

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Mineral Point Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 109 N Iowa St Mineral Point, WI 53565	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788</p> <p>Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately to the administrator of the facility and to other officials, including the State Survey Agency, in accordance with State law through established procedures for 1 of 14 residents (R26) reviewed for abuse.</p> <p>Facility did not report an abuse allegation involving R26 within the required two hours to the state agency (SA).</p> <p>Evidenced by:</p> <p>The facility policy entitled, Abuse, Neglect, and Exploitation, dated 7/15/22, states, in part: .Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions: .Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology .Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>Policy Explanation and Compliance Guidelines: VII. Reporting/Response:</p> <p>A. The facility will have written procedures that include:</p> <p>1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes</p> <p>a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or .</p> <p>R26 was admitted to the facility on [DATE] and has diagnoses that include depression, anxiety and history of malignant neoplasm of breast (a cancer that forms in the cells of the breast).</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R26's Admission Minimum Data Set (MDS) Assessment, dated 1/9/25, shows R26 has a Brief Interview of Mental Status (BIMS) score of 12 indicating R26 has moderate cognitive impairment.</p> <p>On 4/01/23 at 9:45 AM, Surveyor interviewed R26. R26 indicated to Surveyor this morning a CNA (certified nursing assistant) had taken her to the bathroom and assisted R26 back into her recliner. R26 felt she had to go to the bathroom again and she felt she had not emptied out all the way. R26 turned her call light on. The CNA came back in and turned her call light off and told R26 to go in her diaper and the staff would clean her up later. R26 indicated she felt terrible and degraded. R26 was crying as she was telling Surveyor, I don't know if they think I can walk. R26 indicated if she could walk she would not be calling staff to help her. R26 indicated she feels she needs more help than staff give her. R26 indicated the CNA does not like her. R26 indicated she rubbed her stomach and fell back asleep and woke up about 45 minutes later and turned her call light back on. R26 indicated a different CNA answered her call light and took R26 to the bathroom. Surveyor asked R26 if she voiced her concern to anyone and R26 indicated she reported the incident to the male nurse this morning.</p> <p>On 4/01/25 at 1:29 PM, Surveyor interviewed RN C (Registered Nurse) and asked if R26 had brought a concern to him this morning. RN C indicated yes, R26 was tearful and stated the CNA yelled at her about needing to go to the bathroom, turned R26's call light off, and then left R26's room. R26 indicated to RN C it is not her fault that she is unable to walk. Surveyor asked RN C what he did when R26 informed him of that. RN C indicated he asked if R26 felt safe at the facility and R26 indicated yes. RN C indicated he reported the incident to NHA A (Nursing Home Administrator) around 8:30AM-8:45AM. Surveyor asked RN C if R26 reported to him a CNA told her to go in her diaper and would not take her to the bathroom. RN C indicated no. Surveyor asked if yelling at a resident and telling a resident to go in her diaper could be considered abuse. RN C indicated yes.</p> <p>On 4/01/25 at 1:38 PM, Surveyor interviewed NHA A and asked if RN C had reported a concern regarding R26 this morning. NHA A indicated RN C reported before 9:00AM to her that R26 had a concern with a CNA and asked if NHA A would stop in and talk with R26. NHA A indicated she went into R26's room at 9:00 AM and R26 was sleeping. NHA A indicated she went back later two times and R26 was in the bathroom both times. NHA A indicated she went back to attempt to talk with R26 at 11:00 AM and was able to speak with R26 at that time. NHA A indicated R26 informed her that two girls had taken her to the bathroom and a half hour passed after she had been in the bathroom, and R26 felt she had to use the bathroom again and turned her call light on. R26 indicated the CNA answered R26's call light and was short and abrupt with R26, and informed R26 she would be back after she helped with breakfast and was able to find someone to assist the CNA with taking R26 to the bathroom. R26 indicated the CNA turned the call light off and left. NHA A indicated she spoke with the CNA who indicated she had turned R26's call light off and told R26 she would be back with someone to assist her. NHA A indicated she spoke with the CNA about not turning residents' call lights off until the resident has been assisted. NHA A indicated she spoke with the CNA about customer service. NHA A indicated she was going to write the incident up as a grievance but has not had time to yet but feels since talking with Surveyor she needs to report it. NHA A indicated she will go and talk with R26 again. Surveyor asked NHA A to let Surveyor know what she does with the incident.</p> <p>NHA A's investigation/timeline on R26, dated 4/1/25, around 9:00AM, states, Around 9:00 AM RN C, while at the med cart stopped this writer and informed her to check in on room [207] as she made a comment about someone potentially yelling at her .</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, dated 4/1/25, at 2:09:19 PM, states, in part: .</p> <p>Summary of Incident:</p> <p>Allegation Type: Neglect: Intentionally withholding care, disregard of policy or care plan .</p> <p>Is Date and time when occurred known? NO</p> <p>Date occurred . (blank)</p> <p>Time occurred . (blank)</p> <p>Is occurred date and time estimated? (blank)</p> <p>Date discovered . 4/01/25 .</p> <p>Brief Summary of Incident: Surveyor informed this writer at around 1:45PM that resident (R26) reported to her that a cna had told her to go in her diaper (i.e. urinate/defecate in her depends) .</p> <p>Report Submitted Date: 4/1/25 2:09:19 PM .</p> <p>On 4/3/25 7:48 AM, Surveyor interviewed RN C and asked RN C to tell Surveyor again what and when he reported to NHA A regarding R26. RN C indicated it was before 9:00 AM on 4/1/25, when he reported to NHA A that R26 was crying and upset the cna had come in her room and turned her call light off. The cna told R26 she had just been to the bathroom and the cna had breakfast trays to pass. RN C indicated he reported to NHA A R26 stated the cna had yelled at her. RN C indicated he told NHA A he asked R26 if she felt safe and R26 indicated yes.</p> <p>On 4/3/25 at 12:09 PM, Surveyor interviewed NHA A and asked if a resident reports a CNA yelled at her, would this be considered abuse. NHA A indicated yes. Surveyor asked if an allegation of abuse should be reported within two hours and NHA A indicated it should be reported immediately when NHA A hears about it. Surveyor asked when R26 reported to RN C she was yelled at by a CNA, should this have been reported within two hours. NHA A indicated yes.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436</p> <p>Based on observation, interview, and record review, the facility did not ensure each resident received the necessary care and treatment for pressure injuries (PI) to promote healing consistent with professional standards of practice (SOP) for 1 of 2 residents (R11) reviewed for pressure injuries.</p> <p>Staff did not perform hand hygiene and did not treat each pressure injury separately when performing wound care for R11.</p> <p>This is evidenced by:</p> <p>The facility's policy title Clean Dressing Change, dated 7/20/22, states in part: .It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Each wound will be treated individually .</p> <p>R11 admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis affecting right dominant side (paralysis and weakness), stage 2 pressure injury to left buttock, and stage 2 pressure injury to right buttock.</p> <p>R11's physician orders include: Enhanced barrier precautions d/t (Due To) wound.</p> <p>Cleanse left inner buttock wound with soap and water, pat dry. Skin prep peri-wound. Apply foam silicone border dressing.</p> <p>Cleanse right buttock wound with soap and water, pat dry. Apply foam silicone border dressing</p> <p>Cleanse right shin wound with wound cleanser, pat dry. Topically apply leptospermum honey and cover with a gauze island w/brd (With Border) dressing.</p> <p>On 4/1/25 at 2:45 PM, Surveyor observed DON B (Director of Nursing) perform pressure injury wound care for R11. Surveyor observed DON B perform hand hygiene, apply gloves, apply skin prep around R11's left buttock pressure injury, then apply a dressing to the right buttock pressure injury, then apply the dressing to R11's left buttock pressure injury.</p> <p>Of note, DON B did not perform hand hygiene after each of the following tasks: applying skin prep around left buttock pressure injury, applying dressing to right buttock pressure injury, and applying dressing to left buttock pressure injury. DON B treated both pressure injuries at the same time and did not treat each one separately.</p> <p>On 4/1/25 at 3:19 PM, Surveyor interviewed DON B regarding pressure injury treatment for R11. DON B indicated wound care should be performed by treating each wound separately. DON B indicated the left buttock pressure injury and right buttock pressure injury should be treated separately because they are at different locations on the body. DON B indicated since each pressure injury is at a separate location she should treat one at a time and she did not. DON B indicated she should have completed wound care on the left buttock pressure injury and perform hand hygiene prior to moving on to the right buttock pressure injury and did not.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788</p> <p>Based on observation, interview, and record review, the facility did not ensure its medication error rates are not 5% or greater. There were 2 errors in 28 opportunities which affected 2 out of 5 residents (R26 and R16) included in the medication pass task, which resulted in an error rate of 7.14%.</p> <p>Staff did not administer R16's nasal spray per facility policy and standards of practice.</p> <p>R26 did not receive ordered Senna S with her morning medications.</p> <p>Evidenced by:</p> <p>The facility policy titled Nasal Administration, dated 1/23, states in part: .</p> <p>Policy: To administer nasal medications in a safe, accurate, and effective manner .</p> <p>Procedure: .</p> <p>9. Administer medication to a resident or help resident to do so if capable, using the following directions:</p> <p>a. Have resident keep head upright. Keep mouth closed, insert tip of pump, spray or inhaler into the nostril. Point the spray tip in the nose toward the back and outer side of the nose. Press a finger against the side of the nose to close one nostril and lean the head slightly forward so the spray will aim toward the back of the nose. Have resident sniff gently in through open nostril while pump or inhaler is quickly and firmly squeezed or activated.</p> <p>b. Instruct resident to hold breath for a few seconds and then breathe out through mouth .</p> <p>The facility policy titled Medication Administration, dated 1/23, states in part: .</p> <p>Policy: Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so .</p> <p>Medication Administration:</p> <p>1. Medications are administered in accordance with written orders of the prescriber .</p> <p>Documentation:</p> <p>1. The individual who administers the medication dose, records the administration on the resident's MAR (medication administration record) immediately following the medication being given .</p> <p>Example 1:</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R16 was admitted to the facility on [DATE] and has diagnoses that include major depressive disorder and anxiety disorder.</p> <p>R16's Annual Minimum Data Set (MDS) Assessment, dated 3/17/25, shows R16 has a Brief Interview for Mental Status (BIMS) score of 13 indicating R16 is cognitively intact.</p> <p>R16's Physician Orders as of 4/3/25, state in part: .</p> <p>Flonase Allergy Relief Nasal Suspension 50 MCG (micrograms)/ACT (Fluticasone Propionate .) 2 sprays in both nostrils two times a day for allergies . Order Date: 6/27/24. Start Date: 6/28/24 .</p> <p>On 4/02/25 at 7:35 AM, Surveyor observed RN C (Registered Nurse) administer R16's fluticasone nasal spray. RN C administered the sprays into R16's right nare without occluding the left nare, then administered the sprays into R16's left nare without occluding the right nare. RN C did not instruct R16 during the administration.</p> <p>On 4/2/25 at 8:03 AM, Surveyor interviewed RN C and asked what the procedure is for administration of nasal spray. RN C indicated R16 receives only one nasal spray, so I do not have to wait 5 minutes in between administration for more than one nasal spray. Surveyor asked if opposite nare should be occluded while administering spray into nares. RN C indicated he never occludes the opposite nare; RN C just does each nare without occluding opposite nare. Surveyor asked what the facility policy states, and RN C indicated he has been administering medications for a long time. Surveyor informed RN C to check the facility policy for proper procedure for administering nasal sprays. Surveyor asked RN C if he should instruct the resident during the process of administering nasal sprays. RN C indicated he has been administering medications for a long time, but yes the resident should be instructed on what to do during the administration process.</p> <p>Example 2:</p> <p>R26 was admitted to the facility on [DATE] and has diagnoses that include depression, anxiety, and history of malignant neoplasm of breast (a cancer that forms in the cells of the breast).</p> <p>R26's Admission MDS Assessment, dated 1/9/25, shows R26 has a BIMS score of 12 indicating R26 has moderate cognitive impairment.</p> <p>R26's Physicians Orders as of 4/02/25, state in part: .</p> <p>Senna-S Oral Tablet 8.6-50 mg (milligrams) (Sennosides-Docusate Sodium) Give 1 tablet by mouth one time a day for constipation. Order Date: 2/18/25. Start Date: 2/19/25 .</p> <p>On 4/02/25 at 7:47 AM, Surveyor observed RN C administer R26's morning medications. Surveyor reconciled the medications that were administered to R26 compared to R26's MAR. RN C did not include R26's ordered Senna-S in the morning medication pass. R26 did not receive her ordered Senna-S.</p> <p>Of note: RN C had left facility early that day due to sickness. Surveyor was unable to interview him after medications had been reconciled.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R26's April Medication Administration Record (MAR) shows for 4/02/25, R26 received her AM scheduled Senna-S Oral Tablet 8.6-50 mg (Sennosides-Docusate Sodium) by being signed out; Surveyor observed this medication being omitted.</p> <p>On 4/02/25 at 12:20 PM, Surveyor interviewed DON B (Director of Nursing) and asked if she would expect the facility's policies and procedures to be followed regarding medication administration. DON B indicated yes. Surveyor informed DON B of observation of RN C administering R16's nasal spray. Surveyor asked if that would be considered a medication administration error and DON B indicated she would have to check with cooperate. Surveyor informed DON B of R26 not receiving her morning Senna-S. Surveyor informed DON B RN C had signed it out on the MAR but it was not included in medication pass. DON B indicated the Senna-S being omitted would be a medication error.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36253</p> <p>Based on interview and record review, the facility did not ensure residents are free of any significant medication errors for 1 of 6 reviewed for medications (R30).</p> <p>R30 was prescribed an antibiotic that the facility did not administer to her.</p> <p>Findings include</p> <p>R30 was admitted to the facility on [DATE] and has diagnoses that include acquired absence of left foot and infection of skin and subcutaneous tissue.</p> <p>R30's discharge orders, dated and printed on 2/13/25 at 12:32 PM, from the hospital state, Start taking these medications .ciprofloxacin 750 mg (milligrams), take 1 tablet every 12 hours for 19 days. (of note: this order is for twice a day)</p> <p>R30's MAR (Medication Administration Record) shows this medication was never given, and R30 has a skin infection.</p> <p>On 4/02/25 at 10:27 AM, Surveyor interviewed DON B (Director of Nursing) who stated that there was a mix-up with the paperwork that was sent over by the hospital and the ciprofloxacin was not on the orders in the paperwork the facility received. DON B stated the physician saw the resident the next day (progress note indicates this was at or around 2/14/25 at 2:17 PM) and noted that the resident did not have ciprofloxacin on her medications list. When asked if the facility has ciprofloxacin in their medication contingencies, DON B stated, yes. DON B indicated that the facility should have recognized that R30 was admitted with an infection and should have inquired if R30 was prescribed an antibiotic if it was not on the resident's orders. When asked if she thought this was a medication error, DON B indicated that she did but the facility did not document it as a medication error.</p> <p>R30 discharged AMA (Against Medical Advice) on 2/14/25 at approximately 4:30 PM. R30 was not given any ciprofloxacin prior to discharge but orders were sent to a local pharmacy for R30 to pick up.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788</p> <p>Based on observation, interview, and record review, the facility did not assure drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional practices and include the expiration date when applicable in 1 of 1 medication rooms. This has the potential to affect more than a minimal number of Residents.</p> <p>Surveyor observed the following in the medication storage room:</p> <ul style="list-style-type: none"> - 4 bottles of Enema Saline Laxative with expiration dates of 2/25. - 6 boxes of Bisacodyl Suppositories with 12 suppositories in each box with expiration dates of 1/25. - 1 Bottle of Major Cough DM Dextromethorphan Polistirex Extended-Release Oral Suspension with an expiration date of 3/25. - 2 bottles of melatonin 1 mg (milligrams) with 180 caplets in each bottle with expiration dates of 3/25. <p>Evidenced by:</p> <p>The facility policy entitled, Storage of Medication, dated 1/23, states, in part: .Policy: Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.</p> <p>Procedures: .14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal . and reordered from pharmacy . if a current order exists .</p> <p>On 4/2/25 at 10:30 AM, Surveyor observed in the medication storage room [ROOM NUMBER] bottles of Enema Saline Laxatives, 6 boxes of Bisacodyl Suppositories, 1 Bottle of Major Cough DM Dextromethorphan Polistirex Extended-Release Oral Suspension, and the 2 bottles of melatonin. RN C (Registered Nurse) verified the 4 bottles of enemas expired on 2/25, the 6 boxes of bisacodyl suppositories expired on 1/25, the bottle of DM cough Suspension expired on 3/25, and the 2 bottles of melatonin expired on 3/25. RN C indicated the expired medications should not be in circulation.</p> <p>(continued on next page)</p>		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/2/25 at 10:57 AM, Surveyor interviewed DON B (Director of Nursing), who entered to medication storage room with Surveyor and RN C. DON B indicated the 4 bottles of Enema Saline Laxatives, 6 boxes of Bisacodyl Suppositories, 1 Bottle of Major Cough DM Dextromethorphan Polistirex Extended-Release Oral Suspension, and the 2 bottles of melatonin were expired and should not be in circulation. DON B removed the expired medications and indicated they would be disposed.		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436</p> <p>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 infection for 1 of 3 residents (R11) reviewed for enhanced barrier precautions and hand hygiene concerns during medication administration.</p> <p>Staff did not follow Enhanced Barrier Precautions (EBP) of wearing personal protective equipment (PPE) when providing wound care for R11.</p> <p>RN C (Registered Nurse) did not perform hand hygiene at the appropriate times.</p> <p>This is evidenced by:</p> <p>The facility's policy titled Enhanced Barrier Precautions, dated 8/8/24, states in part: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs). Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. An order for enhanced barrier precautions will be initiated for residents with any of the following: i. Wounds . High-contact resident care activities include: . h. Wound care: any chronic skin opening requiring a dressing.</p> <p>The facility's policy titled Hand Hygiene, dated 11/2/22, states in part: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.</p> <p>Hand Hygiene Table, states in part: Condition to use Either Soap and Water or Alcohol Based Hand Rub (ABHR is preferred): Between resident contacts; Before applying and after removing personal protective equipment (PPR), including gloves; Before preparing or handling medications; Before and after handling clean or soiled dressings; When, during resident care, moving from a contaminated body site to a clean body site.</p> <p>Example 1</p> <p>R11 admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis affecting right dominant side (paralysis and weakness).</p> <p>R11's physician orders include:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Mineral Point Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 109 N Iowa St Mineral Point, WI 53565	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Enhanced barrier precautions d/t (Due To) wound</p> <p>Cleanse left inner buttock wound with soap and water, pat dry. Skin prep peri-wound. Apply foam silicone border dressing</p> <p>Cleanse right buttock wound with soap and water, pat dry. Apply foam silicone border dressing</p> <p>Cleanse right shin wound with wound cleanser, pat dry. Topically apply leptospermum honey and cover with a gauze island w/brd (With Border) dressing</p> <p>On 4/1/25 at 2:45 PM, Surveyor observed an Enhanced Barrier Precaution sign on R11's door and there was a bin outside R11's door that contained personal protective equipment to wear for EBP. Surveyor observed wound care for R11 provided by DON B (Director of Nursing). DON B applied gloves and performed wound care to R11's shin and buttocks.</p> <p>Of note, DON B did not wear a gown during R11's wound care.</p> <p>On 4/1/25 at 3:19 PM, Surveyor interviewed DON B regarding EBP and PPE that should be worn during wound care. DON B indicated R11 is on EBP for his wounds. DON B indicated a gown and gloves should be worn during high contact activities with R11 including wound care. DON B indicated she should have worn a gown and did not.</p> <p>41788</p> <p>Example 2:</p> <p>On 4/2/25 at 7:47 AM, Surveyor observed RN C (Registered Nurse) during medication pass. RN C came out of a resident's room with gloves on. RN C removed the gloves and applied new gloves without performing hand hygiene. RN C pushed the medication cart from a resident's room down two hallways to the dining area with the same gloves on. RN C then went to start another resident's medication.</p> <p>On 4/2/25 at 8:03 AM, Surveyor interviewed RN C and asked when hand hygiene should be performed during medication pass. RN C indicated he performs hand hygiene after every other change of gloves due to it is too hard to get gloves on after hand hygiene is performed. Surveyor asked what the standard of practice for hand hygiene and glove change is. RN C indicated technically hand hygiene should be performed in between glove changes.</p> <p>RN C did not perform hand hygiene per standards of practice.</p>		