

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Colonial Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 interview, the facility did not store and follow proper sanitation and food handling practices to prevent foodborne illnesses for 50 residents who consume food out of 51 residents who reside at facility. -The facility's resident refrigerator had food items brought in by family/visitors that were not labeled with resident names, content, or dated which could affect 50 of 51 residents at facility who consume food and this could lead to foodborne illnesses.-The facility's resident refrigerator had food items brought in by residents' families that were not dated for 3 residents (R16, R31, R38) of a possible 50 residents who may use refrigerator to store food. A plastic container of what appeared to be a pasta with meat soup or hotdish with R31's name, was not labeled with content or brought in date. -A plastic container labeled as stir fry with R38's name on it, was not labeled with a brought in or opened date. -A plastic container labeled as chicken soup with R16's name on it, was not labeled with a brought in or opened date. This could lead to foodborne illnesses.-Dietary staff transferred foods to the steam table using hand towels instead of oven mitts, dragging the towels through uncovered pans of food already in steam table which could affect 50 of 51 residents at facility who consume food. This food contamination could lead to a foodborne illness.-Dietary staff did not use proper sanitization techniques when temping foods in steam table prior to serving foods which could affect 50 of 51 residents at facility who consume food and lead to a foodborne illness.Findings include: The facility policy, titled Use and Storage of Food Brought in by Family or Visitors, dated 12/14/2022, states, All food items that are already prepared by the family or visitor brought in must be labeled with content and dated.The prepared food should be consumed by the resident within 3 days.If not consumed within 3 days, food should be disposed of by facility staff.The facility policy, titled General Food Preparation and Handling, last revised 08/16/2022, states, Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination.On 07/06/2026 at 9:40 AM, Surveyor observed resident refrigerator located in a common area had the following:-An opened package of prosciutto without a resident name and not dated when opened. -An opened package of sourdough bread without a resident name and not dated when it was opened. -An opened bottle of V-8 juice without a resident name. Bottle of V-8 had a opened date of 06/30/2026. -An opened package of hard-boiled eggs without a resident name and not dated when opened. The manufacturer expiration date on the package was 07/04/2026. -A plastic container of what appeared to be a pasta with meat soup or hotdish with R31's name, was not labeled with content or brought in date. -A plastic container labeled as stir fry with R38's name on it, without a brought in or opened date. -A plastic container labeled as chicken soup with R16's name on it, without a brought in or opened date. -Signage on door of refrigerator informing staff/family/visitors that all foods brought in should be labeled with resident names, content, and dated when opened. After 3 days from date of (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	food, those foods will be disposed of by facility staff. On 07/06/2026 at 10:10 AM, Surveyor observed Dietary Manager (DM) D going through the resident refrigerator attempting to label and date foods listed above. DM D was observed by Surveyor going to specific resident rooms asking them when foods were brought in by their family members. On 07/06/2026 at 10:10 AM, Surveyor interviewed DM D and asked what facility protocol was for foods brought in by family/visitors for residents and stored in resident refrigerator. DM D stated all foods needed to be labeled with resident's names and dated when opened. DM D stated after 3 days of opened date, a food item was disposed of. DM D stated they check the refrigerator every Monday morning when they come and make sure foods brought in over the weekend are labeled and dated. DM D stated if foods with resident names are not dated, they ask the residents when the food was brought in for them, then dates the food according to what residents state. Surveyor asked DM D if the refrigerator was all staff's responsibility to monitor and DM D confirmed it was. Surveyor asked DM D who checks the food items in refrigerator when they are not there, and DM D stated they were not aware anyone did. On 07/06/2026 at 11:23 AM, Surveyor observed dietary cook (DC) G check temperatures on food for the lunch meal: -DC G did not sanitize the thermometer with alcohol wipe prior to inserting thermometer into a pan of gravy. -DC G did not remove the foil or plastic wrap coverings on the gravy, chicken fried steaks, baked spaghetti, carrots, puree steak, puree carrots and mashed potatoes prior to inserting the thermometer. DC G inserted the thermometer through the food coverings and wiggled thermometer around one spot to check food temps. -DC G did not stir foods prior to checking food temperatures. On 07/06/2026 at 11:30 AM, Surveyor observed DC G remove foil covering on gravy, pick up hand towels lying on a countertop surface nearby, and using a hand towel on each side of the pan, transfer the pan of gravy to the steam table. The hand towels touched inside surface of gravy pan. In the process of placing the gravy pan into the steam table, both hand towels drug over the top of the uncovered pans containing chicken fried steaks and potatoes. The towels came into direct contact with the chicken fried steaks and potatoes. DC G informed Surveyor she could not locate oven mitts. On 07/07/2026 at 9:50 AM, Surveyor interviewed DM D about what the proper technique was for staff to measure temperatures of foods prior to serving. DM D stated the thermometer should be wiped with alcohol before, in between, and after temping foods. Foods should be stirred first, then the thermometer should rest in the food for a minimum of 15 seconds for accurate temperatures. DM D confirmed to Surveyor all foods should have the foil and plastic wrap coverings removed prior to temping and the thermometer should not pass through these as this could cause food contamination. Surveyor asked DM D if using hand towels to handle hot pans of food was appropriate, and DM D stated there were oven mitts available for dietary to use. However, at times the oven mitts are dirty in laundry and there may not be any clean ones available for staff to use by claiming it takes laundry forever sometimes to get them back to us.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure residents (R) were notified of the specific reason for transfer/discharge, in writing to the resident or their representative. This occurred for 4 of 5 residents (R2, R3, R28, and R52) reviewed for hospitalization, out of a sample of 13 residents. -R2 was transferred to the hospital on 3/22/26. A written notice of transfer was not completed.-R3 was transferred to the hospital on [DATE], 11/8/25, and 7/5/26. A written notice of transfer with specific reason for transfer was not completed for all 3 days. -R28 was transferred to the hospital on 1/17/26, 2/3/26, and 3/19/26. A written notice of transfer with specific reason for transfer was not completed for all 3 dates. -R52 was transferred to the hospital on 3/11/26. A written notice of transfer with specific reason for transfer was not completed. This is evidenced by: The facility policy titled, Transfer and Discharge, dated 7/15/22, states in part: 7. Emergency Transfers/Discharges. g. Provide orientation for transfer or discharge to minimize anxiety and to ensure safe and orderly transfer or discharge, in a form and manner that the resident can understand. i. Provide a notice of the resident's bed hold policy to the resident and representative at time of transfer, as possible, but no later than 24 hours of the transfer. The State Operations Manual (SOM), section 42 CFR 483.15(c)(5) Contents of the Notice states in part: The facility's notice must include all of the following at the time notice is provided: The specific reason for the transfer or discharge, the basis under 483.15(c)(1)(i)(A)-(F) Example 1 R2 was admitted to the facility on [DATE], with diagnoses including vascular dementia, depression, arthritis, history of right hip fracture, and a hip replacement. R2's Minimum Data Set (MDS) assessment, dated 4/10/26, documents the facility's inability to complete a Brief Interview for Mental Status (BIMS). This indicates R2 is severely impaired cognitively. On 03/22/26, R2 was transferred to the hospital due to pain after a fall. R2's 3/22/26 notice of transfer to the hospital had a general statement of, The transfer or discharge (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R28's 1/23/26 notice of transfer to the hospital had a general statement of, The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, including hospital transfer. The form did not indicate the specific reason the resident required the transfer. R28 was transferred to the hospital on 2/3/26 for nausea, vomiting, and concern with bowel obstruction. R28's 2/3/26 notice of transfer to the hospital had a general statement of, The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, including hospital transfer. The form did not indicate the specific reason the resident required the transfer. R28 was transferred to the hospital on 3/19/26 for nausea, vomiting, and concern with bowel obstruction. R28's 3/19/26 notice of transfer to the hospital had a general statement of, The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, including hospital transfer. The form did not indicate the specific reason the resident required the transfer. On 7/7/26 at 7:45 AM, Surveyor interviewed Registered Nurse (RN) I regarding transferring a resident to the hospital. RN I stated the aides and staff let the nurses know if something is going on with a resident. This prompts the nurses to assess the resident. RN I stated we then contact the provider for direction. If an order is received to send the resident to the hospital, nurses are to complete the e-interact note that goes to the hospital, talk to the resident, and call the family if the resident wants us to. Nurses then print the order summary, face sheet, and paperwork for the hospital which is sent with the ambulance. Surveyor asked if there was any paperwork that pertains to the resident acknowledging why they were being transferred out. RN I stated we complete the bed hold and transfer notice. Surveyor asked what is documented on the transfer notice. RN I stated the reason that the resident is going to the hospital, which usually is the first option. Surveyor asked what happens to that form. RN I stated that it goes to the business office. On 7/7/26 at 1:10 PM, Surveyor interviewed R28 regarding her recent hospitalizations. R28 stated that she has been doing ok and hasn't had a problem since March. R28 stated they have a hernia, and it causes their bowel to get blocked once in a while. R28 stated they are on a daily stool softener. R28 stated they had to go to the hospital in January, February, and in March because they couldn't stop throwing up and their stomach really hurt. R28 said they knew why they had to go, no one had to tell them. R28 does not remember signing anything to keep their bed, but I had no worries about coming back. On 7/8/26 at 8:23 AM, Surveyor interviewed Director of Nursing (DON) B who stated their expectation is that nursing staff make sure the resident or resident representative know why they are being transferred out. DON B stated the notification can be verbal or in writing but needs to be documented in the record. Surveyor asked what pieces are supposed to be completed for a transfer. DON B stated (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurses complete the e-interact change of condition that goes to the provider, e-interact transfer form that goes to the receiving hospital and gets a signed bed hold or verbal over the phone. DON B indicated staff should complete a transfer notice letting the resident representative know why the resident is being transferred out. The reason should be on the form. DON B stated an example would be shortness of breath. On 7/8/26 at 8:58 AM, Surveyor interviewed Licensed Practice Nurse (LPN) N about transferring a resident to the hospital. LPN N stated that when they send a resident out to the hospital, they have to complete the bed hold/transfer notice. LPN N said we are supposed to write the reason as to why they are transferring out. LPN N indicated that sometimes we get verbal consent over the phone with the family. If it is verbal, then LPN N signs the form themselves. LPN N stated that the facility's transfer notice and bed hold form does not go with the resident but stays here. LPN N indicated the form is given to records, and she is not sure what they do with it. On 7/8/26 at 9:14 AM, Surveyor interviewed Business Office (BO) R regarding their role with hospital transfers. BO R stated they make sure everything is filled out properly. BO R indicated that if staff forget to document the reason for transfer, they find out what it is and add it to the form. Surveyor asked BO R if the resident or their representative is given a copy of the bed hold and transfer notice. BO R stated they ask them if they want a copy and if they do they give them one. Example 4 On 07/07/26, Surveyor reviewed R52's medical record. R52 was admitted to the facility on [DATE], On 03/11/26, R52 was sent to the hospital for evaluation of a bloody nose that would not stop. On 07/07/26, Surveyor reviewed R52's notice of transfer to the hospital on [DATE] which listed a general statement of, The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, including hospital transfer. The form did not indicate the specific reason the resident required the transfer.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not conduct a Preadmission Screening Resident Review (PASRR) - Level II screening to ensure resident with mental illness received the care and services needed. This occurred for 1 of 1 resident (R) reviewed for PASSR, out of the sample size of 13. (R7) R7 has been admitted to the facility for greater than 30 days, has a serious mental disorder, is taking psychotropic medication, and does not have a PASSR Level II completed. This is evidenced by: The facility policy titled, Resident Assessment-Coordination with [PASSAR] (preadmission screening and resident review) Program, dated 11/20/25, states in part:5. If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days:a. The facility should screen the individual using the State's Level 1 screening process and refer any resident who has or may have MD [mental disorder], ID [intellectual disability] or a related condition to the appropriate state designated authority for Level II [PASSAR] evaluation and determination.b. The Level II resident review must be completed within 40 calendar days of admission. R7 was admitted to the facility on [DATE], with diagnoses including post-traumatic stress disorder (PTSD) and mood affective disorder. On R7's day of admission, the facility completed a Brief Interview for Mental Status (BIMS) assessment, which determined a score of 10 out of 15. This means R7's cognition is moderately impaired. On 7/9/25, a Level 1 preadmission screening and resident review (PASRR) was completed on admission and reads in part: Resident is suspected of having a serious mental illness, and includes the documentation that Provider agreed and resident is taking a psychotropic medication. Review of admission paperwork indicates a hospital discharge exemption 30-day maximum was noted and stated R7 was not planned to stay at the facility longer than the permitted exemption period. R7's physician orders include: 12/9/25 07:00 PARoxetine HCl Oral Tablet 10 MG (Paroxetine HCl) Give 10 mg by mouth one time a day for mood disorder. Surveyor completed record review and noted R7 is still a resident at the facility, almost a year after the exemption period. No additional PASRR screenings were completed. On 7/7/26, Surveyor observed behaviors with R7. At 7:18 AM, R7 yelled at Certified Nursing Assistant (CNA) V, R7 did not want to get up. At 7:26 AM, R7 refused to change clothes and brush their teeth. At 7:55 AM, R7 yelled at CNA V, I don't want that breakfast tray. CNA V asked if they were hungry. R7 stated they were not hungry for that rubbish, and they pushed away from the table. CNA V asked R7 if they wanted something else. R7 yelled, get out of here. CNA V quickly grabbed tray and exited room. Surveyor interviewed CNA V regarding R7's demeanor and behavior. CNA V stated R7 has a lot of days like that. On 7/7/26 at 11:50 AM, Surveyor interviewed Director of Nursing (DON) B regarding R7's PASRR completion. DON B stated R7 was not expected to stay greater than 30 days. DON B stated when R7 became a long-term care resident, we did not go back and address the PASSR Level II. Surveyor clarified with DON B that R7 was admitted on [DATE], meaning the PASRR Level 2 was due in 30 days or approximately 8/8/2025. DON B stated unfortunately yes. On 7/8/26 at 8:24 AM, Surveyor attempted to interview the new social service staff member. They were not available. On 7/8/26 at 8:25 AM, Surveyor interviewed License Practical Nurse (LPN) O regarding their role with the PASSR. LPN O stated recently the PASSR became their responsibility. LPN O stated it has been about a month since the previous social services staff member left, and I was asked to help. Surveyor asked what LPN O knew about PASRR requirements. LPN O stated that Level 1 is required during admission for everyone. If the resident has major mental health issues or intellectual disability, the assessment triggers the need for a Level 2 screening. LPN O stated that if the resident is not planned to stay past 30 days, then Level 2 is not (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed. If the resident ends up staying past 30 days, then Level 2 is needed. Surveyor asks what triggers indicate a Level 2 is needed or how is it tracked to know if it is past 30 days admission. LPN O stated they did not have any idea.		

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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** Based on record review and interview, the facility did not ensure that professional standards of practice were met to maintain quality of care for 1 of 1 resident (R) reviewed for diabetic management and 1 of 1 resident reviewed for toileting out of 13 sampled residents.-Facility did not implement immediate hypoglycemic interventions and follow established protocols when R4's blood sugar was 60mg/dL.-Certified Nursing Assistant (CNA) P left R11 sitting unattended on a commode for 37 minutes and failed to monitor, identify, or report an open area between R11's buttocks to licensed nursing staff placing resident at risk for further skin breakdown, and pain.Example 1 Facility policy titled, 'Hypoglycemia Management,' with a revised date of 08/05/22, states: Compliance Guidelines: 3. Residents that have a diagnosis of diabetes or on medications that could lower the blood sugar should have orders for glucose monitoring and treatment of hypoglycemia, unless otherwise ordered by the practitioner. 5. If the blood glucose reading is 70 mg/dL or below, the nurse will utilize the hypoglycemic protocol as per the practitioner's order, with follow up blood glucose as indicated, and notify the practitioner of the results as ordered. 6. Nursing will continue to follow up and observe for any further hypoglycemic episodes post treatment and notify the practitioner of any changes.Facility Standing Orders, with a date of 06/15/26, states: .Diabetic order set: if glucose 60 or less or 300 and higher, recheck for accuracy. if glucose 51 to 60 give juice or 15 grams glucose gel if able to take PO.call MD if glucose less than 60 or greater than 400 unless otherwise specified.Hypoglycemia: if blood glucose 70 or less give orange juice with sugar packet or glucose gel.R4 was admitted to the facility on [DATE] with type 2 diabetes mellitus.R4's physician orders:Check blood sugars QID (four times a day) for diabetes monitoring.Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units 401 and greater give 12 units, notify provider, subcutaneously four times a day for diabetes.Note: R4's orders did not include hypoglycemic interventions or parameters to notify provider.R4's medical record:On 06/28/26 at 7:25 AM, R4's blood glucose was documented as 60.0 mg/dL. No additional assessment, hypoglycemic intervention, or provider notification were documented.On 07/08/26 at 9:30 AM, Surveyor interviewed Registered Nurse (RN) J regarding diabetic monitoring. Surveyor asked RN J if diabetic residents have hypoglycemic interventions entered as an order. RN J stated yes, they should, because if an event were to happen the nurse shouldn't be looking up standing orders to implement. Surveyor asked RN J to explain the facility's hypoglycemic protocol. RN J stated that if a resident's blood sugar is below 70, then the nurse should give orange juice with a sugar packet, recheck blood sugar every 15 minutes until over 70-80, and monitor for hypoglycemic symptoms. Surveyor asked RN J if the provider would be notified. RN J stated yes and that it would be documented in the resident's chart.On 07/08/26 at 9:38 AM, Surveyor interviewed Director of Nursing (DON) B regarding diabetic management. Surveyor asked DON B if the facility's standing orders for diabetic and hypoglycemic management are expected to be entered as an order for diabetic residents. DON B stated yes, unless the provider has a different order set or parameters to monitor. Surveyor asked DON B if residents with insulin interventions should have ordered and care planned to address hypoglycemic events. DON B stated yes. Surveyor informed DON B of R4's blood sugar of 60 with no documented interventions, provider notification, or additional documentation of monitoring for hypoglycemic symptoms. DON B stated being unaware of this. Surveyor asked DON B if R4's provider should have been notified and hypoglycemic interventions in place. DON B stated yes. Example 2 R11 was admitted to the facility on [DATE] with diagnoses (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including obstructive hydrocephalus, hypertensive heart disease with heart failure, chronic obstructive pulmonary disease, type 2 diabetes mellitus, atrial fibrillation, unspecified dementia, and history of transient ischemic attack. R11's Minimum Data Set (MDS) assessment, dated 05/20/26, indicates R11 had Brief Interview of Mental Status (BIMS) score of 10/15 indicating R11 had moderately impaired cognition. R11 required substantial maximal assistance for bed mobility, taking on and off footwear, and rolling left to right. R11 dependent with assistance sitting to lying, chair to bed, toileting, and for transfers. R11 was at risk for PI's but had no PIs on admission. R11's care plan: Focus: Actual/at risk for alteration in skin integrity related to diabetes, edema, impaired mobility, incontinence, and morbidity obesity. Date Initiated: 08/05/25 with revision on: 07/08/26. Interventions: -On 08/05/25, Barrier cream to peri area/buttocks, groin as needed -On 08/05/25, Encourage to reposition as needed, use assistive devices as needed. -On 08/05/25, Observe skin condition with ADL care daily, report abnormalities -On 08/05/25, Pressure redistributing device on bed/chair R11's ADL self-care deficit care plan. Date initiated: 08/05/25 with revision on 05/19/26: Interventions: -On 08/05/25, Toileting assist of 2 with walker. -On 10/07/25, Transfer: EZ stand with assist x2. Invacare sling - X-Large. -On 10/07/25, Transfer: sit to stand lift. On 07/07/26 at 9:21 AM, Surveyor observed CNA P and CNA T enter R11's room and closed R11's door. On 07/07/26 at 9:26 AM, Surveyor observed CNA P and CNA T exit R11's room and closed the door to room. On 07/07/26 at 9:30 AM, Surveyor entered R11's room and observed R11 on commode using the bathroom. Surveyor exited R11's room and closed R11's door. On 07/07/26 at 9:40 AM, Surveyor entered R11's room and observed R11 still sitting on commode using bathroom. R11 stated to Surveyor, I am not sure what I am doing on this, but I am done. Surveyor exited R11 to find a staff member to assist R11. Surveyor could not find assistance at this time. On 07/07/26 at 9:47 AM, Surveyor observed Nurse Practitioner Q walk up to R11's door and asked Surveyor if staff are completing cares. Surveyor informed NP Q that R11 was still on the commode but stated R11 was done. NP Q stated, I will come back. On 07/07/26 at 10:01 AM, Surveyor observed NP Q approach R11's room and asked Surveyor if R11 is still on commode. Surveyor let NP Q know that R11 was on the commode still. NP Q stated, [R11] is still on the commode! NP Q went into R11's room to check on R11 and asked, [R11] are you done using the commode? R11 responded, I sure hope so. NP Q entered and had to push the call light for R11 so staff could come assist R11 off the commode. Surveyor observed R11's call light was activated. On 07/07/26 at 10:02 AM, Surveyor observed NP Q exit R11's room and told R11, Make sure to tell staff you are done using the commode. Surveyor interviewed NP Q and asked if NP Q had to push R11's call light for R11's call light to go on. NP Q reported to Surveyor NP Q had to push R11's call light, and sitting on the commode for that long is not appropriate for [R11's] skin nor should [R11] be left alone that long on commode. On 07/07/26 at 10:07 AM, Surveyor observed CNA P and CNA T enter R11's room to assist R11 off the commode. Surveyor observed CNA T lift R11 up with EZ-stand. Surveyor observed R11 stand to an upright position on EZ-stand. Surveyor observed CNA P wipe R11's buttock area. R11 quickly moaned in pain and stated, That hurts. Surveyor asked CNA P if there was an open sore on R11's bottom. CNA P reported to Surveyor CNA P saw R11 had an open slit between R11's buttocks at the crease last week. Surveyor asked CNA P who knew about the open area on R11's bottom area, since CNA P observed the slit last week. CNA P stated, All staff should know about the open area as we are to apply barrier cream over every time [R11] goes to the bathroom. Surveyor asked CNA P why R11 was left on commode for almost an hour. CNA P stated to Surveyor, R11 likes to sit on commode for a while and so CNA P usually goes in and checks on R11 to see when R11 is done every so often. Surveyor asked did CNA P go in and check on R11 at any time after placing R11 on commode. CNA P (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 - Minimal harm or potential for actual harm Residents Affected - Few	reported to Surveyor CNA P did not get a chance to check on R11. On 07/07/26 at 10:47 AM, Surveyor interviewed R11's Family Member (FM) U and asked FM U if R11 uses the call light when FM U is around. FM U reported R11 forgets easily what the call light is for, so only time it is used is when FM U is in building and reminds R11 or pushes call light for R11. Surveyor asked if FM U is aware of an open sore on R11's bottom. FM U reported no one has told FM U that R11 has an open spot on R11's bottom. On 07/07/26 at 3:41 PM, Surveyor interviewed Licensed Practical Nurse (LPN) E and asked about R11's skin integrity and if CNA P reported any open skin areas for R11. LPN E reported to Surveyor R11 does not have any open skin areas they know about, and CNA P did not report any skin issues before leaving their shift today on 07/07/26. Surveyor informed LPN E that R11 has an open slit between their buttocks in the crease. LPN E reported to Surveyor they were not aware R11 had an open area. LPN E reported they would take care of the concern right away. On 07/07/26 at 3:48 PM, Surveyor interviewed DON B and asked if DON B knew about an open area in between R11's buttocks in the crease. DON B reported to Surveyor they did not know about any open skin areas on R11 and that staff complete weekly skin checks. Surveyor asked DON B what the expectation is for reporting a skin concern for R11. DON B reported CNA P should have reported the skin issue right away so nursing staff can address. Surveyor asked DON B's expectations for how long R11 can sit on commode. DON B reported R11 likes to sit on commode for a long time and often refuses to get off commode until finished. Surveyor asked DON B's expectation of CNA P to check in on R11 and see if they were finished using the commode. DON B reported R11 sometimes wants to stay on for a long time, but staff are to check on R11 periodically and document the attempts. Surveyor reported to DON B that Surveyor could not find documentation of R11's commode uses for long periods of time, nor could Surveyor find interventions in R11's care plan. On 07/08/2026 at 9:11 AM, Surveyor interviewed DON B and ADON C and asked if R11's slit in R11's buttocks could be pressure related due to sitting on commode for a long period of time. ADON C reported to Surveyor R11 does sit on the commode for a long time, so the slit in the crease of R11's buttocks could be pressure related but ADON C would have to go look at the skin injury but has not had a chance yet.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care consistent with professional standards of practice to prevent further deterioration and promote healing of an existing PI for 2 of 3 residents (R) reviewed for pressure injuries (PI) (R35 and R8) out of 13 sample residents. R35 is being cited at a scope and severity level of actual harm/isolated. R8 is being cited at a scope and severity of potential for harm/isolated. R35 was at risk for development of PIs and had 3 Deep Tissue Injuries upon admission to the facility. DTIS were on R35's sacrum, right buttocks, and the right heel. The facility failed to complete a comprehensive skin assessment upon admission, failed to complete weekly wound assessments, and implement offloading interventions. The facility failed to apply an ace wrap correctly to R8's right foot and did not ensure replacement of foam for a post-op shoe was completed. Findings include: Facility policy titled, Pressure Injuries and Non-pressure Injuries, last revised 07/20/22, states: .1. Upon admission: a. A head-to-toe body evaluation will be completed on every resident upon admission/readmission and will be documented on the Admission/readmission Evaluation UDA. If skin is compromised: i. If pressure injury: Initiate the Pressure Injury Weekly Tracker UDA- one per wound. iii. Ensure primary care physicians are aware of wounds/location of wounds and current treatment orders. iv. Ensure appropriate treatment orders for each wound area, as needed. C. Initiate the baseline plan of care related to current skin status and skin risk level. 2. Weekly: a. Complete a head-to-toe skin check and document findings on the Skin Review weekly NSHC UDA. If new areas are present: i. Notify MD. iii. Initiate treatment per order. v. Update Plan of Care. vi. Discuss during shift-to-shift report process. vii. Review with IDT. b. Assess current wounds at least every seven days, or more frequently as needed (e.g., decline in wound, presence of infection, wound healed). 4. As needed or upon a significant change of condition: a. A complete Braden Scale and update care plan as needed if changing/new risk factors. Example 1 R35 was admitted to the facility on [DATE] with diagnoses including displaced intertrochanteric fracture of the right femur, nonrheumatic aortic valve stenosis, anemia, hypertension, arthritis, DTI on sacrum, DTI right buttocks, and DTI right heel R35's Minimum Data Set (MDS) assessment, dated 03/10/26, identified R35 had a Brief Interview for Mental Status (BIMS) score of 13/15 indicating intact cognition. R35 required substantial maximal assistance for bed mobility, taking on and off footwear, rolling left to right, sitting to lying, chair to bed, toileting, and transferring. R35 was at risk for PIs and was admitted with 3 unstageable DTIs, which were present on admission. R35's admission skin assessment dated [DATE], identified R35's Braden scale was scored at 15, indicating moderate risk for skin breakdown. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Of note: the facility did not create a skin integrity care plan for R35 until 03/02/26. R35's care plan: Focus: actual/at risk for skin impairment (bruising, blister, and surgical incision at right hip related to impaired mobility, recent right hip surgery, fragile skin related to age, open area to heel). Date Initiated: 03/02/26. Goal: Will heal without complication. Date initiated 03/02/26. Interventions: On 03/02/26, Administer treatment per MD orders. On 03/02/26, Podiatric care as needed. On 03/02/26, Report evidence of infection such as purulent drainage, swelling, localized heat, increased pain, etc. Notify MD PRN. On 03/02/26, Therapy eval and treat as ordered. On 03/02/26, Toileting program as indicated. R35's physician orders: On 03/02/26, Wound care physician to eval and treat. R35's facility Pressure Injury Weekly Tracker, identified, On 03/05/26, R35 sacrum pressure injury suspected DTI measuring 3.5 x 1.0 x 0.1cm. On 03/01/26-Interventions: specialty mattress. Of note: sacrum DTI present on admission. No assessment/measurements until 03/05/26. On 03/05/26, R35 right buttock pressure injury suspected DTI measuring 5.0 x 4.0 x 0.1cm. On 03/01/26-Interventions: specialty mattress. Of note: right buttocks DTI present on admission. No assessment/measurements until 03/05/26. On 03/05/26, R35 right heel pressure injury suspected DTI measuring 4.0 x 6.0 x 0.1cm closed with moderate serous drainage. On 03/04/26- Interventions: Float heels off bed. Additional interventions/plans are to skin prep three times per week and cover with composite dressing with boarder(waterproof) as needed. Of note: right heel DTI present on admission. No assessment/measurement until 03/05/26. Facility did not have complete documentation on wound characteristics or peri wound tissue. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R35's specialty wound care documentation dated 03/05/26, states initial wound evaluation and management indicate R35 presents with wounds on right hip [surgical wound], right heel, right buttock, and sacrum. R35 had a right heel unstageable DTI measuring 4.0 x 6.0 x 0.1cm with moderate serous drainage. Interventions: skin prep three times per week and cover with composite dressing with boarder (waterproof) as needed, reposition per facility protocol every 2 hours, upgrade off-loading chair cushion, and low air loss mattress. Evaluation by specialty wound care provider weekly, or sooner as needed, with further intervention as indicated based upon treatment plan. R35's Braden scale assessment dated [DATE] indicates moderate risk score of 15. R35's care plan: Focus: actual/at risk for skin impairment, bruising, blister, and surgical incision at right hip related to impaired mobility, recent right hip surgery, fragile skin related to age, open area to heel. Date Initiated: 03/02/26. On 03/06/26, the resident needs pressure reducing mattress to protect the skin while in bed. Facility did not implement a pressure injury care plan with specific interventions to address R35's right heel suspected DTI. R35's physician orders: -On 03/06/26, Enhanced barrier precautions due to wounds. R35's Braden scale assessment: On 03/13/26, R35 scored a 15 which indicates R35 is at moderate risk for skin breakdown. On 03/20/26, R35 scored a 15 which indicates R35 is at moderate risk for skin breakdown. R35's specialty wound care documentation: On 03/12/26, Unstageable DTI of right heel: 3.1 x 5.5 x 0.1cm. Surface area 17.05 cm² Exudate-moderate serous, no signs of infection. Calcium Alginate apply 3 times per week as needed: if saturated, soiled, or dislodged. Apply foam silicone border and faced apply 3 times per week and as needed: if saturated, soiled, or dislodged. Skin prep apply 3 times per week and as needed if saturated, soiled, or dislodged. The wound was cleansed with normal saline and anesthesia, though not required, was achieved using topical benzocaine. Then with clean surgical technique, curette was used to selectively remove biofilm, remove devitalized epidermis and/or dermis over the wound surface area of 17.05 cm². The wound was cleansed again, and a clean dressing was applied. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/26, R35's right buttocks stage 3. 2.9 x 3.1 x 0.1cm. Surface area 8.99 cm2 Exudate Light serous, no signs of infection. House barrier cream apply every shift (3x day) and as needed. R35's facility Pressure Injury Weekly Tracker documentation: On 03/20/26, Rt heel: suspected DTI 3.5 x 5.5 x 0.1 cm. Area closed. Exudate: serosanguinous. Peri-wound dark red or purple and/or non-blanchable. Wound edges distinct, outline clearly visible, attached, even with wound base. No signs of infection. DTI unchanged. Heel protectors, specialty mattress. Skin prep peri wound, apply calcium alginate, 3x week and cover with composite dressing with boarder (waterproof) and as needed. R35's specialty wound care documentation: On 03/26/26, Unstageable (due to necrosis) of the right heel full thickness. 2.2 x 2.5cm Depth unmeasurable due to presence of nonviable tissue and necrosis. Surface area 5.50cm2 Exudate-moderate serous. Thick adherent devitalized necrotic tissue-90%. Granulation tissue 10%. Alginate calcium apply three times per week and as needed: if saturated, soiled, or dislodged. For 16 days; Leptospermum honey apply three times per week and as needed: if saturated, soiled, or dislodged. Foam silicone bdr & faced apply three times per week and as needed: if saturated, soiled, or dislodged. For 16 days Skin prep apply three times per week and as needed: if saturated, soiled, or dislodged. The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, curette was used to surgically excise 1.10cm² of devitalized tissue and necrotic subcutaneous level tissues were removed at a depth of 0.3 cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 90 percent to 70 percent. Hemostasis was achieved and a clean dressing was applied. R35's stage 3 PI right buttocks-resolved. R35's facility Pressure Injury Weekly Tracker, identified, (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 04/02/26, R35 had the right heel suspected DTI measuring 2.0x2.0x0cm closed with moderate serous drainage, 10% granulation, 90% slough, and 90% necrotic tissue, peri wound tissue dark red or purple and/or non-blanchable, acquired in house on 03/04/26. Interventions: Float heels off bed. Skin prep peri wound, Medihoney, apply calcium alginate, three times a week and cover with composite dressing with boarder and as needed. R35's specialty wound care documentation: On 04/09/26, unstageable (due to necrosis) of the right heel-full thickness. 1.5 x 2.2cm. Depth is unmeasurable due to presence of nonviable tissue and necrosis. Surface area 3.30cm² Exudate-moderate serous Alginate calcium apply three times per week and as needed: if saturated, soiled, or dislodged. Leptospermum honey apply three times per week and as needed: if saturated, soiled, or dislodged. Foam silicone bdr & faced apply three times per week and as needed: if saturated, soiled, or dislodged. Peri Wound Treatment-Skin prep apply three times per week and as needed: if saturated, soiled, or dislodged. The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, curette was used to surgically excise 1.32cm² of devitalized tissue and necrotic subcutaneous level tissues were removed at a depth of 0.3 cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 100 percent to 60 percent. Hemostasis was achieved and a clean dressing was applied. On 04/09/26, stage 3 PI sacrum full thickness. 0.9 x 0.3 x 0.2cm. Surface area 0.27cm² Exudate-moderate serous. Slough 100%. Alginate calcium apply three times per week and as needed: if saturated, soiled, or dislodged. For 30 days; Leptospermum honey apply three times per week and as needed: if saturated, soiled, or dislodged. Foam silicone bdr & faced apply three times per week and as needed: if saturated, soiled, or dislodged. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Skin prep apply three times per week and as needed: if saturated, soiled, or dislodged. Selective debridement of slough only. R35's physician orders: On 04/13/26, Liquid Protein, two times a day for wound care 30cc twice a day (may mix with 4oz of beverage of choice). R35's specialty wound care documentation: On 04/16/26, unstageable (due to necrosis) of the right heel full thickness. 1.6 x 2.2 x 0.4cm. Surface area 3.52cm² Exudate-moderate serous. Thick adherent devitalized necrotic tissue 50%. Slough 10%. Granulation 40%. Alginate calcium apply three times per week and as needed: if saturated, soiled, or dislodged. For 30 days; Leptospermum honey apply three times per week and as needed: if saturated, soiled, or dislodged. Foam silicone bdr & faced apply three times per week and as needed: if saturated, soiled, or dislodged. Skin prep apply three times per week and as needed: if saturated, soiled, or dislodged. The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, curette was used to surgically excise devitalized tissue and necrotic subcutaneous level tissues along with slough and biofilm were removed at a depth of 0.41 cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 60 percent to 40 percent. Hemostasis was achieved and a clean dressing was applied. On 04/16/26, stage 3 PI sacrum full thickness. 0.7 x 0.32 x 0.2cm. Surface area 0.21cm² Exudate-moderate serous. Slough 90%. Granulation tissue 10%. Alginate calcium apply three times per week and as needed: if saturated, soiled, or dislodged. For 30 days; Leptospermum honey apply three times (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	per week and as needed: if saturated, soiled, or dislodged. Foam silicone bdr & faced apply three times per week and as needed: if saturated, soiled, or dislodged. Skin prep apply three times per week and as needed: if saturated, soiled, or dislodged. Selective debridement of slough only. R35's specialty wound care documentation: On 04/23/26, wound evaluation and management indicate, R35 presents with a right heel wound now identified as stage 3 pressure wound to the right heel with full thickness measuring 1.7 x 2.0 x 0.2cm with moderate serous drainage, 40% granulation, 50% slough, and 10% necrotic tissue. Interventions: Reposition every 2 hours to offload. R35's facility Pressure Injury Weekly Tracker, identified, On 05/07/26, facility identified the right heel pressure suspected DTI is now identified as a stage 3 PI, measuring 1.7 x 1.7 x 0.2cm with moderate serous drainage, 50% granulation, 50% slough, acquired in house on 03/04/26. Interventions: Interventions: Lie down after meals. Maintain correct wheelchair in position. Turning and repositioning program, heel protectors, and specialty mattress. R35's physician orders: On 06/23/26, wound care to be managed by Specialty wound provider. On 07/02/26, right heel, skin prep peri wound, Medihoney, calcium alginate, abdominal pad, kerlix and secure with tape once daily and as needed. Facility did not implement a pressure injury care plan with specific interventions to address R35's right heel suspected DTI that deteriorated to a stage 3 PI. On 07/06/26 at 9:40 AM, Surveyor observed R35 sitting in wheelchair watching TV. Surveyor observed R35 sitting in front of bedside table resting right heel on bedside table leg underneath the bedside table. Surveyor did not observe an off-loaded boot in R35's room or on R35. On 07/06/26 at 11:55 AM, Surveyor observed R35 sitting in wheelchair working on a crossword puzzle prior to lunch. Surveyor observed R35 sitting in front of bedside table resting right heel on bedside table leg underneath the bedside table. Surveyor observed Certified Nurse Assistant (CNA) P transfer R35 and place them back in the wheelchair to get ready for lunch. Surveyor observed R35 placing right heel on top of bedside table. Surveyor did not observe an off-loaded boot on R35's right foot nor in their room. On 07/06/26 at 12:20 PM, Surveyor observed R35 sitting in wheelchair eating lunch. Surveyor (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed R35 sitting in front of bedside table resting right heel on bedside table leg underneath the bedside table. Surveyor did not observe R35 wearing an offloading boot nor observe a boot in R35's room. On 07/07/26 at 12:58 PM, Surveyor observed R35 sitting at bedside table resting right heel on bedside table. Surveyor observed brown gripper sock on R35's right foot. Surveyor observed R35 did not have an off-loading boot in R35's room and R35 was not wearing an off-loading boot. On 07/07/26 at 1:02 PM, Surveyor interviewed CNA P and asked if R35 had a Pressure Injury (PI) on right heel. CNA P reported to Surveyor R35 had a PI on their right foot near the heel. Surveyor asked CNA P if R35 was supposed to have an offloading boot or heel protector on right foot. CNA P reported to Surveyor CNA P did not know if R35 is supposed to have a heel protector on right foot and CNA P has never seen a boot in R35's room. Surveyor asked CNA P about R35's care plan for lying down after every meal to offload R35's heel. CNA P reported to Surveyor, R35 refuses to lay in bed. CNA P asked R35 earlier if they wanted to get into bed. CNA P reported to Surveyor, R35 refused to lay down after lunch. Surveyor asked CNA P if they documented R35's refusals of not wanting to lay down in R35's medical record. CNA P stated, I reported the refusal to nursing staff, I don't document refusals in the medical record. On 07/07/26 at 1:15 PM, Surveyor interviewed Licensed Practical Nurse (LPN) E and asked them if R35 is supposed to have off-loading boots on to prevent further deterioration of R35's PI to the right heel. LPN E reported to Surveyor that R35 should have off-loading boots on. Surveyor asked LPN E if they knew where the boots were as Surveyor did not observe R35 to have off-loading boots in their room. LPN E entered R35's room and started looking around R35's room. LPN E walked over to R35's closet and found their off-loading boots on the top shelf in the closet sitting behind a stack of clothes. LPN E grabbed R35's off-loading boots and placed the boots on bedside table. LPN E exited R35's room. LPN E did not place offloading boots on R35. On 07/07/26 at 1:51 PM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectation is if R35 refuses to lay down after meals to offload R35's heels. DON B reported to Surveyor R35 refuses a lot, but CNAs are to report right away to nursing staff and then it can be documented in the resident's medical record as a refusal. Surveyor asked DON B if staff had been documenting refusals in R35's medical record. DON B reported they would have to review R35's medical record. Surveyor requested documentation of R35's refusals to lay down after meals. Surveyor asked DON B if R35 is to have heel protector boots on to offload R35's PI to the right heel. DON B reported to Surveyor that R35 is supposed to have an offloading boot on the right foot. On 07/07/26 at 2:21 PM, Surveyor observed LPN E and Assisted Director of Nursing (ADON) C enter R35's room to complete wound dressing change. Surveyor observed R35 did not have offloading boots on while lying in bed. Surveyor interviewed ADON C and asked the expectation of R35 to use the offloading boots. ADON C reported to Surveyor that the offloading boots should be placed on R35 to offload their feet. ADON C reported to Surveyor ADON C will get a physician order placed into the medical record. Surveyor asked ADON C if the offloading boot should be in the physician's orders and (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Colonial Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care planned. ADON C reported to Surveyor once a wound care specialist orders an intervention, staff are to place the order in the medical record and update the care plan. ADON C reported to Surveyor that ADON C works very closely with the wound care provider and ADON C should have entered the order for the offloading boots for R35 and updated R35's care plan. On 07/07/26 at 2:45 PM, Surveyor and ADON C walked by R35's room and looked at R35's foot placement. ADON C stated, Oh I see her foot is sitting directly on top of the bedside table leg underneath the bedside table. Surveyor asked ADON C if they thought the bedside table leg could cause pressure on R35's right heel. ADON C stated they never thought about that. ADON C reported they would get an order for the offloading boots to be placed right away. Surveyor informed ADON C of the wound care provider ordered R35 offloading boots to decrease pressure to the right heel. On 07/08/26 at 9:11 AM, Surveyor interviewed DON B and ADON C. Surveyor asked if R35's stage 3 PI to the right heel could have been avoided if staff had completed a comprehensive skin assessment, continued to offload R35's heels with offloading boots, updated care plan, and placed correct recommendations in medical record for proper interventions to avoid or decrease further PI deterioration. ADON C stated yes it could have probably been avoided. On 07/08/26 at 9:56 AM, DON B [NAME] a document to Surveyor explaining the facility had completed a Past Non-Compliance (PNC) plan for PIs back in June 2026 when they recognized R35 was not properly assessed for skin concerns upon admission on [DATE]. DON B reported the PNC plan was put into place in June when the facility identified PI concerns and then educated staff on facility's PI policy pertaining to R35's right heel injury, and all staff are to assess skin upon admission head to toe thoroughly. Surveyor reviewed PNC plan and noted only nurses were educated about assessing new admissions thoroughly. Surveyor asked DON B why staff are still not following PI interventions for R35 such as lying down after meals and documenting refusals, as well as not applying offloading boots. DON B stated, I guess the facility is not PNC then and more education needs to be had. Example 2 R8 was admitted to the facility on [DATE] with polyneuropathy, chronic venous hypertension (idiopathic) with ulcer of right lower extremity, and pressure ulcer of unspecified site stage 3, and history of frostbite. R8's comprehensive Minimum Data Set (MDS) assessment, dated 04/15/26, noted a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. is intact. R8's physician orders: On 04/16/26 Apply ace wrap in the morning and remove at bedtime. Wrap from toes to below the knee for edema, as resident allows. On 05/23/26 Right plantar foot: wash with normal saline, skin prep peri wound, calcium alginate, cover with boarder gauze, change once daily as needed. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/06/26 at 10:54 AM, Surveyor interviewed R8. Surveyor asked R8 if they had any concerns with cares or services at the facility. R8 stated having trouble with their shoe and pointed to their right foot. Surveyor observed R8's right foot in a post-op shoe. R8 stated the shoe was falling apart. Surveyor asked R8 if they told anyone about this. R8 stated yes, multiple times but was told that they couldn't find one and it had to be ordered. Surveyor asked when R8 was told this. R8 stated for at least a couple months. Surveyor asked R8 how long they had been wearing that shoe. R8 said a long time but couldn't remember exactly. Surveyor asked R8 who was ordering a new shoe. R8 said they couldn't remember. R8's chart does not contain documentation of ordering a new shoe or foam inserts. R8's wound care provider notes indicate: On 06/18/26: stage 3 pressure ulcer (PU) right plantar foot; wound measures 1.5 x 1 x 0.2cm/. Exudate-moderate serous. Granulation tissue-100%. Wound progress-improved evidenced by decreased surface area. Surface area-1.50cm². Surface area decreased by 6.2%. Infection assessment-no signs of infection. On 06/25/26: stage 3 pressure ulcer (PU) right plantar foot; wound measures 1.7 x 1 x 0.2cm. Exudate-moderate serous. Granulation tissue-100%. Infection assessment-no signs of infection. Surface area 1.70cm². Wound present for >435 days and has failed to respond appropriately for over >28 days despite standard management. This includes mitigation of contributing factors and appropriate preventative strategies for pressure reduction. Offloading, pressure reduction cushion, compliance to treatment regimen have been observed. The wound has no signs of infection or osteomyelitis. The wound bed does not contain exposed muscle, tendon, bones, hardware, joint space, or sinus tract. The patient is not diabetic. The patient is not a smoker, is not receiving medications that significantly impact wound healing and is without uncontrolled autoimmune disease. On 07/02/25: stage 3 pressure ulcer (PU) right plantar foot; wound measures 1.1 x 1.6 x 0.2cm. Peri wound radius-maceration. Exudate-moderate serous. Granulation tissue 100%. Wound progress improved and evidenced by increased epithelialization. No signs of infection. Revisit to care goals: Difficulty with footwear. Recommend changing foam in footwear to prevent moistening. Care goals this month: decrease undermining and decrease ulcer area. Of note: footwear with sole cutout for wound was not entered into R8's care plan or orders. On 07/07/26 at 8:12 AM, Surveyor observed R8 ambulating in hallway wearing the post-op shoe on right foot. Surveyor observed an ACE wrap loosely wrapped on right foot over gripper sock. Surveyor asked R8 if they would show Surveyor the post-op shoe and explain a little more about their wound care. R8 removed their shoe on the right foot. Surveyor observed the shoe to have an area cutout of the foam in the mid-arch area. The cutout area was very worn, discolored, and had old remnants of pieces of padding that were placed on top of the shoe's built-in foam. Surveyor asked R8 what the pieces were in the cutout of the shoe. R8 stated that they believed it was pieces of foam that the (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound provider had put in there a while ago. Surveyor asked R8 about the compression wrap on the right foot. R8 raised their pant leg and Surveyor observed the ACE wrap loosely wrapped on right foot up to approximately mid-calf height. Underneath the ACE wrap, Surveyor observed a black gripper sock sticking out on the toes. Surveyor asked R8 when the ACE wrap had been applied. R8 stated yesterday. Surveyor asked R8 if the ACE wrap was normally applied this way, being loose and over the gripper sock. R8 stated sometimes. On 07/07/26 at 12:54 PM, Surveyor observed R8's wound care completed by Licensed Practical Nurse (LPN) E. LPN E removed R8's ACE wrap and sock; Surveyor observed R8's right foot and calf to be edematous. Surveyor asked LPN E if R8's compression wrap was applied by LPN E this morning. LPN E stated no that the ACE wrap was applied the previous evening. Surveyor asked LPN E if it was normal practice for the ACE wrap to be applied loosely over the gripper sock. LPN E stated no, it shouldn't. Surveyor asked LPN E if they were aware of the type of shoe R8 was wearing and any assessments related to it. LPN E stated not knowing what kind of shoe it is or who is supposed to be monitoring or assessing it. On 07/07/26 at 1:24 PM, Surveyor interviewed Assistant Director of Nursing (ADON) C regarding R8's wound care interventions. ADON C stated they complete wound care assessments weekly with wound care provider. ADON C stated they complete weekly assessments of R8's shoe. Surveyor asked ADON C if this is documented. ADON C stated no. Surveyor asked ADON C how they would know if the wound had worsened if they did not have any previous documentation of wound measurements. ADON C could not answer. Surveyor asked ADON C if they were aware of any concerns reported by R8. ADON C stated yes it was addressed last week to order a new shoe, but that the wound care provider wanted podiatry to handle this. Surveyor asked ADON C if podiatry had done this. ADON C stated no because R8 was refusing to see podiatry. Surveyor asked ADON C how long R8 had this post-op shoe. ADON C didn't answer question. R8's medical record noted no documentation of refusing podiatry visits or a consultation with podiatry requested within the last week. On 07/07/26 at 1:51 PM, Surveyor interviewed DON B regarding wound care interventions. Surveyor informed DON B of observation of the ACE wrap on R8's right foot being on loosely and over the gripper sock. Surveyor asked DON B if this was an appropriate application for the ACE wrap. DON B stated no. Facility did not provide any documentation as to whether the boot or new insoles were ordered for R8.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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 1 of 13 residents at risk for falls received adequate supervision and assistance devices to prevent accidents. Facility staff left R11 on commode alone without the ability to use call light for assistance. Findings include: R11 was admitted to the facility on [DATE] with diagnoses including in part, obstructive hydrocephalus, and unspecified dementia. R11's Minimum Data Set (MDS) assessment, dated 05/20/26, identified R11 had Brief Interview for Mental Status (BIMS) score of 10/15 indicating R11 had impaired cognition. MDS identified R11 as being dependent with assistance sitting to lying, chair to bed, toileting, and for transfers. R11's care plan: Focus: Actual/at risk for falls due to weakness, pain, cardiac diagnosis, impaired mobility, and obesity. Date Initiated: 08/05/25 with revision on: 02/16/26: Interventions: -On 06/13/25, staff education including footwear (gripper socks/soled shoes), gait belt for all transfers, 2 person assist for all transfers, go slow and explain what you are doing. -On 08/05/25, Reinforce need to call for assistance. -On 08/06/25, Soft touch call light. R11's ADL self-care deficit care plan. Date initiated: 08/05/25 with revision on 05/19/26: Interventions: -On 08/05/25, Toileting assist of 2 with walker. -On 10/07/25, Transfer: EZ stand with assist x2. Invacare sling - X-Large. -On 10/07/25, Transfer: sit to stand lift. R11's care plan: Difficulty communicating as evidenced by losing track of conversations, memory issues, related to decline in cognitive status, cognitive communication deficit, obstructive hydrocephalus care plan. Date initiated 08/05/25 with revision on 01/27/26: Interventions: -On 08/05/25, Demonstrate understanding by completing task when requested. -On 08/05/25, Speak in a manner that can be understood. -On 08/05/25, Gain individual's attention before beginning to converse. -On 08/05/25, Provide reassurance and patience when communicating with resident. -On 08/05/25, Repeat information as needed. R11's fall risk assessment, dated 05/09/26, identified R11 at risk for falls. On 07/07/26 at 9:21 AM, Surveyor observed Certified Nurse Assistant (CNA) P and CNA T enter R11's room and close R11's door. On 07/07/26 at 9:26 AM, Surveyor observed CNA P and CNA T exit R11's room and close the door to room. On 07/07/26 at 9:30 AM, Surveyor entered R11's room and observed R11 on commode using the bathroom. Surveyor exited R11's room and closed R11's door. On 07/07/26 at 9:40 AM, Surveyor entered R11's room and observed R11 still sitting on commode using bathroom in the middle of the room. Surveyor peeked around curtain and asked R11 if R11 was ok. Surveyor observed R11 trying to scoot commode back with R11's feet on floor scooting and leaning backwards. R11 stated to Surveyor, I am but I am not sure what I am doing on this and why I can't back up, but I am done. My chair must be broken. Surveyor informed R11, R11 was on the commode to use the bathroom. Surveyor asked R11 if R11's call light was in reach. R11 stated, My what? Surveyor explained that R11 had a call light attached to R11's shirt on left shoulder. R11 stated, I cannot see what you are talking about. Surveyor exited R11's room to find assistance. Surveyor could not find assistance at this time. On 07/07/26 at 9:47 AM, Surveyor observed Nurse Practitioner (NP) Q walk up to R11's door and asked Surveyor if staff are completing cares. Surveyor informed NP Q that R11 was still on commode but stated that R11 was done. NP Q stated, I will come back. On 07/07/26 at 10:01 AM, Surveyor observed NP Q approach R11's room and asked Surveyor if R11 is still on commode. Surveyor let NP Q know that R11 was still on the commode. NP Q stated, R11 is still on the commode! NP Q went into R11's room to check on R11 and asked, [R11] are you done using the commode? R11 responded, I sure hope so. NP Q entered and had to push the call light for R11 so that staff could come assist R11 off the commode. Surveyor (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed R11's call light go on. On 07/07/26 at 10:02 AM, Surveyor observed NP Q exit R11's room and told R11, Make sure to tell staff you are done using the commode. Surveyor interviewed NP Q and asked if NP Q had to push R11's call light for R11's call light to go on. NP Q reported to Surveyor NP Q had to push R11's call light, and sitting on the commode for that long is not appropriate for [R11's] skin nor should [R11] be left alone that long on commode. Surveyor asked NP Q if R11 is appropriate to be left alone to use call light as R11 seemed confused about the use of the call light. NP Q reported to Surveyor R11 has been declining in memory and should not be left alone to use the call light. On 07/07/26 at 10:07 AM, Surveyor observed CNA P and CNA T enter R11's room to assist R11 off the commode. Surveyor observed CNA T lift R11 up with EZ-stand. Surveyor asked CNA P why R11 was left on commode for about 45 minutes. CNA P stated to Surveyor, R11 likes to sit on commode for a while and so CNA P usually goes in and checks on R11 to see when R11 is done every so often. Surveyor asked CNA P did CNA P ever go in and check on R11 at any time after placing R11 on commode at 9:26 AM. CNA P reported to Surveyor CNA P did not get a chance to check on R11. On 07/07/26 at 10:14 AM, Surveyor interviewed CNA P and asked if R11 uses call light appropriately. CNA P reported R11 uses call light about 50/50. CNA P reported to Surveyor R11 sometimes refuses to use call light. Surveyor asked CNA P if refusals to use call light are documented or care planned. CNA P reported to Surveyor CNA P does not document refusals in medical record. On 07/07/26 at 10:47 AM, Surveyor interviewed R11's Family Member (FM) U and asked FM U if R11 uses the call light when FM U is around. FM U reported that R11 forgets easily what the call light is for so the only time it is used is when FM U is in building and reminds R11 or pushes call light for R11. On 07/07/26 at 3:33 PM, NP Q (Nurse Practitioner) dictation note: R11 seen today psychiatric follow-up evaluation the patient [R11] reports that R11 would just want to go home. R11 reports sleeping and eating well. There is noted progression of dementia, as the patient is unsure of how to use the call light appropriately. These changes in cognition should be communicated to staff to implement in the plan of care with the decline in cognition. Follow up in 4 weeks or sooner if changes in mood or behaviors. Cognition: alert, oriented x2; decline noted as patient is unsure of how to use the call light appropriately, consistent with progression of dementia- Judgement: poor/impaired; further decline given inability to use call light appropriately- Insight: poor/impaired; further decline given inability to use call light appropriately. On 07/07/26 at 4:00 PM, Summary for Provider (SBAR) change in condition: Outcomes of physical assessment: Positive findings reported on the resident/patient evaluation for this change in condition were:- Mental Status Evaluation: Increased confusion (e.g. disorientation) Resident [R11] also was seen by psych provider [NP Q] today and provider had stated that resident was noted to have more confusion and seemed that she was not able to comprehend how to use call light today. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: Per psych provider [NP Q] please check on resident more frequently to make sure resident care needs are met due to inability to comprehend how to use call light. On 07/07/26 at 3:48 PM, Surveyor interviewed DON B and asked how long R11 can sit on commode. DON B reported R11 likes to sit on commode for a long time and often refuses to get off commode until finished. Surveyor asked DON B's expectation of CNA P to check in on R11 and see if R11 was completed using the commode. DON B reported R11 sometimes wants to stay on for a long time, but staff are to check on R11 periodically and document the attempts. Surveyor reported to DON B that Surveyor could not find documentation of R11's commode uses for long periods of time, nor could Surveyor find interventions in R11's care plan.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who receives nutrition and hydration maintains acceptable parameters of nutritional status unless the resident's clinical condition demonstrates otherwise for 1 of 13 residents (R6) reviewed for nutrition and hydration. R6 had a daily fluid restriction of 1500cc. On 03/12/26, 03/13/26, 03/17/26, 03/22/26, 03/29/26, 04/19/26, 04/20/26, 05/10/26, 05/23/26, 05/29/26, 06/22/26, and 06/30/26, R6 went over the fluid restriction. The facility did not complete additional lung assessments or notify the provider. This is evidenced by: R6 was admitted to the facility on [DATE] with stage 5 chronic kidney disease with heart failure and dependence on renal dialysis. R6's physician orders include: 01/03/26 24-hour fluid intake one time a day for monitoring. 03/21/26 1500 cc Fluid intake - record q shift. Dietary - Breakfast: 360cc, Lunch 240cc, Dinner 240cc Nursing - AM: 280cc, PM: 280cc, NOC 100cc three times a day for heart failure, dialysis. Surveyor reviewed R6's medication administration record (MAR) and noted R6 exceeded the 1500 cc fluid restriction: 03/12/26: 1640 cc 03/13/26: 1720 cc 03/17/26: 1680 cc 03/22/26: 1660 cc 03/29/26: 1720 cc 04/19/26: 1800 cc 04/20/26: 1740 cc 05/10/26: 1960 cc 05/23/26: 2080 cc 05/29/26: 1800 cc 06/22/26: 1600 cc 06/30/26: 1760 cc Of note: no documentation of additional lung assessments or provider notification were documented. On 07/07/26 at 2:49 PM, Surveyor interviewed Registered Nurse (RN) I regarding fluid restrictions. Surveyor asked RN I to explain the process for nursing if a resident exceeds a fluid restriction. RN I stated that if a resident goes over their fluid restriction, the nurse should complete a thorough lung assessment, notify the provider and document all of this in the resident's chart. On 07/08/26 at 9:36 AM, Surveyor interviewed Director of Nursing (DON) B regarding R6's fluid restriction. Surveyor asked DON B how R6's fluid restriction is monitored. DON B stated the overnight nurse tallies the daily total in R6's MAR and the Assistant DON (ADON) reviews this daily. Any overages are discussed with the provider. Surveyor asked DON B if this is documented. DON B stated the ADON is currently on vacation, but that it should be documented. Surveyor asked DON B if the expectation was for nursing to complete additional assessments and notify the provider when the fluid restriction was exceeded. DON B stated yes. No additional documentation was provided demonstrating the provider was notified of R6 exceeding the fluid restriction or additional lung assessments were completed.		

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure resident was free from complications of a feeding tube for 1 of 1 resident reviewed for tube feedings in a sample of 13 residents (R5).The facility did not verify proper Percutaneous Endoscopic Gastrostomy (PEG) tube placement on R5 prior to administering medication through it which could result in physical harm to resident.Findings include: The facility policy, titled Verifying Placement of Tube Feeding, last revised 08/10/2022, states, Before beginning a feeding, flushing a tube, or administering medication via a feeding tube, proper placement and functioning will be verified.for gastrostomy tubes, check that the enteral retention device is properly approximated to the abdominal wall by gently tugging on the tube and taking note of the marking on the tube.R5 was admitted to the facility on [DATE] with diagnoses including dysphagia, spastic quadriplegic cerebral palsy, epilepsy and history of venous thrombosis and embolism. R5 receives all medications via a PEG tube. R5 is nonverbal and has a Brief Interview for Mental Status (BIMS) score of 0 which is severe cognitive impairment. On 07/07/2026 at 7:15 AM, Surveyor observed Licensed Practical Nurse (LPN) E administer medication via a PEG tube to R5. LPN E verified R5's PEG tube placement by auscultation above the epigastrium while injecting air into a syringe. LPN E aspirated less than 5ml of gastric contents using same syringe. LPN E did not verify R5's PEG placement by gently pulling on the tube for retention or confirming tube marking/measurement on feeding tube at insertion site prior to administering R5's medications via the PEG tube. On 07/07/2026 at 7:30 AM, Surveyor asked LPN E how R5's PEG tube placement is monitored for possible migration outward. LPN E stated daily PEG tube measurements from insertion are done by nursing and documented on the medication administration record (MAR). LPN E demonstrated measurement of R5's PEG tube of 19cm from insertion site to surveyor and compared it prior documentations in R5's MAR. LPN E stated to Surveyor she was not aware that auscultation is no longer recommended for checking placement of feeding tubes. LPN E stated they were not aware of recent standards of practice for correct verification of feeding tube placement was observation for changes in external length of tubing from insertion site. On 07/07/2026, record review of R5's physician orders: Measure G-tube daily and record in centimeters in the morning for G-tube placement - measure from ABD (abdomen) to end of tube. R5's medication administration record (MAR) indicated daily AM documentation of feeding tube measurements. R5's MAR did not include documentation of feeding tube measurements with each medication or enteral feeding administrations throughout the day.On 07/07/2026 at 8:13 AM, Surveyor interviewed director of nursing (DON) B and asked how facility nursing staff should verify correct feeding tube placement prior to enteral feedings and medications administrations. DON B stated feeding tubes should be measured from insertion site prior to every administration of medications or feedings to ensure safe administration of medications/feedings and monitor for accidental misplacement of feeding tube.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Colonial Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not provide the necessary respiratory care and services for 1 of 1 resident (R5) reviewed of a sample of 13 residents.R5's bilevel positive airway pressure (BiPAP) machine was not applied per provider's orders.This is evidenced by:R5 was admitted to the facility on [DATE] with obstructive sleep apnea and asthma.R5's most recent significant change Minimum Data Set (MDS) assessment, dated 06/17/26, noted a Brief Interview for Mental Status (BIMS) score of 0/15, indicating severe cognitive impairment. R5 was noted to be dependent for all activities of daily living (ADL).R5's care plan, dated 11/05/25, with a target date of 09/18/26, states: Obstructive sleep apnea used bipap with a goal to adhere to CPAP/BiPAP regimen. Interventions include: encourage resident's use of CPAP/BiPAP.R5's physician orders:06/11/26 BI-PAP SETTING 14/8, PATIENT HAS TO HAVE BIPAP MACHINE ON WHEN SHE IS SLEEPING INCREASING PRESSUE TO 14/8, EVEN IF IT IS NOT NIGHT. DO THIS DILIGENTLY. ADD O2 bleed at 1 liter to Bipap three times a day related to Sleep apnea.On 07/06/26 at 9:19 AM, Surveyor observed R5 sitting upright in recliner with eyes closed. BiPAP machine was observed on nightstand and not in use on R5. Surveyor attempted to talk with R5 but R5 did not open eyes or interact.On 07/06/26 at 10:38 AM, Surveyor entered R5's room and observed R5 sitting upright in recliner with eyes closed. No BiPAP observed in use on R5. Surveyor again attempted to speak with R5. R5 did not open eyes or respond. Surveyor heard R5 making quiet snoring sounds.On 07/06/26 at 11:45 AM, Surveyor entered R5's room and observed Certified Nursing Assistant (CNA) L and CNA M providing assistance to R5's roommate. Surveyor observed R5 sitting in recliner in upright position with eyes closed and snoring softly. No BiPAP was in use. Surveyor asked CNA L if R5 was sleeping. CNA L stated yes. Surveyor asked CNA L if R5 was supposed to have a BiPAP on. CNA L stated only at night.On 07/06/26 at 11:49 AM, Surveyor interviewed Registered Nurse (RN) H regarding R5's BiPAP. Surveyor asked RN H when R5 was supposed to use the BiPAP. RN H stated when in bed sleeping. Surveyor asked RN H about R5's order to have BiPAP used anytime R5 was sleeping. RN H the provider said it could be left off if R5 was sleeping in the chair. Surveyor asked RN H if this communication with the provider was documented. RN H stated not being sure and would look. No additional documentation was provided.On 07/06/26 at 11:53 AM, Surveyor interviewed Director of Nursing (DON) B regarding R5's BiPAP. Surveyor asked DON B if R5's BiPAP was supposed to be in use while sleeping. DON B stated yes. Surveyor explained to DON B of the multiple observations of R5 sleeping without the BiPAP in place. DON B stated that R5 was likely not sleeping and just had their eyes closed. Surveyor informed DON B of observing snoring sounds. DON B stated if R5 was sleeping, then BiPAP should be on.		

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NAME OF PROVIDER OR SUPPLIER Colonial Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that its medication error rate was not 5 percent or greater for 2 residents (R5, R47) of 3 residents observed for medication administration in a sample of 13 residents. The facility:-Did not ensure R5's crushed Phenytoin was completely dissolved in water, and all medication particles were administered via R5's gastric tube resulting in R5 not receiving accurate dose of medication.-Did not correctly administer R5's subcutaneous injection of Lovenox possibly resulting in incorrect absorption/dosing of R5's Lovenox. -Gave R47 2 tablets of aspirin when physician order indicated 1 tablet to be given resulting in overdosing of R47's aspirin. -Had a medication error rate of 11.11%.Findings:The facility policy, titled Medication Administration Enteral Tubes, dated 01/2026, states, The souffle cup is rinsed with water to get all of the medication contained within the cup to facilitate the ordered dose.The facility policy, titled Medication Administration General Guidelines, dated 02/2026, states, Medications are administered as prescribed in accordance with manufacturer's specifications, good nursing principles and practices.Prior to administration, review and confirm for each individual client on the Medication Administration Record (MAR).The Federal Drug Administration Prescribing information for Lovenox (an anticoagulant medication used to prevent clots) states, Administered via deep subcutaneous (fatty tissue layer located between the skin and the muscle) injection only.grasp and pinch a fold of skin between the thumb and forefinger.and hold the skin fold throughout the entire injection.Example 1R5 was admitted to the facility on [DATE] with diagnoses that include dysphagia, spastic quadriplegic cerebral palsy, epilepsy and history of venous thrombosis and embolism. R5 receives all medications via a PEG (a soft, flexible tube placed directly through abdominal wall into the stomach allowing delivery of liquid nutrition and medications). R5 is nonverbal and has a Brief Interview for Mental Status (BIMS) score of 0 which is severe cognitive impairment. On 07/07/2026, record review of R5's physician orders:-Enoxaparin Sodium (Lovenox) injection solution prefilled syringe 30mg/0.3ml - inject 30 mg subcutaneously in the morning for DVT (Deep Vein Thrombosis) prophylactics. -Phenytoin oral tablet chewable 50mg - Give 3 tablets via G-tube three times a day. Dissolve in water before administration for epilepsy.On 07/07/2026 at 7:15 AM, Surveyor observed licensed practical nurse (LPN) E administer medications to R5 via a PEG tube. LPN E crushed the Phenytoin chewable tablet and placed it into a cup of water. LPN E mixed the phenytoin particles with a spoon attempting to dissolve medication. LPN E stated to Surveyor the phenytoin medication was difficult to completely dissolve and get out of the cup. LPN E proceeded to administer the phenytoin via R5's PEG tube. Surveyor observed several particles of undissolved phenytoin medication attached to the sides and bottom of cup. LPN E rinsed the cup with a small amount of water and administered via R5's PEG tube, then disposed of the cup into garbage. Surveyor observed the cup in the garbage with several particles of the phenytoin medication remaining in cup. On 07/07/2026 at 8:13 AM, Surveyor interviewed director of nursing (DON) B and asked what the facility's protocol is for nursing staff to administer crushed medications via a PEG tube. DON B stated crushed medications are dissolved in water, and the medication must be completely dissolved without particles remaining before administering into a PEG tube. Surveyor asked DON B if phenytoin was available in a liquid form, and DON B stated she was not definite on that. DON B confirmed with Surveyor the facility should check with R5's physician and pharmacy provider if an available liquid form of phenytoin is appropriate for R5 to ensure correct dosing of phenytoin is administeredOn 07/07/2026 at 7:18 AM, Surveyor observed LPN E administer R5's Lovenox injection. LPN E injected the Lovenox into R5's (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right upper abdomen at a 90-degree angle. LPN E did not grasp and pinch a fold of R5's abdominal skin prior to inserting Lovenox into R5's abdomen. LPN E did not hold a pinch of R5's abdominal skin fold throughout the entire Lovenox injection. On 07/07/2026 at 8:14 AM, Surveyor interviewed DON B and asked what the facility's protocol is for nursing staff administering subcutaneous injections. DON B stated nursing is to pinch a fold of skin at injection site and hold while injecting medication. DON B confirmed absorption of medication can be affected if medication is not injected correctly. Example 2R47 was admitted to the facility on [DATE] with diagnoses that include intellectual disabilities and morbid obesity. R47 has a BIMS score of 9/15, which means moderate cognitive impairment. R47's physician orders: Aspirin Chew tab 81mg - Give 81mg orally one time a day for antiplatelet therapy related to morbid obesity due to excess calories. On 07/07/2026 at 7:45 AM, Surveyor observed medication aide (MA) F administer medications to R47. MA F stated to Surveyor 2 tablets of aspirin were to be administered according to the MAR. MA F administered 2 tablets of Aspirin 81mg whole in applesauce to R47. Surveyor observed R47 take all of the medication.		

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure residents are free of any significant medication errors for 1 of 3 residents (R) observed during medication administration in a sample of 13 residents (R5). The facility staff did not ensure R5's crushed Phenytoin was completely dissolved in water, and all medication particles were administered via R5's gastric tube resulting in R5 not receiving accurate dose of medication. Findings include: The facility policy, titled Medication Administration Enteral Tubes, dated 01/2026, states, The souffle cup is rinsed with water to get all of the medication contained within the cup to facilitate the ordered dose. The facility policy, titled Medication Administration General Guidelines, dated 02/2026, states, Medications are administered as prescribed in accordance with manufacturer's specifications, good nursing principles and practices. Prior to administration, review and confirm for each individual client on the Medication Administration Record (MAR). R5 was admitted to the facility on [DATE] with diagnoses including dysphagia, spastic quadriplegic cerebral palsy, epilepsy and history of venous thrombosis and embolism. R5 receives all medications via a Percutaneous Endoscopic Gastrostomy (PEG) tube. R5 is nonverbal and has a Brief Interview for Mental Status (BIMS) score of 0/15, which is severe cognitive impairment. R5's physician orders: Phenytoin oral tablet chewable 50mg - Give 3 tablets via G-tube three times a day. Dissolve in water before administration for epilepsy. Note: Phenytoin (also known as Dilantin) is an anticonvulsant medication primarily used to prevent and control seizures in epilepsy patients. Phenytoin requires periodic blood level monitoring to determine safe serum drug levels and determine correct dosing and need for drug dose titrations. On 07/07/2026 at 7:15 AM, Surveyor observed Licensed Practical Nurse (LPN) E administer medications to R5 via a PEG tube. LPN E crushed the Phenytoin chewable tablet and placed it into a cup of water. LPN E mixed the phenytoin particles with a spoon attempting to dissolve medication. LPN E stated to Surveyor the phenytoin medication was difficult to completely dissolve and get out of the cup. LPN E proceeded to administer the phenytoin via R5's PEG tube. Surveyor observed several particles of undissolved phenytoin medication attached to the sides and bottom of cup. LPN E rinsed the cup with a small amount of water and administered via R5's PEG tube, then disposed of the cup into garbage. Surveyor observed the cup in the garbage with several particles of the phenytoin medication remaining in cup. On 07/07/2026 at 8:13 AM, Surveyor interviewed director of nursing (DON) B and asked what the facility's protocol is for nursing staff to administer crushed medications via a PEG tube. DON B stated crushed medications are dissolved in water, and the medication must be completely dissolved without particles remaining before administering into a PEG tube. Surveyor asked DON B if phenytoin was available in a liquid form and DON B stated she was not definite on that. DON B confirmed with surveyor the facility should check with R5's physician and pharmacy provider if an available liquid form of phenytoin is appropriate for R5 to ensure correct dosing of phenytoin is administered.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This has potential to affect 51 of 51 residents reviewed. -R35 is on Enhanced Barrier Precautions (EBP) and Certified Nursing Assistant (CNA) P did not perform proper hand hygiene practices during personal care or utilize Personal Protective Equipment (PPE).-Medication Aide (MA) F directly touched R47's medications with their fingers for 1 of 3 residents (R) observed during medication administration (R47). Findings include: Example 1 Surveyor reviewed facility policy titled, Enhanced Barrier Precautions, dated last revised 03/25/24, which states: .3. Implementation of Enhanced Barrier Precautions: b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities (described below) and may not need to be donned prior to entering the resident's room. 4. High contact resident care activities include: c. Transferring. d. Providing hygiene. F. Changing briefs or assisting with toileting. R35 was admitted to the facility on [DATE] with diagnoses including displaced intertrochanteric fracture of the right femur, nonrheumatic aortic valve stenosis, anemia, hypertension, and arthritis. R35's Minimum Data Set (MDS) assessment, dated 03/10/26, indicated R35 had Brief Interview for Mental Status (BIMS) score of 13/15, indicating R35 had intact cognition. R35 was at risk for PIs and 3 unstageable DTIs were present on admission. Surveyor reviewed R35's medical record. R35's physician orders: -On 03/02/26, Wound care physician to eval and treat. -On 03/06/26, Enhanced barrier precautions due to wounds. On 07/06/26 at 11:55 AM, Surveyor observed Personal Protective Equipment (PPE) cart outside R35's room near door. Surveyor observed a sign labeled, EBP. On 07/06/26 at 11:55 AM, Surveyor observed CNA P enter R35's room. Surveyor observed that CNA P did not sanitize hands upon entering R35's room. CNA P did not don PPE before entering R35's room. Surveyor observed CNA P don gloves once in room and then transfer R35 to bed to check and change R35's brief. Surveyor observed CNA P lean over R35's bed with scrub top touching R35's blankets on bed. Surveyor observed CNA P place R35 in a wheelchair. CNA P did not utilize correct PPE in R35's (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EBP room. On 07/06/26 at 1:35 PM, Surveyor interviewed CNA P and asked why CNA P did not utilize PPE while providing peri cares to R35 when transferring R35 from wheelchair to bed. CNA P reported to Surveyor CNA P should have applied gown and gloves prior to entering R35's room because of R35's open wound on foot. On 07/07/26 at 3:48 PM, Surveyor interviewed Director of Nursing (DON) B and asked for expectation for utilizing PPE in an EBP room as for R35. Surveyor informed DON B of Surveyor's observations of CNA P not donning PPE when entering R35's room and providing personal cares. DON B reported to Surveyor expectation is CNA P should have applied gown and gloves prior to transferring R35 to bed to provide peri cares as R35 is on precautions for R35's open wound on heel. Example 2 R47 was admitted to the facility on [DATE]. On 07/07/2026 at 7:45 AM, Surveyor observed medication aide (MA) F administer medications to R47. While MA F was preparing R47's medications, Surveyor observed MA F pop out each medication from its original prepackaged bubble pack provided by pharmacy into their fingers, then place each medication using their fingers into one medication cup containing applesauce. MA F was not wearing gloves and did not perform hand hygiene between each medication. Surveyor observed MA F administer these medications to R47, and R47 took the medications. On 07/07/2026 at 7:59 AM, Surveyor asked MA F what the proper technique was for removing prepackaged medications. MA F stated the medications are individually removed from the packaging and placed into medication cups. Surveyor asked MA F if it was recommended to touch medications directly with fingers or ungloved hands and MA F stated it was not the correct way to remove the medications from packaging. MA F stated, I was taught to pop the pills from the packs into the medication cups.		