STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525350	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health Services	702 W Dolf St Colby, WI 54421

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 - Immediate jeopardy to resident health or safety 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. (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not immediately report to the physician a significant decline in condition for 1 of 3 residents (R) reviewed for change of condition (R2).The facility did not immediately consult with the resident's physician regarding R2's significant change of condition on 07/13/25 at 3:00 PM until 07/14/25 at 1:52 PM, when R2 had a decline in cognition, developed an inability to communicate, had noted thick phlegm coming out of mouth, developed an inability to pivot transfer with assist of 2, and required use of a Hoyer lift for transfers, which ultimately required R2 to be transferred the emergency room (ER) and then to critical care for unresponsiveness, diaphoresis (excessive sweating), and bilateral crackle sounds noted in lungs. R2 was diagnosed with a Cerebrovascular Accident (CVA) (stroke) and pneumonia.The facility's failure to promptly consult with the physician about R2's change of condition, created a finding of immediate jeopardy that began on 7/13/25. Surveyor notified Nursing Home Administrator (NHA) A and Director of Nursing (DON) B of the immediate jeopardy on 08/06/25 at 10:01 AM. The immediate jeopardy was removed on 08/06/25; however, the deficient practice continues at a scope/severity level of D (isolated/potential for more than minimal harm) as the facility continues to implement its action plan. Findings include:Surveyor reviewed the facility protocol titled Change in Condition of the Resident, last revised on 09/20/22, which states in part, .References: Change in condition; When to report to the MD. Interact Version 4.5 tool states,Immediate notification with any symptom, sign, or apparent discomfort that is acute or sudden in onset and a marked change in relation to usual symptoms and signs or unrelieved by measures already prescribed.Vital signs:Report immediately: -if Systolic BP >200mmHg or <90mmHg, Diastolic >115mmHg -Abrupt significant change in cognitive function from usual, with or without altered level of consciousness. -Sudden change in level of consciousness or responsiveness. -Gait disturbances-Abrupt onset of slurred speech, or other new focal neurological findings. -Lung sounds-Abrupt onset of wheezing, rales, or rhonchi (new)-Dyspnea - Abrupt onset of SOB (shortness of breath) with pain, fever, or respiratory distress or with progressive leg edema.-Abrupt change in speech, with or without other focal neurological findings. -Walking difficulty-Acute onset accompanied by other neurological signs. Non-immediate reporting: -Diastolic BP >90mmHg -Persistent change from usual cognitive function with no criteria met for immediate notification. -Gradual change in level of consciousness not associated with other criteria for immediate notification.-Significant recent changes in gait without other symptoms or findings. -Recently progressive or persistent minor SOB without other symptoms. -Recent onset not resolving spontaneously.R2 was admitted to the facility on [DATE] with diagnoses including, in part, Parkinson's disease, muscle weakness, unsteady on feet, pyothorax without a fistula, pneumonitis, schizophrenia, and hypotension.R2's Minimum Data Set (MDS) assessment, dated 07/15/25, identified R2 required assistance from 1-2 people for bed mobility, taking on and off footwear, rolling left to right, sit to lying, chair to bed, toileting, and transfers. Surveyor reviewed R2's physician orders, which included:.-Monitor VS (vital signs) daily with special attention to blood pressure.-Continue IV antibiotics.-Reassess respiratory status and infection regularly. -Neurology consult.-Full Code. Surveyor reviewed R2's admission assessment, which states in part:-On 07/10/25, R2 did not have any swallowing issues presently. Alert and oriented to time, place, and person. Breath sounds were clear bilaterally. Vital signs are stable. R2's vital signs:On 07/10/25 at 3:47 PM, blood pressure (BP) 126/80, heart rate (HR) 85, and respirations 20. Surveyor reviewed R2's progress notes from 07/10/25-07/18/25:-Nurse daily skilled observation note:On 07/10/25 at 9:00 PM, a daily nurse assessment was conducted, indicating R2's respiratory status was even and regular, unlabored. R2's neuromuscular system had no issues. Progress notes from the Nurse Practitioner (NP): On 07/11/25 at 3:00 PM, NP visit today, the patient [R2] is seen lying in bed, appearing comfortable at rest. She is pleasant during the visit, providing only brief statements and yes or no responses. She tells me that she misses eating food, although she seems to understand the need for tube feeding due to dysphagia. She did experience nausea yesterday, and staff report that this seems to be relieved with as-needed Zofran. She is currently requiring supplemental O2 to maintain SpO2 greater than 90%. Vital signs have been stable, afebrile. There are no indications of increased shortness of breath, chest pain, fever, chills, diarrhea, constipation, dysuria or other urinary concerns. NP's physical examination: general- no acute distress, comfortable at rest. Respiratory- clear, no wheeze, no accessory muscle use. Musculoskeletal- no erythema, no increased warmth, no significant joint deformity. Neurological- cranial nerves grossly intact, able to move all four extremities, sensation intact

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility did not ensure 2 out of 3 residents (R) reviewed, (R2, R1), who had changes in condition were provided immediate care and treatment consistent with professional standards of practice (N6, Wisconsin Nurse Practice Act) for neurological/comprehensive assessments. The facility did not perform neurological assessments from 07/12/25 at 10:46 AM until 07/14/25 at 1:52 PM, when R2 had a decline in cognition, developed an inability to communicate, had noted thick phlegm coming out of mouth, developed an inability to pivot transfer with assist of 2 and required use of Hoyer lift for transfers, which ultimately required R2 to be transferred to the emergency room (ER) and then to critical care for unresponsiveness, diaphoresis, and bilateral crackle sounds noted in lungs. R2 was diagnosed with a Cerebrovascular Accident (CVA) (stroke) and pneumonia. While at the hospital, R2 suffered cardiac arrest and is now intubated and on a ventilator.The facility's failure to provide immediate care and treatment for a resident who displayed changes in condition from 07/12/25 until 07/14/25, created serious harm for R2, which created a finding of immediate jeopardy that began on 07/12/25. Nursing Home Administrator (NHA) A and Director of Nursing (DON) B were notified of the immediate jeopardy on 08/06/25 at 10:01 AM. The immediate jeopardy was removed on 08/06/25; however, the deficient practice continues at a scope/severity level of G as the facility continues to implement its removal plan and as evidenced by the following example: The facility did not assess R1 for a decline in cognition and noted reddened penis with purulent drainage from the tip of R1's penis. R1 became unresponsive on 7/14/25 and was transferred to critical care, diagnosed with a urinary tract infection, hypotension (low blood pressure) and decreased oxygen levels. Findings include:Surveyor reviewed the facility protocol titled Change in Condition of the Resident, last revised on 09/20/22, which states in part, When a resident presents with a possible change of condition, such as fall or noted changes in mental or physical functioning:1. Assess the resident's need for immediate care/medical attention. Provide emergency care as needed. 2. Assess/evaluate the resident: This assessment could include, but is not limited to the following: A. Vital signs, oxygen saturation, blood glucose level C. Swelling, edema, discoloration. E. Personality, behavioral, and/or cognitive changes F. Alteration in level of consciousness, ability to respond.H. Sensory weakness or change I. Generalized or localized weakness J. Speech disorder K. Gait, posture, or balance changeM. Reflexes, response to stimuli, neurological signs Q. Dyspnea, or irregular breathing 3. Notify the resident's physician of any use-interaction change in condition. a. Immediate notification: for any symptom, sign of apparent discomfort that is: i. Acute or sudden in onset, and ii. A marked change in relation to usual symptoms and signs, or iii. unrelieved by measures already prescribed requires a phone call to the provider.5. Monitor the resident's condition frequently until stable or transported to a higher level of care if needed. 6. Ensure the resident's condition is included on the 24-hour report to be reviewed later by the IDT. According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis.A nurse conducting a neurological assessment should systematically evaluate the patient's mental status, cranial nerves, motor function, sensory function, coordination, and reflexes. Key actions include assessing the level of consciousness, orientation, pupil reaction, muscle strength, gait, sensation, balance, and performing specific tests for coordination and reflexes.Example 1:R2 was admitted to the facility on [DATE] with diagnoses including, in part, Parkinson's disease, muscle weakness, unsteady on feet, pyothorax without a fistula, pneumonitis, schizophrenia, and hypotension. R2's Minimum Data Set (MDS) assessment, dated 07/15/25, identified R2 required assistance from 1-2 people for bed mobility, taking on and off footwear, rolling left to right, sit to lying, chair to bed