at 9:50 AM, Surveyor asked CNA M at nurses' station to provide the documentation sheets CNAs record on for monitoring every 30 minutes of R5's whereabouts. CNA M was unable to locate the sheet for current day. Surveyor asked vice president of services (VPS) I for documentation of every 30-minute checks by staff for R5's whereabouts. VPS I could not find any records for that date. VPS I stated a check sheet must not have been started on R5 that day. VPS I confirmed there was no documented proof of every 30-minute checks on R5 being done by staff. VPS I pulled the 30-minute check records for the past 30 days on R5. On 03/05/2025 between 2:00 PM and 10:00 PM, there was no documentation of every 30-minute checks on R5. On 03/06/2026 between 6:00 PM and 9:30 PM, there was no documentation for every 30-minute checks on R5. On 03/17/2026 between 12:01 AM and 6:00 AM, there was no documentation for every 30-minute checks on R5. On 03/18/2026 between 4:00 PM and 11:59 PM, there was no documentation of every 30-minute checks on R5. VPS I confirmed these dates lacked proof of staff observation of R5's whereabouts. VPS I stated all residents are assessed for risk of wandering behaviors and if a resident is determined to have such unsafe behaviors, a Wanderguard bracelet would be placed on that resident. VPS I stated all staff have been educated on wandering behaviors, how to use the Wanderguard system, what to do if an elopement occurs, and how to redirect residents who make attempts to elope.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525334	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tomahawk Health Services	720 E Kings Rd Tomahawk, WI 54487

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interviews, the facility did not ensure the safety of food handling in accordance with professional standards for food service safety. This had the potential to affect all 48 residents that eat orally. Prepared food placed in the walk-in cooler had been covered but was not labeled or dated, food in dry storage was not covered or dated, and 2 opened containers of milk were in milk cooler without indication of when they were open or when they should be used by resulting in the potential for foodborne illnesses to spread.Findings include:The facility's guidelines titled, Labeling and Dating dated 2017, states in part, All foods should be dated upon receipt before being stored. Food labels must include: the food item name. the date of preparation/receipt/removal from freezer, the use by date as outlined in attached guidelines. Guidelines assume that food is properly stored, covered, and handled. Guidelines apply, regardless of storage location.On 3/17/26 at approximately 8:30 AM, during initial kitchen tour, Surveyor interviewed Kitchen Account Manager V, who replied, Yes, when Surveyor asked if the prepared individual pureed cake cups and the vegetables in the serving container, in the walk-in cooler, should be labeled and dated.Kitchen Account Manager V stated, these should have been dated, when two open containers of milk were found in the milk cooler.Surveyor observed an uncovered box of potatoes with no label or date. Kitchen Account Manager V stated, These had a cover on them with the date, but we had people helping us because of the storm yesterday, so I don't know what happened to it.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not maintain an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections for all 44 residents in the facility.The facility failed to protect residents from risk of transmission of communicable disease as follows: No airborne precaution signs posted on residents diagnosed with COVID Certified nursing assistant (CNA) staff not using proper N95 masks when entering rooms of positive COVID residents PPE carts stocked with one size N95 masks for all staff to use, despite FIT testing recommendations. Staff not using proper PPE during catheter care Proper hand hygiene not being used during wound care Commercial washer and dryer temperatures not monitored/logged to ensure proper decontamination of soiled linens. Dirty linens not covered in a shared shower room and a resident with dementia observed rummaging through them Commercial soaps, shampoos, deodorants, lotions observed open, undated, and partially used for more than one resident in a shared shower room. Used surgical masks lying on PPE carts outside of resident rooms Findings include: Example 1 The facility policy, titled Infection Prevention and Control Program last revised 07/23/2024, states in part: All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services.All staff shall use PPE according to established facility policy.single use devices must be discarded after use. Centers for Disease Control (CDC) guidelines for healthcare providers, dated 06/24/2024, indicate that COVID-19 is primarily airborne, spreading through inhalation of respiratory virus particles. The CDC recommends airborne precautions to be used in healthcare settings. On 03/17/2026 at 8:00 AM, upon entrance into facility, survey team was informed by Director of Nursing (DON) B that one resident tested positive for COVID-19 and airborne precautions were in place for that resident. At time of exit from facility on 03/19/2026, 11 residents and 4 staff tested positive for COVID-19. On 03/18/2026 at 10:36 AM, Surveyor observed certified nursing assistant (CNA) Q and CNA R exit room of a COVID positive resident wearing regular face masks. Airborne precaution sign was posted outside of resident's room. The sign indicated use of gown, gloves, fit-tested respirator (N95 mask) and additional PPE based on point-of-care risk assessment. Surveyor interviewed both CNA Q and CNA R what type of precautions are taken for a COVID positive resident. CNA Q and CNA R stated regular masking, gloving, washing hands and gowns. Surveyor asked both CNAs what resources are used upon entering a room with airborne precautions. CNA Q pointed to the sign posted outside of the resident's room. CNA Q stated she was not aware airborne precautions required an N-95 mask. On 03/19/2026 at 8:14 AM, Surveyor observed a resident in the memory care unit wander into room [ROOM NUMBER], another resident's room. No airborne precaution signs were posted outside of room. No PPE cart was outside of resident's room. CNA R informed Surveyor the resident who resided in room [ROOM NUMBER] tested positive for COVID the evening before. Surveyor asked CNA R when airborne precautions should be put in place for positive COVID cases and CNA R stated, Right away. CNA R stated it is difficult to keep wandering residents out of other residents' rooms and they cannot keep doors to rooms closed because most of the residents are at risk of falling. CNA R stated there (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	are no other interventions they are aware of to keep wandering residents out of COVID positive rooms. Example 2 On 3/17/26 at 12:08 PM, Surveyor observed R39 was on airborne precautions. Shortly after this, Surveyor observed CNA W put on PPE and enter R39's room. CNA W did not put on a N95 as indicated. On 3/17/26 at 12:20 PM, Surveyor interviewed CNA W, who read sign outside R39's door and stated she should have worn an N95 mask and did not. On 3/18/26 at 2:29 PM, Surveyor interviewed DON B who stated when R39 was on airborne precautions, the expectation would be for staff to wear an N95 when entering the resident's room. Example 3 On 03/19/2026 at 11:00 AM, Surveyor observed PPE carts outside of rooms of positive COVID residents. One size (regular) of N95 masks was stocked in all the carts. Surveyor interviewed CNA F and CNA M if each staff person has their own fitted N95 mask to wear into airborne precaution rooms. CNA F stated, No, we just grab a mask out of the cart. At 11:10 AM, Surveyor interviewed DON B, who is also the infection preventionist, if all staff were FIT tested for N95 masks. DON B confirmed all patient care staff are annually FIT tested for proper N95 mask use. DON B stated regular size N95 masks are what is stocked in the PPE carts because that is the size most staff wear. DON B stated if a different size mask is needed, that staff person can go to a storage closet to obtain. Record review of FIT testing done on all staff indicated seven direct care staff who have worked from 03/17/2026 to 03/19/2026 during COVID outbreak at facility, were overdue on FIT testing. Last FIT test dates ranged from 08/06/2022 to 09/28/2024, which is past annual testing requirements. On 03/18/2026, Surveyor interviewed DON B on what staff expectations were for infection prevention with emphasis on current COVID outbreak at facility. DON B stated it had been over a year since some of the staff had COVID education. DON B stated all staff receive infection prevention training and are expected to follow infection prevention guidelines based on facility protocol. Example 4 R18 was admitted to the facility on [DATE] with diagnoses that include progressive multiple sclerosis and neuromuscular dysfunction of bladder. R18's orders include enhanced barrier precautions due to Foley catheter and wounds. On 3/17/26 at 9:27 AM, Surveyor observed R18's catheter hooked under bed. The end of catheter tube at the drain port was not in the holder but was lying directly on the floor. On 3/18/26 at 12:33 PM, Surveyor observed Certified Nurse Assistant (CNA) M empty R18's catheter bag. CNA M set urinal directly on floor, emptied catheter bag into urinal with drain port touching edge of the urinal. On 3/18/26 at 12:40 PM, Surveyor interviewed CNA M about using a barrier on the floor to keep urinal from contamination since it touches R18's open catheter tubing. CNA M stated she may have been told that at one time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/18/26 at 2:30 PM, Surveyor interviewed DON B, who stated she would expect staff to put a barrier down on the floor before putting collection container on the floor. Example 5 On 3/18/26 at 12:15 PM, Surveyor observed Licensed Practical Nurse (LPN) H perform wound care on R18. LPN H applied inner dressing, removed her gloves and did not wash her hands or use hand sanitizer prior to putting on new gloves and completing the wound care. On 3/18/2026 at 12:30 PM, Surveyor interviewed LPN H, who stated she thought she washed her hands after each glove change. On 3/18/2026 at 2:30 PM, Surveyor interviewed DON B who stated the expectation is that staff should wash their hands or use hand sanitizer after removing gloves each time. Example 6 On 03/18/2026 at 7:00 AM, Surveyor observed and interviewed laundry aide (LA) T on the processing of dirty linen. Surveyor asked LA T to provide a log of water temperatures for the washing machine, as well as a temperature log for dryer. LA T stated the machines do not indicate water and air temperatures and there is no way for staff to monitor them. LA T stated maintenance can identify water and air temperatures, but laundry staff cannot. LA T stated no logs are kept of any temperatures. On 03/19/2026 at 8:26 AM, Surveyor interviewed Maintenance Director (MD) K on how washing machine water temperatures and dryer temperatures are monitored. MD K stated laundry staff monitor and keeps logs of those temperatures. Surveyor received clarification from both LA T and MD K on who monitors temperatures in laundry. MD K stated both the washing machine and dryer are older products, and there is no way to see a temperature display on the units. Both LA T and MD K confirmed there is no temperature logs being kept for either unit. MD K stated the water temperature that comes out of the hot water heater specifically for the washing machine is set at 145 degrees Fahrenheit. MD K and LA T stated they were not aware what recommended water temperatures were for sanitization of laundry during processing. Example 7 On 03/17/2026 at 9:16 AM, Surveyor observed a resident in shower room [ROOM NUMBER] rummaging through dirty linen hamper. Resident was pulling dirty linen towards body and digging deep into hamper looking for a shirt. Room to shower room [ROOM NUMBER] was open and no lid was on dirty linen hamper. Example 8 On 03/17/2026 at 9:16 AM, in shower room [ROOM NUMBER] Surveyor observed bottles of Head & Shoulders, Hairtage, Loreal and [NAME] Moisture brand shampoos located within the shower without caps and partially used. A bottle of Hempz lotion and one bottle of Eucerin lotion was observed on table next to shower, partially used. One container of Old Spice deodorant, with top off and signs of usage was observed on table next to shower. One partially used bar of Caress soap observed lying on table. None of these used products were labeled with a resident's name or dated when opened. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Example 9 On 03/18/2026 at 7:05 AM, Surveyor observed a ripped clear garbage bag with soiled incontinent briefs lying on top of a soiled linen cart in the laundry collection area. Example 10 On 03/18/2026, Surveyor observed a used surgical mask lying on top of PPE cart outside of a resident's room who was positive for COVID. No staff were present near PPE cart.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, interviews, and record review, the facility did not provide care adhering to accepted standards of practice for 4 of 5 residents reviewed. (R2, R6, R21, and R39)Faciity did not follow manufacturer guidelines for proper placement of continuous glucose monitoring device for R2, R6, R21, and R39.Nursing did not prime insulin pens before administering insulin to R2, R6, R39.Nursing administered a dose of Ferrous Sulfate to R21 without confirming with phsyician what the dose was. Order in R21's medical record did not state dosage. Example 1The facility policy with a revision date of 08/05/2022, titled, NSG - Blood Glucose Monitoring, states, The nurse will perform the blood glucose test utilizing the facility's glucometer as per manufacturer's instructions. On 03/17/26 at 9:28 AM. Surveyor noticed R2 was lying in bed with chest exposed and had a continuous glucometer sensor (Libre) applied to his/her upper left chest. Surveyor confirmed this with Licensed Practical Nurse (LPN) P who provided the manufacturer insert. According to the insert, it clearly stated the sensor is to be applied to the upper arms only. Surveyor asked LPN P if they were aware of the sites to use for the device. LPN P shared that they were having trouble with the Libres falling off, so she looked up alternative sites online and found they could be applied to the upper chest. Surveyor asked LPN P if they utilize alternative sites, do they obtain orders and approval from the physician. LPN P said she didn't even think about it. On 03/18/2026 at 7:25 AM, Surveyor asked R21 where the sensor device was located. R21 pulled down her shirt by the neck area exposing the sensor was placed on her left upper chest. On 03/18/2026 at 11:14 AM, Surveyor observed R39's glucometer sensor was placed on their upper left chest area. On 03/18/2026 at 7:53 AM, Surveyor asked and R6 showed their glucometer sensor was applied to their upper left chest. On 03/18/2026 at 7:53 AM, Surveyor interviewed Director of Nursing (DON) B and inquired about the placement of the glucose sensors. DON B stated they looked it up and found information online. Surveyor asked for their policy on the continuous glucose devices and DON B stated they did not have a policy for use of the devices and they did not obtain approval orders from the physician to use alternative sites. Surveyor reviewed R2, R6, R21, and R39's care plans and physician orders, and there was no mention that alternative sites may be used for the continuous glucose monitoring sensors. Example 2 The facility policy dated 01/2026, titled, Medication Administration Subcutaneous Insulin, under the heading Insulin Pens, indicates, .8. Prime the insulin pen. a. Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures the pen is working correctly. b. Each click is 1 unit. c. Dial the pen up 2 units, unless otherwise specified by the manufacturer. d. Point pen needle towards the ceiling and gently tap the side. e. Press the button on the bottom all the way in, you should see a drop of insulin come out. If you do not see the drop, repeat the priming process. 9. Dial the dose to the prescribed insulin dose . On 03/18/2026 at 7:25 AM, Surveyor observed LPN H administer Lantus insulin to R21. LPN H attached the needle to the insulin, dialed up the dose, and administered the insulin to R21 without priming the needle. On 03/18/26 At 7:40 AM, Surveyor observed DON B administer Lantus insulin to R2. R2's orders was Glargine (Lantus) insulin 43 units twice a day. DON B placed needle on the insulin pen and pulled up 45 units and administered the 45 units to the resident and said that is how the pen is primed. On 03/18/2026 at 7:53 AM, Surveyor observed DON B administer Lantus insulin to R6. R6's order was to give Lantus insulin 10 units every day. DON B dialed up 12 units and administered the 12 units to the resident. On 03/18/2026 at 11:14 AM, Surveyor observed LPN H administer two insulins to R39. R39's insulins included Humalog and Toujeo. LPN H applied the new needles but did not prime the pens. Surveyor asked LPN H if they were aware of priming the pen needles. LPN H stated, We prime them when we first open one, but do not need to do them every time. Example 3 The facility policy titled, Medication Orders, revised 01/23, states the elements of the medication orders includes dose and dose form and any dose or order that appears inappropriate, considering the resident's age, condition, allergies or diagnosis, is verified by nursing with the prescriber. On 03/18/2026 at 7:25 AM, Surveyor observed LPN H administer Ferrous (continued on next page)

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Tomahawk Health Services	720 E Kings Rd Tomahawk, WI 54487

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sulfate 325mg to R21. When Surveyor was reconciling the medications, R21's physician order for Ferrous Sulfate, initiated on 10/19/25, stated to take one tablet by mouth every other day. There was no measurable dose on the order. There were no notes found in R21's record indicting the correct number of milligrams R21 was to receive. On 03/18/2026 at 11:34 AM, Surveyor interviewed DON B and asked what the expectation would be if a resident has an order for Ferrous Sulfate with no dosage. DON B stated the expectation would be for the staff to clarify the dose with the physician.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record reviews, the facility did not ensure medication error rates are not 5 percent or greater for 4 of 5 residents reviewed during medication pass.The facility error rate was 22.22%. Example 1 The facility policy titled, Medication Orders, revised 01/23, states the elements of the medication orders include dose and dose form and any dose or order that appears inappropriate, considering the resident's age, condition, allergies or diagnosis, is verified by nursing with the prescriber. On 03/18/2026 at 7:25 AM, Surveyor observed LPN H administer Ferrous Sulfate to R21 without confirming the physician order contained a dosage for R21. R21's physician's orders dated 10/19/25 notes: Ferrous Sulfate one tablet by mouth every other day. Surveyor reviewed R21's notes and found that the dosage was not clarified with the physician. LPN H administered Ferrous Sulfate 325mg. There were no notes found in R21's record indicating the correct number of milligrams R21 was to receive. On 3/18/26 at 11:34 AM, Surveyor asked DON B what the expectation would be if a resident has an order for Ferrous Sulfate with no dosage. DON B stated the expectation would be for the staff to clarify the dose with the physician. Example 2 The facility policy dated 01/2026, titled, Medication Administration Subcutaneous Insulin, under the heading Insulin Pens, indicates, .8. Prime the insulin pen. a. Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures the pen is working correctly. b. Each click is 1 unit. c. Dial the pen up 2 units, unless otherwise specified by the manufacturer. d. Point pen needle towards the ceiling and gently tap the side. e. Press the button on the bottom all the way in, you should see a drop of insulin come out. If you do not see the drop, repeat the priming process. 9. Dial the dose to the prescribed insulin dose . On 03/18/25 at 7:25 AM, Surveyor observed LPN H administer Lantus insulin to R21. LPN H failed to prime the insulin pen before administering insulin dose. Example 3 On 03/18/26 at 11:14 AM, Surveyor observed LPN H administer Humalog 10units and Toujeo (330 units/ml)-40units of insulin to R39. Needle was not primed for either, resulting in incorrect dosing. Surveyor asked LPN H if they were aware of priming the pen needles. LPN H stated, We prime them when we first open one, but do not need to do them every time. Example 4 On 3/18/26 at 7:40 AM, Surveyor observed DON B administer Lantus insulin to R2. R2's physician orders state: Glargine (Lantus) insulin 43 units subcutaneous twice a day. DON B placed needle on the insulin pen and pulled up 45 units and administered the 45 units to the resident and said that is how the pen is primed. Because of the incorrect procedure, there is no way to determine whether R2 received the correct dose of insulin. Example 5 On 03/18/2026 7:53 AM, Surveyor observed DON B administer Lantus to R6. Order was to give Lantus 10 units subcutaneously every day. DON B drew up 12 units and administered the 12 units to the R6, which resulted in wrong dose of insulin. On 03/18/2026 at 11:34 AM, Surveyor interviewed DON B and asked about tracking and trending of medication errors. DON B said the facility tracks errors and addresses them at least quarterly in QAPI meetings.

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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. Based on interview and record review, the facility did not notify the physician as indicated by parameters in physicians' orders for a significant weight increase for 1 out of 13 residents (R) R46. This is evidenced by:R46 was admitted to the facility 12/21/21 with a diagnosis that included atrial fibrillation. R46 has a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating cognitively intact.R46's Quarterly Minimum Data Set (MDS) with an end date of 2/26/26, Section K: weight 128#.R46's care plan initiated 2/24/26, with a target date of 4/18/26, states, Actual dehydration or risk for alteration in hydration related to diuretic use. Goal: Will maintain adequate hydration as evidenced by good skin turgor, moist oral mucosa, and stable weights. R46 was hospitalized , diagnosed with congestive heart failure (CHF), and on 2/20/26 Furosemide, a diuretic, was prescribed 20 MG by mouth every morning.R46's physician orders dated 2/25/26 is as follows: daily weights, call Medical Doctor (MD) if weight change of 3 pounds in 1 day or greater than 7 pounds in one week, one time a day for CHF. Record review indicated no weights recorded or documentation of reason for not obtaining R46's weight on 3/8/26 and 3/10/26. On 3/12/26, R46's weight was 128.4 pounds. On 3/13/26, R46's weight was 131.8 pounds, indicating a weight gain of 3.4 pounds in one day.On 3/16/26, R46's weight was 124.4 pounds. On 3/17/26, R46's weight was 127.8 pounds, indicating a weight gain of 3.2 pounds in one day.Surveyor was unable to find documentation to support R46's provider was updated of weight changes. Surveyor requested and was not provided any evidence to indicate provider was notified.Surveyor requested facility policy for following physician's orders and/or change in condition and was provided with a document for practice guidelines for reporting changes in condition.On 3/19/2026 at 11:25 AM, Surveyor interviewed DON B, who stated the expectation would be that nursing staff report to provider as per orders indicated.

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	525334	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tomahawk Health Services	720 E Kings Rd Tomahawk, WI 54487

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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 interview and record review, the facility failed to report events which had the potential to cause serious harm or injury for 1 of 3 residents reviewed (R23).R23 is cognitively impaired, eloped without facility knowledge, and the alarm system was not working properly.Findings include:R23 was admitted to the facility on [DATE].Most recent Minimum Data Set (MDS) assessment indicates a Brief Interview for Mental Status (BIMS) score of 00/15, indicating severe cognitive impairment.On 02/24/26 at approximately 12:50 PM, R23 was observed walking around the parking lot of a local thrift store by reporting party (RP) D. RP D called Police Officer (PO) C who responded shortly after. R23 was reported to have about an inch of snow on top of R23's head. PO C called Emergency Medical Services (EMS) who assisted in taking R23 to the hospital for evaluation. The facility was contacted and asked if they were aware R23 was not in the facility. The facility was not aware R23 had left. R23 had a Wanderguard bracelet on which did not set the alarm off upon exiting the facility. The facility reported the alarm system was faulty.The facility was not aware of R23 being missing until being contacted by law enforcement. The temperature the day of the incident was a high of 25 degrees, snowing, and had wind gusts at 15 miles per hour. R23's cognition is severely impaired. R23's jacket is described as a lined, lightweight satin [NAME] jacket. The facility is only about 280 feet from the river which increases the risk for harm. The thrift store where R23 was located is a 12-14-minute walk from the facility.Surveyor has determined due to the high-risk factors and potential for serious harm or injury; this incident was reportable to the State Agency. The facility failed to report the incident.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide written information specifying bed-hold duration and payment policy to the resident or resident representative for 1 resident (R49) for 3 residents reviewed for bed-hold information in a sample of 13 residents. The facility failed to provide a written bed-hold agreement to R49's legal representative upon transfer to the emergency department (ED), or within 24 hours of transfer to the ED, or document in R49's medical record that bed-hold information was provided to a legal representative. This resulted in R49's legal representative to be uninformed of cost to resident to hold R49's bed, if desired, during R49's hospitalization. Findings include:The facility policy, titled Bed Hold Notice, last revised on [DATE], states in part: As part of the admission packet and at the time of a transfer to the hospital.the facility will provide the resident and/or resident representative written information that specifies.the duration of the State bed-hold policy.the reserve bed payment policy.in the event of an emergency transfer of a resident.the facility will document attempts.facility will keep a signed and dated copy of the bed-hold notice.in the resident's medical record.R49 was admitted to the facility on [DATE] and had diagnosis of recurrent falls, displaced left intertrochanteric hip fracture. On [DATE] at 9:00 PM, R49 was transferred to the ED after exhibiting increased lethargy, confusion, non-reactive pupil on the right and unstable vital signs. R49 was subsequently admitted to the hospital for further workup. On [DATE] at 12:31 PM, record review indicates the hospital case manager notified the facility R49 would not be returning to the facility upon discharge from the hospital. Record review of R49's medical record did not have a signed bed-hold policy included. R49's medical record had no documentation that R49 or R49's representative received notification, written or by phone, of facility's bed-hold policy.On [DATE] at 1:31 PM, Surveyor interviewed business office manager (BOM) U for evidence of a bed-hold notification provided to R49 or R49's representative following R49's transfer to the ED on [DATE]. BOM U stated a phone call was personally placed to R49's wife on same day of R49's transfer to the ED. BOM U stated R49's wife declined the bed to be held at the facility for R49, as it was planned for R49 to be moved to another facility upon discharge from hospital. BOM U stated the phone conversation with R49's wife was not documented in R49's medical record. BOM U stated it was not facility routine to document information provided to a resident or resident representative in a medical record if unable to do a written notification of bed-hold immediately upon transfer and BOM U was not aware this was a CMS (Center for Medicare and Medicaid Services) requirement. On [DATE] at 1:12 PM, Surveyor interviewed R49's representative if made aware of bed hold notification following R49's transfer to the ED. R49's representative could not recall a phone conversation regarding bed hold information and/or cost of a bed hold on [DATE]. R49's representative did, however, confirm it was decided R49 would not be returning to the facility, and informed someone at the facility not to hold a bed. R49's representative denied receiving a written notification of bed-hold policy. To be noted: R49 was discharged home from the hospital on hospice and expired a short time after, therefore is not available for interview.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not implement the comprehensive care plan for accident prevention for 2 residents (R5, R43) of 3 residents reviewed for accidents in a sample of 13 residents. The facility did not implement care plan intervention of R5 always wearing grip socks or shoes when ambulating to prevent falls from occurring. This could result in R5 falling and sustaining serious physical injury.The facility did not implement care plan intervention providing gripper strips at R43's bedside to prevent falls when getting self out of bed. Findings include:The facility policy, titled Fall Prevention and Management Guidelines, last revised 07/18/2024, states in part: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls or reduce the possibility/severity of injury.Example 1R5 was admitted to the facility on [DATE] and has diagnoses that include post-traumatic stress disorder (PTSD), unspecified dementia with behavioral disturbance, wandering, repeated falls, and noncompliance with medical treatment and regimen due to unspecified reasons. R5 has a Brief Interview for Mental Status (BIMS) score of 4/15, which means severe cognition impairment. R5 has a legal representative for health care decision making. R5's care plan, last revised 12/09/2025, with target date of 04/21/2026, states: At risk for falls due to dementia, receiving anxiety meds, Dx (diagnosis) of wandering. Interventions include.ensure shoes have proper grip.Record review for R5 indicated R5 had 2 falls on 01/19/2026, 2 falls on 01/20/26 and one fall on 01/22/2026. Record review indicated documented wandering behaviors. On 03/17/2026 at 12:04 PM, Surveyor observed R5 sitting in dining room wearing no grip socks on feet and no shoes. Surveyor observed R5 ambulate in dining room and back to his room without proper grip socks or shoes on feet. Certified nursing assistant (CNA) staff were observed talking to R5 when up ambulating in hallway without shoes or grip socks. No CNA staff intervened or reminded R5 to place shoes/grip socks on for safety. On 03/19/2026 at 9:39 AM, Surveyor interviewed certified nursing assistant (CNA) F about fall prevention for R5. CNA F stated staff try to keep close eye on R5; however, R5 moves about independently and will take shoes off. Example 2R43 was admitted to the facility on [DATE] and has diagnoses that include hemiplegia and hemiparesis following cerebral infarction (brain stroke) affecting left side, vascular dementia with behavioral disturbances, wandering, generalized anxiety disorder. R43 has a BIMS score of 10/15, which means moderate cognitive impairment. R43 has a legal representative for healthcare decision making. R43's care plan, last revised 02/03/2026, with target date of 05/11/2026, states: At risk for falls due to weakness post CVA (cerebral vascular accident), dementia. Interventions include.gripper strips at bedside.Record review for R43 indicated on 02/27/2026 R43 was found sitting on floor in room [ROOM NUMBER] next to bed. R43 was attempting to get to bathroom. Record review indicated documented wandering behaviors. On 03/19/2026 at 8:10 AM, Surveyor observed R43 lying in bed resting. Surveyor did not observe signs of grip strips on floor next to R43's bed.

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NAME OF PROVIDER OR SUPPLIER Tomahawk Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 720 E Kings Rd Tomahawk, WI 54487	

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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** Based on observations, interviews, and record reviews, the facility did not revise resident's care plan following the completion of a Minimum Data Set (MDS) assessment for 1 of 13 residents reviewed. R2's care plan notes that R2 receives opioids, foot care, daily feet inspections, blue boot to right foot, hand splints, and assist with urinal. R2 is a double amputee, is no longer receiving opioids, refuses hand splints, and has a Foley catheter in place.R2 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes, contractures of both hands and knees due to palmar fascial fibromatosis, left below the knee amputation, cervical neck pain, bow back pain, neuropathy, enlarged prostate, and urinary retention. R2's Minimum Data Set (MDS) dated [DATE] indicates R2 uses an indwelling Foley catheter. R2's most recent Brief Interview of Mental Status (BIMS) score, dated 03/16/26, was 8 of 15 indicating moderately impaired cognition. On 03/17/2026 at 9:00 AM, Surveyor observed R2 lying in bed. R2 was noted to have had bilateral below the knee amputations and an indwelling Foley catheter. Surveyor asked R2 about his pain which R2 stated that he used to be on opioids that seemed to work the best, but it was all taken away to try other things. Surveyor asked about hand contractures and R2 stated that he used to have splints on at night but does not want them or like them. OPIOIDS: On 03/19/2026 at 9:02 AM, Surveyor interviewed Medication Assistant (MA) O who reported that R2 is no longer on opioids because he was more confused and it did not help. Surveyor reviewed R2's medication administration record (MAR) and found the last time R2 received an opioid was 12/1/25. Surveyor reviewed R2's care plan, last revised on 02/25/26, states, Opioid use r/t BKA to LLE, chronic pain. MDS assessment was completed on 12/17/25. The care plan was not revised to reflect R2's current situation. RANGE OF MOTION: Surveyor reviewed R2's care plan titled, ADL self-care deficit, with a revision date of 02/25/26. R2's care plan interventions include right hand splint - see orders. Surveyor reviewed the physician orders and found no orders for hand splints. On 03/19/2026 at 9:02 AM, Surveyor interviewed Medication Assistant (MA) O who reported R2 no long wears hand splints due to refusals, I can't even remember the last time I saw [R2] use them. MDS assessment was completed on 12/17/25. The care plan was not revised to reflect R2's preference. FOOT CARE: Surveyor reviewed R2's electronic health records (EHR) and found R2 had a right below the knee amputation upon re-entry to the facility on [DATE]. MDS assessment was completed on 12/17/25. R2's care plan titled, ADL self-care deficit, with a revision date of 02/25/26, states to use blue protective boot on the right foot when in bed. Care plan titled, Endocrine system, notes to provide diabetic foot care and inspect feet daily. MDS assessment was completed on 12/17/25. The care plan was not revised timely to reflect R2's current needs. URINARY CATHETER: Surveyor reviewed R2's EHR and found that R2 had an indwelling Foley catheter placed on 5/9/25. R2's care plan titled, ADL self-care deficit, with a revision date of 02/25/26, states, TOILETING: Assist of 2 ASSIST WITH MALE URINAL TO AVOID FRICTION ON PLASTIC. R2's MDS dated [DATE] indicated R2 utilizes an indwelling Foley catheter. R2's care plan was not revised to reflect his current status. On 03/19/2026 at 9:16 AM, Surveyor interviewed [NAME] President of Success (VPS) I and explained the concerns listed above. VPS I stated, Looks like we need to do a better job updating the care plans. They should have removed the old information.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 1 resident reviewed (R7).Facility staff did not obtain weights and vitals prior to or after dialysis appointments on several occasionsFindings include:Facility Policy titled, Hemodialysis, last revised 09/10/23, reads in part: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goas and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis.The licensed nurse will communicate to the dialysis facility by utilizing the Pre-Dialysis Communication assessment, that will include.vital signs.documentation of weights.R7 was admitted to the facility on [DATE].R7's most recent Minimum Data Set (MDS) assessment reflects a Brief Interview for Mental Status (BIMS) score of 15/15, indicating no cognitive impairment.R7's pertinent diagnoses include acquired absence of kidney, chronic kidney disease stage 5, end stage renal disease, heart failure, history of malignant neoplasm of kidney, and dependence on renal dialysis.R7's pertinent physician orders include: Complete pre-dialysis assessment, print and send with resident to dialysis every Monday, Wednesday, and Friday. Vital signs weekly on day shift every Friday for shower day. Weekly weight (obtain reweight if change of 5 pounds since last weight) every Friday on day shift for shower day. Do not obtain blood pressure or blood draws on dialysis access site: left arm fistula.R7's care plan includes potential for weight fluctuations related to fluid status changes. Dependency on hemodialysis presence of fistula/graft/catheter related to chronic kidney disease end stage with intervention of record dry weights and report significant changes as ordered.Surveyor reviewed R7's Pre-dialysis assessments for February. Out of 12 days of dialysis, vital signs, minus blood pressure, were not completed prior to dialysis appointment. 7 of the 12 days there were no weights obtained. One pre-dialysis assessment was absent.Surveyor reviewed R7's Pre-dialysis assessments for March. Out of 7 days of dialysis, Vital signs, minus blood pressure, were not completed prior to dialysis. One day, no vitals signs, including blood pressure, were completed prior to dialysis appointment. 5 of the 7 dialysis days, no weight was obtained prior to appointment.Surveyor reviewed R7's post-dialysis assessments for February. Out of 12 days of dialysis, 3 assessments were absent. One day no weight was obtained after dialysis appointment.Surveyor reviewed R7's post-dialysis assessments for March. Out of 7 days of dialysis, no weight was obtained after dialysis appointment. On 03/04/26 there was an indication of an 11.4-pound weight loss. On 03/09/26, there was an indication of a 7.8-pound weight gain.Surveyor reviewed R7's Electronic Health Record (EHR). R7's orders indicate weekly weight and vital signs. Facility policy states both should be obtained before and after dialysis treatments which occur 3 times per week.On 03/19/26 at 12:56 PM, Surveyor interviewed Certified Nursing Assistant (CNA) M. CNA M stated R7 should have R7's weight obtained prior to dialysis appointments and on shower days. CNA M stated R7's vital signs should be obtained on dialysis days, and blood pressure every day.On 03/19/26 at 1:03 PM, Surveyor interviewed Registered Nurse (RN) S. RN S stated a full set of vital signs and weight should be completed on days of dialysis which are Monday, Wednesday, and Friday. RN S stated a pre-dialysis, and post-dialysis should be completed.On 03/19/26 at 1:07 PM, Surveyor interviewed Director of Nursing (DON) B. DON B stated it is the facility's expectation that nursing staff would obtain a full set of vital signs and weight before and after dialysis treatments. DON B stated there is a pre-dialysis assessment that gets completed and sent with R7 to R7's dialysis appointment. DON B stated there is a dialysis communication form that nursing staff completes, and monitoring in place for the fistula. It is DON B's expectation that all these tasks are completed.