

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER Suring Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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, staff and resident interview, and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible for 3 residents (R) (R3, R4, and R10) of 3 sampled residents. Staff did not use a gait belt while assisting R3 with a transfer. On 4/4/26, R4 fell out of bed and fractured their right humerus (long bone in the upper arm that extends from the shoulder to the elbow). Staff indicated the bed malfunctioned and/or the mattress moved during cares. An intervention was not added to R4's care plan post-fall. R10 fell on 4/16/26. An intervention was not added to R10's care plan post-fall. Findings include: The facility's Safe Resident Handling/Mobility/Transfers policy, revised 11/29/23, indicates: .Mechanical lifting equipment or other approved transferring aids will be used based on the resident's needs to prevent manual lifting, except in medical emergencies .Resident lifting and transferring will be performed according to the resident's individual plan of care. The facility's Accidents and Supervision policy, revised 10/8/24, indicates: .Identification of Hazards and Risks: a. All staff are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. b. The facility should make reasonable efforts to identify the hazards and risk factors for each resident .Implementation of Interventions .d. Documenting interventions (e.g. plans of action developed through the QAA committee or care plans for the individual resident) .The facility's Bed Maintenance and Inspections policy, revised 3/1/25, indicates: It is the policy of this facility to conduct regular inspections of all bed frames, mattresses, and bed rails if any as part of a regular maintenance program to identify and avoid areas of possible entrapment .Bed frame, mattress, and bed rail inspections will be conducted upon each item entering the facility and then placed on a regularly scheduled inspection and maintenance cycle according to the manufacturer's recommendations, to include manufacturer's timeframe recommendations. 1. R3 was admitted to the facility on [DATE] and had diagnoses including metabolic encephalopathy, hemiplegia and hemiparesis, aphasia, and history of CVA (otherwise known as stroke). R3's Minimum Data Set (MDS) assessment, dated 5/12/26, stated R3 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating severe cognitive impairment. A self care deficit related to cerebrovascular accident (CVA) (stroke) care plan, revised 1/31/26, contained an intervention to transfer with the assistance of 1 staff with a Sara lift. A fall risk care plan, revised 10/31/25, indicated R3 was at risk for falls, accidents, and incidents. On 6/2/26 at 1:34 PM, Surveyor observed Certified Nursing Assistant (CNA)-J transfer R3 from wheelchair to toilet via Sara lift. CNA-J moved the lift in front of R3's wheelchair and assisted R3 by lifting up the back of R3's pants. After CNA-J finished the transfer, Surveyor asked if R3 had a gait belt. CNA-J indicated maybe somewhere in the room. Surveyor observed a gait belt on R3's nightstand. On 6/2/26 at 1:40 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed staff should use a gait belt and not lift a resident up by the back of their pants. 2. R4 was admitted to the facility on [DATE] and had diagnoses including weakness, obesity, and essential tremor, and chronic obstructive pulmonary disease (COPD). R4's MDS assessment, dated 3/27/26, stated R4 had a BIMS score of 11 out of 15, indicating moderate (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitive impairment. A care plan, revised 8/15/25, indicated R4 had an activities of daily living (ADL) self-care performance deficit related to chronic respiratory failure with hypoxia. The care plan contained an intervention (dated 10/7/24) for assist of 2 staff with bed mobility. A falls care plan, dated 6/20/24, contained revised interventions (dated 4/28/26) to follow therapy recommendations for transfers - Hoyer lift with 2 staff; and physical therapy (PT)/occupational therapy (OT) to evaluate and treat as ordered or as needed (PRN). A progress note, dated 4/4/26 at 11:55 AM, indicated Medication Technician (MT)-F informed the nurse that R4 was on the floor. The nurse went to R4's room and observed R4 on their backside on the floor by the side of the bed. CNA-G had assisted R4 to the ground. R4 had a skin tear on the left forearm caused by metal from a bracelet. R4 denied hitting their head and any other injuries at the time. Staff transferred R4 back to bed via Hoyer lift and noted R4 was comfortable. A progress note, dated 4/4/26 at 5:11 PM, indicated R4 fell from bed at 9:30 AM. R4 fell to the right side and CNA-G was able to ease the force of the fall. R4 had right shoulder pain (at a level 8 out of 10) and as well as right elbow and left arm pain where R4 incurred a skin tear during the fall. R4's shoulder pain was not relieved by Tylenol and tramadol administered together at 3:40 PM. The physician gave an order to send R4 to the Emergency Department (ED) for evaluation. A progress note, dated 4/5/26 at 3:09 AM, indicated R4 returned to the facility at 11:00 PM and had a closed fracture of the right humerus neck. Instructions were to wear sling, apply ice 20 minutes several times daily, and use Tylenol as ordered for pain control. An orthopedic referral was completed. An Interdisciplinary Team (IDT) note, dated 4/10/26 at 11:34 AM, indicated R4 slid out of bed onto the floor during AM cares on 4/4/26. A Root Cause Analysis (RCA) indicated R4 had little control of their trunk and limbs due to decline and illness. Previous fall interventions were in place at the time of the fall per staff. R4's mattress was adjusted to have increased security and stability. R4 continued to decline health-wise and declined Hospice services despite education. Maintenance staff checked all beds for security and stability. New orders included to send R4 to the ED for evaluation and treatment. The note indicated R4 continued to be a fall risk due to a decline in health. The goal was to keep R4 free from major injury. On 6/2/26, Surveyor reviewed the facility's fall investigation. Witness statements indicated R4's mattress shifted off the bed frame during cares and R4 was lowered to the floor by staff in a controlled manner. MT-F notified the nurse who observed R4 on the floor adjacent to the bed. R4 didn't know what happened and stated they were getting washed up and were then on the floor. R4 was assessed and transferred back to bed via Hoyer lift. R4 was positioned comfortably in bed and monitored. R4 had experienced a recent gradual overall decline in physical condition. R4 carried a significant amount of weight through the trunk and demonstrated decreased trunk control, impaired balance, and a reduced ability to independently control and reposition their upper and lower extremities. The deficits increased R4's need for staff assistance with mobility, positioning, transfers, and ADLs. R4 weighed 298.8 pounds on 4/2/26 which contributed to R4's immobility. Maintenance staff inspected R4's bed and mattress following the incident. No structural defects, equipment malfunctions, or mechanical failures were identified. The bed was a facility-owned bariatric bed with an appropriately sized bariatric mattress designed for and compatible with the bed frame. The mattress was properly sized and able to be securely positioned to the bed frame. A facility-wide inspection of beds was completed on 4/5/26 to identify similar safety concerns and verify proper function and stability. As a precautionary measure, bed, wheel, and brake hardware were inspected and tightened as needed to ensure optimal stability and safe operation. Staff were educated on following care plans and positioning/repositioning residents. The investigation indicated R4 came to rest on the floor during morning cares after R4's mattress became displaced from the bed frame. Staff interviews, documentation review, and equipment inspections were completed. The investigation found no evidence of intentional misconduct, abuse, neglect, or failure to respond appropriately. Environmental review confirmed adequate space around the bed to allow staff to safely provide care from both sides. The root cause of the fall was determined to be mattress displacement during the provision of care. Equipment defect, environmental hazards, and/or (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff misconduct were not identified as contributing factors. A witness statement from MT-F on 4/4/26 indicated MT-F was present while R4 was turned toward CNA-G during morning cares. During the turn, the bed malfunctioned and the air mattress began to slide off the bed frame toward MT-F. R4 rolled unexpectedly toward CNA-G. CNA-G attempted to prevent R4 from falling out of bed but was unable to fully stop the fall. MT-F attempted to stabilize the air mattress as it shifted toward MT-F. MT-F observed CNA-G safely and slowly assist R4 to the floor. R4 slid onto the floor and landed on their side and buttocks. A witness statement from CNA-G, dated 4/4/26, indicated the bed malfunctioned while R4 was being turned toward CNA-G during morning cares. The air mattress started to slide off the bed frame in the opposite direction which caused R4 to roll unexpectedly toward CNA-G. CNA-G attempted to prevent R4 from falling out of bed but was unable to fully stop the fall. CNA-G lowered R4 to the floor as safely and slowly as possible. R4 landed on their backside. The investigation included signed education for nursing staff on following care plans, positioning/repositioning, and the use of equipment, including ensuring all equipment is in good working condition prior to use. On 6/2/26 at 10:19 AM, Surveyor attempted to interview R4 who looked at Surveyor but did not respond. Surveyor noted R4's mattress was strapped securely to the bed via 3 straps and the air mattress was functioning. R4 was no longer wearing a sling. On 6/2/26 at 12:39 PM, Surveyor interviewed Registered Nurse (RN)-H who responded to R4's fall on 4/4/26. RN-H indicated MT-F told them that R4 was on the floor. RN-H observed CNA-G with R4 and confirmed there were 2 staff present during the transfer. RN-H indicated R4 had a cut on their arm. R4 was transferred back to bed via Hoyer lift and did not complain of pain at that time. R4 complained of shoulder pain later in the day and was transferred to the ED. On 6/2/26 at 3:30 PM, Surveyor interviewed Maintenance Director (MD)-I who indicated they inspect 5 to 6 beds each month but do not inspect all beds each month. MD-I confirmed they did a sweep of all beds in April (2026). MD-I indicated they follow manufacturer's guidelines if there are any. On 6/2/26, Surveyor requested the date R4's bed was last checked prior to the incident and the manufacturer's guidelines for the bed. On 6/2/26 at 4:07 PM, Nursing Home Administrator (NHA)-A provided documentation that R4's bed was last checked on 4/6/26. NHA-A also provided the manual for a Comfort Zone Lateral Rotating Mattress Alternating Pressure with Low Air Loss bed. Surveyor reviewed the manual which did not contain frequency for maintenance checks. NHA-A also provided an Inspection of Beds and Mattresses sheet that indicated inspections were completed on 3/31/26, 4/30/26, and 5/31/26. The inspection sheet did not list which beds were inspected. On 6/2/26, 6/3/26, and 6/11/26, Surveyor attempted to contact MT-F and CNA-G via phone with no answer and no way to leave a voicemail. On 6/2/26 at 2:18 PM, Surveyor interviewed DON-B who indicated R4's mattress slid a bit but did not go off the bed. The movement of the mattress caused R4's weight to shift off the mattress as R4's weight distribution was uneven. R4 was lowered to the ground by CNA-G. DON-B indicated the facility did immediate education. DON-B indicated staff were following the care plan and 2 staff were present during cares. DON-B indicated all beds, including R4's, were checked for safety, brakes, and mattress securement post-fall. Surveyor informed DON-B that R4's care plan did not contain an intervention added post-fall related to the root cause of the fall. 3. R10 was admitted to the facility on [DATE] and had diagnoses including discitis (a painful inflammation and infection of the intervertebral discs of the spine), lymphedema, Body Mass Index (BMI) 60 to 60.9, and osteomyelitis. R10's MDS assessment, dated 4/29/26, stated R10 had a BIMS score of 15 out of 15, indicating intact cognition. A care plan, dated 9/5/25, indicated R10 was at risk for falls, accidents, and incidents related to impaired mobility. The care plan contained interventions to anticipate and meet R10's needs (dated 10/1/25); Be sure R4's call light is within reach and encourage R4 to use it for assistance as needed. R4 needs prompt response to all requests for assistance (dated 7/16/25); Follow facility fall protocol (dated 7/16/25); and Physical therapy (PT) evaluate and treat as ordered or PRN (dated 10/1/25). A care plan, initiated 1/17/26, indicated R10 was at risk for alteration in musculoskeletal status due to osteomyelitis and gout. The care plan contained an intervention to monitor for fatigue and plan (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activities during optimal times when pain and stiffness is abated (dated 1/17/26). A care plan, revised 7/18/25, indicated R10 had an ADL self-care performance deficit related to osteomyelitis of vertebra, thoracic region. The care plan contained an intervention for the assistance of 1 staff for transfers with a four-wheeled walker (revised 4/12/26). On 4/16/26, R10 had a witnessed fall during a transfer and fractured a toe. An IDT review note, dated 4/23/26 at 12:55 PM, indicated a nurse was called to R10's room before supper on 4/16/26. R10's knees buckled when a CNA was transferring them into bed and R10 was lowered to the floor. R10 was anxious post-fall, was assessed by the nurse, and was transferred into bed via Hoyer lift. The IDT determined the root cause of the fall was R10's movement without awareness of activity or foot placement. R10 remained a stand-by assist with the assistance of one staff. Therapy continued to work with R10. New interventions included: Educate R10 to slow down and think about R10's movements when walking and transferring; R10 will continue to work with therapy to increase strength and progress in independence. (Of note: On 6/2/26, Surveyor noted R10's care plan was not updated with the new interventions post-fall.) On 6/2/26 at 11:57 AM, Surveyor interviewed R10 who indicated a therapist spoke with them regarding the fall. R10 was educated on taking time to ensure their feet were underneath them. R10 indicated they did not ensure their feet were underneath them when their knees buckled and they went to the floor on 4/16/26. R10 indicated staff were present during the transfer and R10 can transfer with stand-by assistance. On 6/2/26 at 2:18 PM, Surveyor interviewed DON-B who indicated R10's therapist provided education post-fall. When Surveyor indicated there were no interventions added to R10's care plan post-fall so other staff were aware and could prevent the incident from potentially happening again, DON-B was surprised interventions were not added. On 6/5/26 at 2:59 PM, NHA-A sent an email to Surveyor which contained supporting documentation that revealed R10's care plan and Kardex (an abbreviated care plan used by nursing staff) were reviewed and updated after the event to ensure ongoing communication of interventions to direct care staff. Upon review of the information, Surveyor noted the care plan contained different dates than the care plan Surveyor reviewed while at the facility. The care plan sent via email contained an intervention to monitor for fatigue and plan activities during optimal times when pain and stiffness are abated that indicated the intervention was initiated on 4/20/26 and revised on 6/2/26. A care plan Surveyor reviewed while at the facility on 6/2/26 indicated the same intervention was initiated on 1/17/26.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on staff interview and record review, the facility did not provide pharmaceutical services to ensure the accurate administration of medication. This practice had the potential to affect more than 4 of the 40 residents residing in the facility. The facility's controlled substance record books were missing signatures for narcotic counts. Findings include: The facility's Controlled Substance Administration and Accountability policy, revised 4/15/24, indicates: It is the policy of this facility to promote safe, high-quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion, or accidental exposure. All controlled substances are accounted for in one of the following ways: .ii. All controlled substances obtained from a non-automated medication card or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided. .h. The controlled drug record serves the dual purpose of recording both narcotic disposition and patient administration. .j. The charge nurse or designee conducts a daily visual audit of the required documentation of controlled substances. .b. Areas without automated dispensing systems utilize a substantially-constructed storage unit with two locks and a paper system for 24-hour recording of controlled substance use. .Inventory verification. .b. For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift. On 6/2/26 at 9:43 AM, Surveyor reviewed narcotic signature books for medication cart A and noted staff verification signatures were missing in the following books on the following dates: Book 25: 3/2/26, 3/3/26, 3/5/26-3/8/26, 3/14/26-3/29/26, 4/7/26-4/9/26, 4/21/26-4/22/26, 4/24/26-4/25/26, 4/29/26, 5/1/26, 5/5/26, 5/6/26, 5/9/26-5/12/26, and 5/14/26. Book 26: 3/10/26, 3/11/26, 3/17/26, 3/25/26, 3/29/26, 3/30/26, 3/31/26, 4/4/26, 4/5/26, 4/7/26-4/11/26, 4/14/26, 4/21/26, 4/22/26, 4/24/26, 4/25/26, 4/29/26, 5/1/26, 5/6/26, 5/9/26-5/11/26, 5/14/26, 5/18/26, and 5/24/26-5/25/26. Book 27: 4/17/26, 4/21/26, 4/23/26, 4/27/26, 4/28/26, 4/29/26, 5/1/26, 5/5/26, 5/6/26, 5/8/26, 5/9/26-5/12/26, 5/14/26, 5/18/26, 5/21/26, and 5/24/26. On 6/2/26 at 9:43 AM, Surveyor reviewed narcotic signature books for medication cart B and noted staff verification signatures were missing in the following books on the following dates: Book 24: 3/8/26, 3/10/26, 3/11/26, 3/13/26, 3/21/26- 3/26/26, 3/27/26, 3/29/26, 4/2/26, 4/7/26, 4/8/26, 4/11/26, 4/13/26, 4/14/26, 4/21/26-4/22/26, 4/24/26-4/30/26, 5/3/26, 5/5/26-5/6/26, 5/15/26, 5/20/26, and 5/25/26. Book 25: 4/5/26, 4/7/26-4/9/26, 4/11/26, 4/13/26, 4/14/26, 4/21/26, 4/22/26, 4/24/26-4/27/26, 4/29/26-5/1/26, 5/3/26, 5/5/26-5/6/26, 5/14/26, and 5/20/26. On 6/2/26 at 9:44 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-K who indicated nurses are required to count narcotics in medication carts with another nurse at the beginning and end of each shift. LPN-K indicated nurses signing in and signing out are required to sign the controlled substance record book acknowledging the narcotic count. LPN-K acknowledged there were multiple missing signatures in the controlled substance record books. On 6/2/26 at 11:10 AM, Surveyor reviewed missing signatures in the controlled substance record books for medication carts A and B with Director of Nursing (DON)-B who indicated 2 nursing staff are required to count narcotics and sign medication controlled substance record books at each change of shift. DON-B reviewed and acknowledged the missing signatures.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 6 residents (R) (R12, R13, R2, R7, R14, and R15) of 12 sampled residents. R12 had a gastric tube. An enhanced barrier precautions (EBP) sign was not posted outside the entrance to R12's room. R12's care plan stated R12 was on universal precautions. R13 had a right heel wound with daily dressing changes. An EBP sign was not posted outside the entrance to R13's room. R13's care plan stated R13 was on universal precautions. R2 had a colostomy. An EBP sign was not posted outside the entrance to R2's room. R2's care plan stated R2 was on universal precautions. R7 had wounds that required daily dressing changes. An EBP sign was posted outside the entrance to R7's room. A PPE cart in R7's room contained a contact/isolation sign. R7's care plan stated R7 was on universal precautions. A PPE cart in R14's room contained a contact precautions sign. R14's medical record indicated contact precautions were discontinued in May 2026. A PPE cart in R15's room contained a contact precautions sign. R15's medical record indicated contact precautions were discontinued in May 2026. Findings include: The facility's Transmission-Based (Isolation) Precautions policy, revised 6/4/24, indicates: 1. Facility staff will apply transmission-based precautions (TBP), in addition to standard precautions, to residents who are known or suspected of being infected or colonized with certain infectious agents requiring additional controls to prevent transmission. 2. The facility will use standard approaches as defined by the Centers for Disease Control and Prevention (CDC) for TBP: airborne, contact, and droplet precautions. The category of TBP will determine the type of personal protective equipment (PPE) to be used .e. Signage that includes instructions for use of specific PPE will be placed in a conspicuous location outside the resident's room, wing, or facility-wide. Additionally, either the CDC category of TBP or instructions to see the nurse before entering will be included in the signage. The facility's Enhanced Barrier Precautions policy, revised 9/9/25, indicates: It is the guideline of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms (MDROs). 2. Initiation of EBP: .b. An order for EBP will be obtained for residents with any of the following .wounds .feeding tubes, ostomies, and indwelling medical devices. 3. Implementation of EBP: a. Make gowns and gloves available immediately near or outside the resident's room. 1. R12 was admitted to the facility on [DATE] and had diagnoses including gastrostomy status and irritant contact dermatitis due to friction or contact with body fluids. A care plan, revised 4/1/25, indicated R12 was on EBP due to a feeding tube. The care plan contained an intervention, dated 12/15/25, to maintain universal precautions when providing resident care. On 6/2/26, Surveyor reviewed a staff communication list that indicated R12 was on EBP. On 6/2/26 at 9:15 AM, Surveyor did not observe an EBP sign posted near the entrance to R12's room. Surveyor observed R12's room multiple times during the day and noted an EBP sign was still not posted at 4:00 PM when Surveyor exited the facility. On 6/2/26 at 2:20 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R12 had a gastric tube and should have an EBP sign posted outside the entrance to R12's room. 2. R13 was admitted to the facility on [DATE] and had diagnoses including pressure ulcer right heel stage 3 and non-pressure chronic ulcer of unspecified part of left lower leg limited to breakdown of skin. R13's Minimum Data Set (MDS) assessment, dated 3/23/26, stated R13 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. A care plan, revised 5/14/26, indicated R13 was on EBP due to a right heel unstageable pressure ulcer. The care plan contained an intervention, dated 10/9/25, to maintain universal precautions when providing resident care. R13's medical record contained the following wound care order: ~ Stage 3 right heel wound: Cleanse wound with normal saline, pat dry, apply Santyl to wound bed, cover with ADB and wrap in Kerlix once daily and as needed for wound care (dated 5/20/26) On 6/2/26 at 9:15 AM, Surveyor did not observe EBP signage posted near the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	entrance to R13's room. Surveyor observed R13's room multiple times during the day and noted an EBP sign was still not posted at 4:00 PM when Surveyor exited the facility. On 6/2/26 at 1:09 PM, Surveyor interviewed R13 who indicated their wound dressing is changed daily by staff. R13 did not recall an EBP sign posted on their door. On 6/2/26 at 1:38 PM, Surveyor interviewed DON-B who indicated R13 had a wound with a daily dressing change and an EBP sign should be posted near the entrance to R13's room. DON-B indicated R13 was not on universal precautions as indicated in R13's care plan. 3. R2 was admitted to the facility on [DATE] and had diagnoses including Crohn's disease of the large intestine and history of methicillin-resistant Staphylococcus aureus (MRSA) infection. A care plan, revised 5/27/26, indicated R2 was on EBP due to a colostomy. The care plan contained an intervention, dated 6/20/23, to maintain universal precautions when providing resident care. On 6/2/26, Surveyor reviewed a staff communication list that indicated R2 was on EBP. On 6/2/26 at 9:15 AM, Surveyor did not observe an EBP sign posted near the entrance to R2's room. Surveyor observed R2's room multiple times throughout the day and noted an EBP sign was still not posted at 4:00 PM when Surveyor exited the facility. On 6/2/26 at 11:35 AM, Surveyor interviewed Registered Nurse (RN)-H who indicated R2 was on EBP and had an ostomy. On 6/2/26 at 11:45 AM, Surveyor interviewed DON-B who indicated R2 was on EBP due to a colostomy. DON-B verified there should be an EBP sign posted near the entrance to R2's room. 4. R7 was admitted to the facility on [DATE] and had diagnoses including cellulitis, lymphedema, and irritant contact dermatitis. A care plan, dated 6/20/23, did not indicate R7 was on EBP or contain a wound focus. The care plan contained an intervention, dated 9/20/24, to maintain universal precautions when providing resident care. On 6/2/26, Surveyor reviewed a staff communication list that indicated R7 was on EBP. R7's medical record contained the following wound care orders: ~ Left posterior thigh wound: Cleanse wound with normal saline, pat dry, apply Aquacel to wound bed then apply sacral border foam dressing every shift and as needed with incontinence (dated 4/27/26) ~ Right anterior thigh wound: Cleanse wound with normal saline, pat dry, apply house stock barrier cream to skin every shift and as needed (dated 5/27/26) ~ Right lower leg wound: Cleanse with normal saline and use skin prep to wound. Cover with ABD pad daily and as needed (dated 5/31/26) On 6/2/26 at 9:15 AM, Surveyor did not observe an EBP sign posted near the entrance to R7's room. Surveyor observed a contact/isolation sign on top of a PPE cart in R7's room. Surveyor observed R7's room multiple times during the day and noted an EBP sign was still not posted at 4:00 PM when Surveyor exited the facility. On 6/2/26 at 9:52 AM, Surveyor observed a housekeeper cleaning R7's room without a gown. On 6/2/26 at 2:20 PM, Surveyor interviewed DON-B who indicated R7 was on EBP for wounds that required daily dressing changes. DON-B indicated a contact/isolation sign should not be on the PPE cart in R7's room. DON-B also indicated R7's care plan should include EBP and wound care interventions. 5. R14 was admitted to the facility on [DATE] and had diagnoses included chronic obstructive pulmonary disease (COPD), respiratory failure with hypoxia, panlobular emphysema, pneumonia, and pulmonary emboli. A care plan, dated 9/20/24, indicated R14 had risk for exposure to infection/illness from the community. The care plan contained an intervention, dated 9/20/24, to maintain universal precautions when providing resident care. On 6/2/26 at 9:15 AM, Surveyor observed a contact precautions sign on top of a PPE cart in R14's room. Surveyor observed R14's room multiple times throughout the day and noted the contact precautions sign was still present at 4:00 PM when Surveyor exited the facility. On 6/2/26 at 1:38 PM, Surveyor interviewed DON-B who indicated R14 was not on precautions. DON-B indicated the contact/isolation sign should have been removed from R14's room in May 2026. DON-B indicated R14's roommate had been on contact isolation for possible pink eye and became asymptomatic the end of May. 6. R15 was admitted to the facility on [DATE] and had diagnoses including cerebral infarct, encephalopathy, and hemiplegia. A care plan, dated 2/25/25, indicated R15 had risk for exposure to infection/illness from the community. The care plan contained an intervention, dated 3/20/25, to maintain universal precautions when providing resident care. On 6/2/26 at 9:15 AM, Surveyor observed a contact precautions sign on top of a PPE cart in R15's room. Surveyor observed (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER Suring Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R15's room multiple times during the day and noted the contact precautions sign was still present at 4:00 PM when Surveyor exited the facility. On 6/2/26 at 1:21 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-L who was not aware R15 was on precautions. CNA-L indicated CNA-L needed to speak with the nurse to confirm if CNA-L needed to wear PPE in R15's room. On 6/2/26 at 1:38 PM, Surveyor interviewed DON-B who indicated R15 was not on precautions. DON-B indicated the contact/isolation sign should have been removed in May 2026. DON-B indicated R15 had been on contact isolation precautions for possible pink eye that cleared up the end of May.		