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	05/21/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49353 Based on observation, interview and record review, the facility failed to ensure residents received care and treatment in accordance with professional standards of practice for 2 of 15 residents (R) reviewed for quality of care (R34, R29). R34 did not receive adequate assessment and monitoring of edema associated with congestive heart failure (CHF) per current professional standards of practice. R29 did not receive adequate assessment and monitoring of cellulitis per current professional standards of practice. This is evidenced by: Example 1 According to the National Institutes of Health (NIH) Congestive Heart Failure (CHF): Nursing Diagnosis, 2023, indicates nurse assessment of CHF is to assess current symptoms such as dyspnea, fatigue, orthopnea, peripheral edema, vital signs, cardiovascular examination such as abnormal heart sounds, jugular venous distention. Respiratory examination such as auscultate lung sounds for crackles or wheezing and assess respiratory effort, daily weights, edema assessments, dietary habits, weight changes, medication adherence and any side effects related to diuretics or blood pressure medications, and assess emotional well-being related to potential anxiety or depression related to the chronic nature of CHF. According to National Institutes of Health, 2020, edema assessments should include visual inspection, palpation, and circumference and length measurement of the edema present on a routine basis to monitor for worsening. Circumference measurements of the lower extremity edema should be measured at two points, the maximum circumference of calf and ankle, and mark above the measurement line to ensure repeat measurements are accurate. The height of the edema should be marked to note if edema increases beyond initial measurement. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the American Heart Association and the Heart Failure Society of America, 2015, Heart Failure Management in Skilled Nursing Facilities Recommendation Guidelines include identifying residents at low or high risk for exacerbation and implement standing order/assessment guidelines to document weight goals, vital signs (including orthostatic blood pressures), heart failure (HF) medications, medications to avoid (eg, nonsteroidal anti-inflammatory drugs), and patient/family education. Nursing staff should have advanced training in fluid volume assessments, HF medications, assessment of exacerbations, and when to notify the provider regarding changes in condition or weight. Patients at risk for exacerbation should have daily weights, with a gain of 3-5 lbs over 3 to 5 days reported to provider, advanced assessment of volume status, vital signs and oxygen saturation completed daily. R34 was admitted to the facility on [DATE] with pertinent diagnoses of right knee effusion, diastolic congestive heart failure, atrial fibrillation, and farmer's lung. R34's admission Minimum Data Set (MDS) assessment dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 15/15 indicating cognition intact, had shortness of breath with exertion and lying flat, and had impaired range of motion on one lower extremity. R34's care plan, dated 04/30/25, states: Will be free of complications related to edema/excess fluid volume with interventions of reporting signs and symptoms of edema/fluid overload, such as change in mental status, weight gain, neck vein distention, abnormal lung sound, extremity swelling . Will maintain adequate hydration with interventions of monitoring for poor skin turgor and decreased urine output . Will exhibit no acute cardiac distress with interventions to obtain weights as ordered. Of note: Lung sound assessments were not completed on a routine basis or with changes, urine output was not monitored, and weights were not completed per order. R34's physician orders: 04/30/25 Weight - on admit, daily x2, weekly x3, monthly. Obtain reweight if change of 5 lbs. since last weight. 05/14/25 Furosemide Oral Tablet 40 MG (Furosemide) Give 1 tablet by mouth one time a day for CHF AND Give 1 tablet by mouth one time a day for CHF for 1 Day 05/15/25 Daily weight one time a day for CHF 05/16/25 Apply Tubi grips to BLE - on every morning; remove at bedtime for edema 05/17/25 Spironolactone Oral Tablet 25 MG Give 1 tablet by mouth one time a day for CHF R34's weights: 04/30/25 165.1 lbs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/02/25 163.1 lbs. 05/03/25 164.1 lbs. 05/14/25 177.2 lbs. 05/15/25 177.8 lbs. 05/16/25 180.4 lbs. 05/17/25 178.1 lbs. 05/18/25 179.2 lbs. 05/19/25 178.4 lbs. 05/20/25 179.6 lbs. Of note: No weight was documented for 10 consecutive days between 05/04/25 - 05/13/25. Provider was notified on 05/14/25 of the 13.1 lb increase in weight. Surveyor reviewed R34's daily assessments and noted the following: 04/30/25: Lungs clear, heart regular; +2 edema to RLE and +1 edema to LLE. Pedal pulses equal and normal. 05/01/25 - 05/13/25: Respiratory: Regular/unlabored. No edema noted. No lung sound assessment noted. No pedal pulses assessment noted. 05/14/25: +2 BLE edema. Respiratory: Regular/unlabored. No lung sound assessment noted. No pedal pulses assessment noted. 05/15/25: +2 BLE edema. Respiratory: Regular/unlabored. No lung sound assessment noted. No pedal pulses assessment noted. 05/16/25: BLE edema. Respiratory: Regular/unlabored. No lung sound assessment noted. No pedal pulses assessment noted. 05/17/25: +2 BLE edema. Respiratory: Regular/unlabored. No lung sound assessment noted. No pedal pulses assessment noted. 05/18/25: +2 BLE edema. Respiratory: Regular/unlabored. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No lung sound assessment noted. No pedal pulses assessment noted. 05/19/25: +1-2 BLE edema. Respiratory: Regular/unlabored. No lung sound assessment noted. No pedal pulses assessment noted. 05/20/25: No edema noted. Respiratory: Regular/unlabored. Lung sounds clear. No pedal pulses assessment noted. Of note: Edema assessments reviewed did not include circumference and length measurements or skin temperature. Surveyor reviewed R34's provider notes and noted the following: 05/01/25: Respiratory assessment - clear, no wheeze, no accessory muscle use. Cardiovascular assessment - irregular rate and rhythm, no murmur, lower extremities without edema. Denies increased shortness of breath while at rest 05/07/25: Respiratory assessment - clear, no wheeze, no accessory muscle use. Cardiovascular assessment - irregular rate and rhythm, no murmur, lower extremities without edema. Vital signs have been stable. Denies increased shortness of breath while at rest. 05/14/25: Of concern, patient has 2+ edema noted to BLEs today. Weight is up over 10 pounds over the past several days as well. He reports symptoms of paroxysmal nocturnal dyspnea and increased nocturia, as well as cough with whitish sputum production. Denies shortness of breath at rest. Discussed with nursing staff. Cardiovascular assessment - irregular rate and rhythm, no murmur, lower extremities with 2+ edema. Respiratory assessment - clear, no wheeze, no accessory muscle use. New orders: - order CBC, BMP, and BMP around 05/21/25. - daily weights to monitor fluid status, response to furosemide and spironolactone. - referral to Heart Failure clinic. Of note: Daily weights completed per order starting 05/14/25. Heart Failure clinic appointment scheduled for 05/22/23 at 1:30 PM. 05/16/25: Patient continues to have 2-3+ edema to BLEs. Lung sounds are clear and denies increased respiratory distress. Assessment and Plan - Adding furosemide 20 mg at 12:00 PM x5 days. Increase spironolactone from 12.5 mg to 25 mg daily. Continuing furosemide 40 mg daily. Monitor for worsening edema, weight gain, increased dyspnea, orthopnea, decreased exercise tolerance, and signs of fluid overload. Daily weights essential to track response to diuretic therapy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Of note: Medication orders were implemented 05/16/25. No additional edema monitoring was noted in assessments. No orders were implemented to monitor fluid intake or output. On 05/19/25 at 9:42 AM, Surveyor observed R34 sitting in recliner in room. R34 was observed wearing gripper socks and Tubi grips in place with 3+ BLE, pitting edema. R34's socks and Tubi grip were rippled in various areas demonstrating pitting areas on top of both feet and ankles. R34's feet were flat on the floor. R34's raised pant leg was just below knee and Surveyor observed the top of Tubi grip rolled down creating a deep indentation in upper calf. R34's edema extended to just below knee on both legs. On 05/20/25 at 6:51 AM, Surveyor observed R34 ambulating independently with feet in wheelchair in hallway. R34 had gripper socks and Tubi grips on with 3+ BLE, pitting edema just behind toes, on top of feet, and extending into calf. On 05/20/25 at 10:46 AM, Surveyor interviewed Certified Nursing Assistant (CNA) G regarding Tubi grips. CNA G stated that CNAs typically apply and remove Tubi grips and sizing is determined by the nurse. CNA G was unable to state what size Tubi grip R34 was wearing. On 05/20/25 at 2:43 PM, Surveyor interviewed Registered Nurse (RN) E regarding Tubi grip assessment and sizing. RN E stated there are a couple different options available for sizes in Tubi grips and the nurse determines which size to pick based on visual inspection. Surveyor asked RN E if measurements of any kind were used to assess for Tubi grip size. RN E stated no. Surveyor asked which size Tubi grip R34 was wearing. RN E stated not knowing for sure, but that most of the nurses typically use the same size for everyone. On 05/21/25 at 10:15 AM, Surveyor interviewed Licensed Practical Nurse (LPN) H regarding edema assessments and Tubi grips. LPN H stated no standard of practice being in place for HF and edema related to assessments. LPN H stated that weights, vital signs, intake/output monitoring frequency are determined by the provider. LPN H stated lung sounds are only typically assessed if there is a change observed in fluid or respiratory status. Surveyor asked how edema is monitored for worsening. LPN H stated by weight gain or increase in size. Surveyor asked how size is determined. LPN H stated using the pitting scale of 0-4. Surveyor asked if nursing staff do any kind of circumference measurement to assess and monitor edema. LPN H stated no. On 05/21/25 at 10:30 AM, Surveyor interviewed RN F regarding edema assessments and Tubi grips. Surveyor asked RN F how fluid volume is assessed and monitored in residents with CHF and edema. RN F stated they would typically do daily weights and monitor intake and output. Surveyor asked RN F if this was being completed for R34. RN F stated daily weights were started on 05/14/24, but no intake and output monitoring has been completed. Surveyor asked why this was not being monitored. RN F stated because the provider did not order it. Surveyor asked RN F how Tubi grips are assessed for fit and efficacy. RN F stated that it should be flat on the skin with no ripples, lay just behind the toes and reach just below the knee. RN F stated that once Tubi grips are cut from the box and placed on a resident, no assessment of the Tubi grip is completed to assess for compression. Surveyor asked RN F how long a Tubi grip can be used. RN F was not sure. Surveyor asked RN F what size Tubi grip was being used for R34. RN F stated not knowing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/25 at 10:40 AM, Surveyor interviewed LPN H and RN F regarding manufacturer's recommendation for Tubi grip size and length of use. RN F provided Surveyor with the Mediline Tubi grip packages of sizes E and G. Surveyor noted the manufacturer's instructions: 1) Measure the area with the largest circumference. Use the sizing chart to determine the appropriate sized bandage to deliver the desired compression and cut to desired length. Further instructions state, Change Frequency: up to 7 days. Surveyor asked LPN H and RN F if they were aware of these instructions. Both LPN H and RN F stated no, they had never read these instructions before. On 05/21/25 at 2:01 PM, Surveyor interviewed Director of Nursing (DON) B regarding edema assessments. DON B stated that no current standard of practice is in place for assessing and monitoring edema and all assessments completed are per provider order. Surveyor asked DON B if she was aware of the current standard of practice to assess edema using circumference measurements, assessing lung sounds, monitoring daily weights, and intake and output. DON B stated that she was not aware of the circumference measurements, but the other assessments are only completed if the provider orders to do so. Surveyor asked DON B if she was aware that the Tubi grip manufacturer's recommendation is to complete a circumference measurement and choose a size based on the measurement. DON B stated not being aware of this. DON B stated acknowledgment the facility's current practice in assessing and monitoring did not follow current professional standards of practice and had the potential of negatively affecting resident's outcomes. Example 2 According to National Institutes of Health, 2023, Cellulitis management includes thoroughly inspecting the affected area for any signs of skin breakdown. The area should be demarcated with a marker to monitor for continuous spread. The area should be palpated to note any presence of warmth, tenderness, or purulent drainage. R29 was admitted to the facility on [DATE] with pertinent diagnoses of dementia, anemia, and hypertensive chronic kidney disease stage 3. R29's most recent quarterly MDS assessment dated [DATE] noted a BIMS score of 08 indicating moderate cognitive impairment and infection of the foot is present. R29's care plan states: ADL self-care performance deficit with interventions of skin inspection completed weekly and daily with cares. Observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. Check nail length, trim, and clean on bath day and as necessary. Of note: Facility was unable to provide documentation of nail care and inspection on bath day. R29's provider orders: 05/14/25 Doxycycline Hyclate Oral Tablet 100 MG (Doxycycline Hyclate). Give 1 tablet by mouth two times a day for left great toe infection for 7 Days. 05/14/25 Warm soapy water soak 15 minutes 2 times daily. Surveyor reviewed R29's progress notes and noted the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/12/25 Note: RN trimmed R29's toenails. R29 stated that his left great toe nail was hurting. Nails are thick. After pressing down on the nail, a small amount of purulent drainage was noted and toe is warm and red. NP notified. No new orders. R29 is on the list to see podiatry in 1 week for nail evaluation and trim. Of note: Podiatry assessed R29 on 05/19/25. No new orders received. Surveyor found no documentation of redness, tenderness, drainage, wounds, or signs of infection by nursing prior to 05/14/25 or after. Surveyor reviewed R29's provider notes and noted the following: 05/14/25 - R29 is being seen today due to staff reports of left great toenail pain. Reports continued pain to left great toenail, and (particularly when comparing to other foot) there is erythema noted to left toes and distal portion of foot. He experiences pain with slight manipulation of toenail, which has significant onychomycosis. Vital signs have been stable, afebrile. Denies chest pain, fever, chills, nausea, vomiting, diarrhea, constipation, dysuria or other urinary concerns. Extremities - no lower extremity edema bilaterally, no clubbing or cyanosis, erythema noted to left toes and distal portion of foot, pain with slight manipulation of left great toenail, significant onychomycosis of left great toenail and other toenails. Assessment and Plan - Cellulitis of left toe - Started doxycycline 100 mg twice daily for 7 days. Recommended warm soapy water soaks for 15 minutes twice daily and Band-Aid application to toenail per patient's request. Monitor for spreading erythema, increased pain, fever, or purulent drainage that would indicate worsening infection requiring IV antibiotics. Of note: No documentation of erythema monitoring noted in nursing documentation following this note on 05/14/25. On 05/21/25 at 9:32 AM, Surveyor observed R29's left foot. The left great toe was edematous. Redness seen on top of foot approximately 1 inch below toes spreading to great toe, 2nd, 3rd, and 4th toes. All toenails were yellow in color, thickened and raised. Great toenail was approximately 1/4 inch thick. No purulent drainage noted. Patchy areas noted on top of foot between great toe and second toe. R29 denied pain at this time, but stated it comes and goes. No markings on foot were observed noting where erythema was being monitored. On 05/21/25 at 10:37 AM, Surveyor interviewed RN F regarding cellulitis assessments. RN F stated a progress note should be completed assessing skin condition (color, temp, etc.) in by nurse each shift. Surveyor asked RN F how to assess for improvement/worsening of cellulitis. RN F stated that a line is sometimes drawn and then monitored, but the NP would usually be the one to start this. Surveyor asked RN F if marking the red area would be expected to monitor for worsening. RN F stated that it is not expected as part of assessment but recognizes why that would be important. (continued on next page)

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	525350	A. Building B. Wing	05/21/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/25 at 12:41 PM, Surveyor interviewed DON B regarding cellulitis assessments. DON B stated not having a standard of practice in place and assessment and monitoring is ordered by the provider. DON B stated that staff are expected to assess residents daily and document findings that are abnormal. Surveyor asked DON B if it would be expected to see documentation of R29's skin assessment in relation to recent diagnosis of cellulitis. DON B stated yes, staff should be documenting redness, swelling, discharge/drainage, tenderness/pain, vital signs, fever, edema, and whatever the provider orders to monitor. Surveyor asked DON B if staff would be expected to mark the area of redness to monitor if it was worsening. DON B stated no, unless the provider orders it. Surveyor asked DON B if she was aware that current standards of practice recommend marking the area to monitor the spread of infection as this also helps evaluate antibiotic efficacy. DON B stated no, that they rely on the provider's judgement to determine what assessments and monitoring should be completed per current standards.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record review, the facility did not provide pharmaceutical services including procedures that ensure the accurate acquiring/accounting for, receiving, dispensing, administering and reconciliation of all drugs and biologicals to meet the needs of each resident for residents (R) R49, R113 and R262. Findings include: Example 1 Surveyor reviewed facility policy titled, Disposal of Medications, dated as revised in January 2024, stated in part, .1. Discontinued medications and/or medications left in the nursing care center after a resident's discharge, which do not qualify for return to the pharmacy, are identified and removed from current medication supply in a timely manner according to state and federal regulations for disposition . On 05/19/25 at 10:07 AM, Surveyor toured medication storage room on 400 hall with Registered Nurse (RN) E. Surveyor observed a locked narcotic box located on the wall. Surveyor asked RN E if RN E could unlock box and Surveyor assess what is in the locked narcotic box. Surveyor observed R49's Butalbital bottle with 24 capsules noted in the bottle. Surveyor observed R113's Oxycodone 5mg tabs pack with quantity of 30 tabs located in pack sitting in the locked narcotic box on wall in medication storage room. On 05/19/25 at 10:17 AM, Surveyor interviewed RN E and asked RN E if R49 and R113 are still residents in the building. RN E indicated R49 and R113 are no longer residents in the building. R113 was discharged over a week ago from the facility. Surveyor asked RN E what the process is for narcotics left in the locked box after residents are discharged from the facility or passed away. RN E indicated RN E knows two licensed staff members are supposed to destruct the narcotics after resident is discharged and RN E stated RN E is unsure why these medications have not been destroyed. RN E stated RN E will complete this now. On 05/19/25 at 1:27 PM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked what the process is for narcotic storage after a resident has been discharged from facility. NHA A stated NHA A understands there were two residents, R49 and R113, who were discharged over a week ago. NHA A stated nursing staff should have destroyed these medications right after residents were discharged . NHA A stated two nurses are destroying the narcotics right now, and NHA A is placing education out to staff about not storing narcotics past the time the residents have been discharged from the facility. 49353 Example 2 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Wisconsin Nurse Practice Act, a licensed nurse must administer medications according to the licensed prescriber's order of dosage, route, frequency, and duration. Administering medications without an order is a violation of the nursing scope of practice and prohibited by law. R262 was admitted to the facility on [DATE] with pertinent diagnoses of Alzheimer's disease and dementia with behavioral disturbance. R262's physician orders: 04/25/25 alprazolam oral tab 0.25mg (Alprazolam) Give 1 tab orally every 8 hours as needed (PRN) for anxiety. Surveyor reviewed R262's progress notes and noted: 05/09/25 8:40PM, Clinical follow-up note - R262 was exit seeking and trying to self-transfer. 1/2 tablet of PRN Alprazolam given per family request. Surveyor reviewed R262's medication administration record (MAR) and noted: On 05/09/25 at 6:42 PM, physician ordered dose of Alprazolam 0.25 mg was documented as administered with attached note stating resident exit seeking and trying to self-transfer. 1/2 tablet of PRN Alprazolam given per family request. Result: Effective. On 05/21/25 at 2:01 PM, Surveyor interviewed Director of Nursing (DON) B regarding this medication administration. DON B stated yes, that a half dose was administered. Surveyor asked DON B if there was a provider order to give this dose. DON B was unable to locate an order. Surveyor asked DON B if this would be an acceptable practice for nursing staff to administer a medication in a dosage different than prescribed. DON B stated yes, residents have the right to determine what medication dosage they want to take. Surveyor asked DON B if DON B was aware this is not an acceptable practice as it is outside a nurse's scope of practice. DON B acknowledged that a nurse should not administer medications outside of a prescriber's order, and the provider should be contacted for an order to administer medications in a different dosage.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 48793 Based on observation, record review and interview, the facility did not ensure a medication error rate of 5% or less for 2 of 5 residents (R32 and R50) observed for medication administration. The facility had 37 opportunities and 2 medication errors resulting in a 5.41% error rate. Licensed Practical Nurse (LPN) D administered two different inhalers in the wrong sequence for R32. LPN D administered Carafate after breakfast for R50. This is evidenced by: Facility policy titled, Oral inhalations dated January 2023, stated in part, .Inhaler Sequencing: 1. Bronchodilators/Beta Agonists-administer first if more than one inhaler to be administered at the same med pass time. a. These agents work by promoting bronchodilation which relaxes bronchial smooth muscle. 2. Anticholinergic Agents a. Antagonizes the action of acetylcholine with resulting bronchodilation 4. Corticosteroids-administer last if more than one inhaler to be administered at the same med pass time . Example 1 On 05/20/25 at 7:53 AM, Surveyor observed LPN D administer R32's Fluticasone Propionate inhaler as the second inhaler, which is a Corticosteroid based inhaler, out of 3 inhalers administered during R32's medication pass. LPN D then waited 5 minutes and administered R32's Anor Ellipta inhaler which is an Anticholinergic based inhaler. On 05/20/25 at 12:31 PM, Surveyor interviewed LPN D and asked LPN D what the facility process is for sequencing inhalers when using multiple inhalers. LPN D stated LPN D tried to sequence the right way but was unsure which inhaler went second and third. Surveyor informed LPN D beta agonists such as Albuterol was administered correctly as the first inhaler but the second inhaler for R32 should have been the Anticholinergic inhaler (Anor Ellipta) and then the Corticosteroid inhaler (Fluticasone propionate). LPN D stated LPN D should have double checked this before administering inhalers. On 05/20/25 at 12:40 PM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked NHA A what the expectation is for sequencing inhalers when using multiple inhalers. NHA A stated LPN D should be following the facility policy which indicates beta agonists such as Albuterol was administered correctly but the second inhaler for R32 should have been the Anticholinergic inhaler (Anor Ellipta) and then the Corticosteroid inhaler (Fluticasone propionate) last. (continued on next page)

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	05/21/2025

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

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 2 Surveyor reviewed R50's physician orders that state in part, .-On 03/25/25, Carafate Oral Suspension 1 GM/10ML (Sucralfate)-Give 10 ml orally two times a day for small intestines Arteriovenous malformations (AVMs). Give before meals . On 05/20/25 at 8:01 AM, Surveyor observed LPN D administer Carafate 10mls to R50 during medication pass. Surveyor observed R50's breakfast tray was empty, and a Certified Nurse Assistant (CNA) came into R50's room and took R50's breakfast tray while LPN D was administering Carafate. On 05/20/25 at 8:06 AM, Surveyor interviewed LPN D and asked LPN D if R50's Carafate was to be given before breakfast or after breakfast. LPN D stated physician orders for R50 do say give before breakfast. LPN D stated LPN D should have gotten into R50's room before now but LPN D did not. On 05/20/25 at 12:40 PM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked NHA A what the expectation is for administering Carafate to R50 before meals to help coat the stomach as intended use is for. NHA A stated LPN D should follow the physician orders for Carafate use with R50.

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	05/21/2025

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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 - Few	Provide and implement an infection prevention and control program. 30570 Based on observation, interview and record review, the facility staff did not implement infection control practices when warranted. Facility staff did not perform hand hygiene when warranted during care affecting 1 of 7 residents (R) observed for care (R19). Insulin pens were not disinfected for 2 of 2 observations for R6. This is evidenced by: Example 1 Surveyor requested and received the facility policy titled Hand Hygiene dated 11/02/2022. The policy in part read: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility. Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards practice. 2. Hand hygiene is indicated and will be performed under conditions listed in, but not limited to. the attached hand hygiene table. Additional Considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves; perform hand hygiene prior to donning gloves, and after immediately after removing gloves. Hand Hygiene Table: ~Before applying and after removing personal protective equipment (PPE), including gloves. ~After assistance with personal body functions . Facility policy titled Subcutaneous Insulin, dated revised in January 2023, stated in part, .Procedures: #9. Prepare Injection: c. Swab rubber cap with antimicrobial agent . (continued on next page)

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	05/21/2025

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

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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 - Few	On 5/20/25 at 7:03 AM, Surveyor observed Certified Nursing Assistant (CNA) C provide morning care for R19. CNA C entered R19's room, proceeded to R19's closet to obtain clothes, obtain a clean brief, and gather care supplies that were brought to R19's bed. CNA C did not perform hand hygiene prior to handling R19's clean clothing and clean brief. CNA C went to R19's sink and performed hand hygiene, donned gloves to wet a washcloth and apply soap to a cloth. CNA C washed and dried R19's upper body, applied deodorant and donned a clean shirt. CNA C returned to the sink and wet a cloth and applied soap to wash R19's peri area. CNA C removed her gloves and proceeded to dress R19 with a clean brief, clean pants, and clean socks. CNA C did not perform hand hygiene after she removed her contaminated gloves and proceeded to dress R19 with clean brief and clothing. On 5/20/25 at 7:17 AM, Surveyor interviewed CNA C about the observation. CNA C expressed she should have washed her hands when gloves were removed after peri care and before proceeding to touch clean items. CNA C further expressed hand hygiene is important for infection control. On 5/21/25 at 9:43 AM, Surveyor interviewed Director of Nursing (DON) B regarding the expectation of staff hand hygiene when entering resident rooms for care and when removing gloves after performing peri care. DON B expressed she would expect staff to perform hand hygiene when entering resident rooms to assist with care. DON B further expressed she would expect staff to perform hand hygiene when removing gloves after peri care and before proceeding with dressing resident with clean clothing. 48793 Example 2 On 05/20/25 at 7:45 AM, Surveyor observed Registered Nurse (RN) E prep R6's Humalog pen 13 units and Lantus pen 42 units. Surveyor did not observe RN E cleanse tip of rubber on insulin pens to sanitize the tip before applying the needle and administering insulin in R6's lower left quadrant of abdomen. On 05/20/25 at 12:26 PM, Surveyor interviewed RN E and asked what the process is for sanitizing insulin pens. Surveyor stated to LPN E that Surveyor did not observe RN E sanitize the rubber cap on insulin pen with a microbial agent before applying the insulin needle and administering insulin to R6. RN E stated RN E did forget to sanitize the rubber tips of insulin pens with an alcohol pad. RN E stated RN E should have sanitized before administering to R6. On 05/20/25 at 12:40 PM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked NHA A what the expectation is for sanitizing insulin pens. NHA A stated facility policy indicates the rubber caps be sanitized before applying insulin needle to insulin pens for administration.