STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525363	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Suring Health and Rehab Center	430 Manor Dr Suring, WI 54174

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY 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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure 1 of 5 sampled residents (R1) received care and treatment in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) and failed to ensure a change of condition was recognized and acted upon timely.On 8/26/25, R1 complained of increased pain and difficulty breathing. The Nurse Practitioner (NP) was notified and indicated R1 could have additional acetaminophen up to 4000 milligrams (mg) in a 24 hour period in addition to tramadol and could use diclofenac or stock pain reliever for back/shoulder pain. The NP also gave an order to try to wean R1 off oxygen which the NP presumed was used for anxiety/pain and indicated if R1 continued to require oxygen, staff should notify the NP. The orders were not transcribed in R1's medical record at that time. According to staff interviews, R1 was tearful, reported ongoing pain and difficulty breathing, and cried out in pain during the evening hours. R1's medical record did not contain evidence of assessments of R1's condition or documentation that R1 required oxygen throughout the evening. There were no additional updates to the NP or Medical Doctor (MD) until R1 requested to go to the emergency room (ER). At the ER, R1 was diagnosed with sepsis, right pleural effusion, and acute renal failure and was subsequently transferred to another hospital and admitted to the Intensive Care Unit (ICU). The facility's failure to recognize a change of condition, complete thorough assessments, and provide timely care for a resident with increased pain and difficulty breathing despite the use of oxygen led to a finding of immediate jeopardy that began on 8/26/25. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 9/5/25 at 9:57 AM. The immediate jeopardy was removed on 9/5/25, however, the deficient practice continues at a scope/severity level D (potential for more than minimal harm/isolated) as the facility continues to implement its action planFindings include:The facility's Pain Management policy, dated 2/5/25, indicates the facility must ensure pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Facility staff should use a systematic approach for recognition, assessment, treatment, and monitoring of pain. The facility's Notification of Changes policy, dated 3/2025, indicates the facility must inform the resident, consult with the resident's physician, and/or notify the resident's family member or legal representative when there is a change in condition such as a significant change in the resident's physical, mental, or psychosocial condition and circumstances that require a need to alter treatment. According to the Wisconsin Nurse Practice Act, N6.03(1): A Registered Nurse (RN) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis.On 9/3/25, Surveyor reviewed R1's medical record. R1 had diagnoses including heart failure, diabetes, anxiety, and lymphedema. R1's Minimum Data Set (MDS) assessment, dated 6/28/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 was R1's own decision maker.A care plan, dated 7/23/25, indicated R1 had altered respiratory status/difficulty breathing related to heart failure with a goal to maintain a normal breathing pattern. The care plan contained interventions to use oxygen per nasal cannula 1 to 4 liters per minute (LPM) as needed for shortness of breath (SOB), respiratory distress, or comfort; and monitor for signs/symptoms of respiratory distress and report to physician as needed, including increased respirations, decreased pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, cough, pleuritic pain, accessory muscle usage, and skin color changes to blue/grey.R1's Medication Administration Record (MAR) indicated R1 received scheduled acetaminophen (a non-opioid anlagesic medication used to treat mild to moderate pain) 1000 mg three times daily for pain (up to 4000 mg total per day) (start date 6/21/25); tramadol (an opioid medication used to treat pain) 50-100 mg every 6