

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 01/28/2026
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 - Many	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 transmission of communicable disease and infection. This practice had the potential to affect all 46 residents residing in the facility. R37 tested positive for Influenza on 1/21/26. There was not a contact/droplet sign or a personal protective equipment (PPE) cart outside R37's room. In addition, staff completed cares without the proper PPE. R2 was on precautions due to a diagnosis of Influenza A. Certified Nursing Assistant (CNA)-L did not don the appropriate PPE and Registered Nurse (RN)-I reused a disposable gown to enter R2's room. In addition, RN-I removed an N95 respirator prior to exiting the room. R43 was on droplet precautions due to a diagnosis of Influenza A. CNA-E and CNA-K did not don appropriate PPE prior to entering R43's room. R7 tested positive for COVID-19. There was an enhanced barrier precautions (EBP) sign outside R7's room and a PPE cart that contained N95 respirators. CNA-C applied an N95 respirator over a surgical mask prior to entering R7's room. R20 had a Foley catheter. There was not an EBP sign or a PPE cart outside R20's room. In addition, staff completed cares without the proper PPE. R1 received nutrition via tube feeding. There was not an EBP sign or a PPE cart outside R1's room. In addition, CNA-D and CNA-E did not wear gowns while transferring and assisting R1 in the bathroom. R3 was on EBP. During wound care, RN-I did not wear a gown. In addition, RN-I pulled down a surgical mask to talk to R3. R12 was diagnosed with Influenza on 1/22/26. A contact/droplet sign indicated to keep the door closed. The door was observed open on multiple occasions. R48 was symptomatic for Influenza on 1/20/26. R48's roommate was diagnosed with Influenza on 1/22/26. A contact/droplet sign indicated to keep the door closed. The door was observed open on multiple occasions. R36's roommate tested positive for Influenza on 1/21/26. There was not a contact/droplet sign or a PPE cart outside R36's room. R40 had a Foley catheter. There was not an EBP sign or a PPE cart outside R40's room. The facility's respiratory line list, dated 1/6/26, indicated Licensed Practical Nurse (LPN)-F had a symptom onset date but did not identify symptoms. LPN-F tested positive for COVID-19; however, the line list did not contain retest dates. CNA-D and Social Services Director (SSD)-M did not have well dates identified on a staff/resident line list. In addition, R29's roommate was diagnosed with influenza A. R29 was not monitored for signs/symptoms of respiratory illness. Uncovered resident clothing was observed in the hallway. Findings Include: The facility's Transmission-Based (Isolation) Precautions policy, revised 6/4/24, indicates: .2. The facility will use standard approaches as defined by the Centers for Disease Prevention and Control (CDC) for transmission-based precautions (TBP): airborne, contact, and droplet precautions. The category of TBP will determine the type of personal protective equipment (PPE) to be used .4. Residents on TBP should remain in their rooms except for medically necessary care.9. Initiation of TBP (Isolation Precautions): a. Nursing staff may place residents with suspected or confirmed infectious diarrhea, influenza, or symptoms consistent with a communicable disease on TBP/isolation empirically while awaiting confirmation. b. An order for TBP/isolation will be obtained for residents who are known or suspected to be infected or colonized with infectious agents that require additional (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. From 1/26/26 to 1/28/26, Surveyor reviewed R37's medical record. R37 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD) with acute exacerbation, acute kidney failure, and unspecified dementia. R37's Minimum Data Set (MDS) assessment, dated 11/19/25, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R36 had moderately impaired cognition. R37's medical record indicated a diagnosis of Influenza was added on 1/22/26. A progress note, dated 1/21/26 at 5:59 AM, indicated R37 had an elevated temperature. A progress note, dated 1/22/26 at 11:29 AM, indicated a chest X-ray revealed mild right lower lobe infiltrate. R37 tested positive for Influenza A. A progress note, dated 1/22/26 at 6:38 PM, indicated a chest X-ray was probable for right lower lung pneumonia. The physician ordered Tamiflu and to treat R37 for probable pneumonia. Surveyor reviewed R37's temperatures which were as follows: ~ On 1/22/26 at 6:31 AM - 98.8 degrees Fahrenheit (F) ~ On 1/21/26 at 5:08 PM - 100.4 degrees F ~ On 1/21/26 at 12:49 PM - 101.5 degrees F ~ On 1/21/26 at 10:54 AM - 100.4 degrees F ~ On 1/21/26 at 2:30 AM - 100.4 degrees F ~ On 1/20/26 at 8:08 PM - 98.7 degrees F On 1/26/26 at 10:20 AM, Surveyor noted there was not a TBP sign or PPE cart outside R37's room. Surveyor observed R37 in the room with a visitor. On 1/26/26 at 10:34 AM, R37 asked Surveyor if R37's portable oxygen tank was out of oxygen. Surveyor asked CNA-N to assist R37. Surveyor observed CNA-N enter R37's room without donning PPE. CNA-N indicated R37 was out of oxygen and wheeled R37 unmasked out of the room to fill the portable tank. CNA-N filled R37's portable tank and wheeled R37 back to R37's room. CNA-N did not complete hand hygiene when exiting R37's room. On 1/26/26 at 10:50 AM, Surveyor interviewed CNA-N who indicated R37 was not on contact/droplet precautions. CNA-N stated staff rely on signs outside residents' doors for whether or not to use TBP, including the appropriate PPE to wear and precautions to follow. CNA-N indicated there was an Outbreak List at the nurses' station. CNA-N stated if a resident is on the Outbreak List, he/she is on contact/droplet precautions and a date is listed that indicates when precautions can be discontinued. CNA-N stated residents have the right to leave their rooms; however, staff suggest residents on contact/droplet precautions wear a mask when leaving their rooms. CNA-N confirmed staff should complete hand hygiene when exiting a resident's room. On 1/26/26 at 2:00 PM, Surveyor observed an Outbreak List at the nurses' station. R37 was not on (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	fibrillation. R3's MDS assessment, dated 9/20/25, had a BIMS score of 15 of 15 which indicated R3 had intact cognition. A care plan, dated 9/17/25, indicated R3 was on EBP due to a stage 3 right heel pressure injury. R3's medical record contained an order for daily and as needed wound care. On 1/27/26 at 10:26 AM, Surveyor observed LPN-J complete hand hygiene and don a gown and gloves. Surveyor also observed RN-I complete hand hygiene and don gloves. RN-I held R3's right foot/heel in an elevated position while LPN-J completed wound care. LPN-J and RN-I both wore surgical masks. The facility had confirmed cases of COVID-19 and Influenza A. During the observation, RN-I pulled down RN-I's surgical mask to talk to R3. On 1/27/26 at 10:36 AM, Surveyor interviewed RN-I who stated RN-I did not have to wear a gown while assisting with wound care if RN-I did not touch any wound drainage. On 1/27/26 at 10:38 AM, Surveyor interviewed LPN-J who stated RN-I did not have to wear a gown while assisting with wound care because RN-I did not touch any wound drainage. On 1/27/26 at 3:24 PM, Surveyor interviewed DON-B who was also the facility's Infection Preventionist (IP). DON-B stated droplet/contact precautions included airborne precautions and stated if staff see a sign for droplet/contact precautions, they should wash hands and don a gown, gloves, eye protection, and an N95 respirator. DON-B indicated staff should not reuse disposable gowns and stated staff who provide wound care or wound care assistance should wear a gown and gloves. DON-B confirmed the facility was in an outbreak and stated staff should wear surgical masks when working the floor. 8. From 1/26/26 to 1/28/26, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] and had diagnoses including COPD, chronic respiratory failure with hypoxia, panlobular emphysema, and history of malignant neoplasm of bronchus and lung. R12's MDS assessment, dated 12/13/25, had a BIMS score of 12 out of 15 which indicated R12 had moderately impaired cognition. R12's medical record contained a diagnosis of Influenza (dated 1/22/26) and a diagnosis of pneumonia (dated 1/26/26). A progress note, dated 1/21/26 at 7:21PM, indicated R12 fell on 1/19/26 and had increased weakness. R12's oxygen saturation was 85-91% on 2 liters of oxygen. R12 had respiratory distress and R12's lungs sounded coarse with a wet cough. R12 was sent to the Emergency Department (ED). A progress note, dated 1/22/26 at 6:52 PM, indicated R12 tested positive for Influenza. A progress note, dated 1/22/26 at 10:25 PM, indicated R12 returned to the facility with a diagnosis of Influenza and would start Oseltamivir. Isolation precautions were initiated. A progress note, dated 1/26/26 at 4:45 PM, indicated R12 was weak and lethargic with increased confusion, decreased orientation, rapid and shallow breathing, and a temperature of 101.7 degrees. A COVID-19 swab was unsuccessful. R12 was transferred to the hospital. (continued on next page)		

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 01/28/2026
NAME OF PROVIDER OR SUPPLIER Suring Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Manor Dr Suring, WI 54174	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A progress note, dated 1/28/26 at 4:54 PM, indicated R12 returned from the hospital and was treated for pneumonia and Influenza. R12 was placed on contact isolation precautions. On 1/26/26 at 10:20 AM Surveyor noted R12's door was open and R12 was in bed. There was a contact/droplet sign on R12's door and a PPE cart outside the room. On 1/26/26 at 10:40 AM, Surveyor interviewed CNA-N who indicated R12 was on contact/droplet precautions and tested positive for Influenza. When Surveyor indicated the precautions sign stated to keep the door closed, CNA-N indicated doors for residents on contact/droplet precautions should be kept closed unless the residents are fall risks. CNA-N indicated R12 and R12's roommate were not fall risks. On 1/26/26 at 2:00 PM, Surveyor observed an Outbreak List at the nurses' station. R12 was on the list with a last date of isolation on 1/31/26. On 1/26/26 at 3:06 PM, Surveyor noted R12's door was open. R12 was in bed and a contact/droplet sign was on the door. On 1/28/26 at 1:34 PM, Surveyor interviewed DON-B who indicated residents on contact/droplet precautions should have their doors closed to reduce transmission. DON-B verified R12 went to the hospital for respiratory distress on 1/21/26 and was diagnosed with Influenza. DON-B stated Influenza had spread down the hall. 9. From 1/26/26 to 1/28/26, Surveyor reviewed R48's medical record. R48 was admitted to the facility on [DATE] and had diagnoses including encephalopathy, hemiplegia, cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery, and monoplegia of upper limb following cerebral infarction. R48's MDS assessment, dated 11/16/25, had a BIMS score of 3 out of 15 which indicated R36 had severely impaired cognition. A Hospice progress note, dated 1/23/26 at 4:44 PM, indicated R48's roommate (R12) tested positive for Influenza B. R48 had a temperature of 100.1 degrees and refused an Influenza swab. Hospice advised facility staff to use contact/droplet precautions for R48. On 1/26/26 at 10:20 AM, Surveyor noted R48's door was open and R48 was in a wheelchair in the room. There was a contact/droplet sign on the door and a PPE cart outside the room. On 1/26/26 at 10:40 AM, Surveyor interviewed CNA-N who indicated R48's roommate (R12) was on contact/droplet precautions and was positive for Influenza. CNA-N confirmed R48 declined an Influenza test. CNA-N indicated R48 was symptomatic with an elevated temperature so staff followed contact/droplet precautions. When Surveyor indicated the sign outside the room indicated to keep the door closed, CNA-N indicated doors for residents on contact/droplet precautions should be kept closed unless the resident(s) in the room are fall risks. CNA-N indicated R48 and R12 were not fall risks. On 1/26/26 at 2:00 PM, Surveyor observed an Outbreak List at the nurses' station. R48 was not on the Outbreak List. R12 was on the Outbreak List with a last date of isolation on 1/31/26. On 1/26/26 at 3:06 PM, Surveyor noted R48's door was open and R48 was in a wheelchair in the room. There was a contact/droplet sign on the door. (continued on next page)		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 01/28/2026
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/27/26 at 8:30 AM, Surveyor noted R48's door was open and R48 was in bed. There was a contact/droplet sign on the door. On 1/27/26 at 1:45 PM, Surveyor noted R48's door was open and R48 was in a wheelchair in the room. There was a contact/droplet sign on the door. On 1/27/26 at 2:00 PM, Surveyor observed an Outbreak List at the nurses' station. R48 was on the Outbreak List with a last date of isolation on 1/31/26 with fever listed next to the date. On 1/28/26 at 1:34 PM, Surveyor interviewed DON-B who stated residents on contact/droplet precautions should have their doors closed to reduce transmission. DON-B indicated DON-B was told by Hospice staff that R48 had an elevated temperature but declined COVID-19 and Influenza tests. D		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not implement their antibiotic stewardship program to ensure the accurate use of antibiotics for 4 residents (R) (R13, R9, R11, and R2) of 7 sampled residents. R13 did not meet Loeb's criteria for a urinary tract infection (UTI) but received antibiotic therapy. The physician was not consulted to determine if the antibiotic should have been continued when R13 did not meet the criteria for a UTI. R9 did not meet Loeb's criteria for a UTI but received antibiotic therapy. The physician was not consulted to determine if the antibiotic should have been continued when R9 did not meet the criteria for a UTI. R11 did not meet Loeb's criteria for a respiratory tract infection but received antibiotic therapy. R2 was prescribed a prophylactic antibiotic. R2's medical record did not indicate the prophylactic antibiotic was routinely assessed for continued use. The facility's Antibiotic Stewardship Program policy, revised 5/29/24, indicates: .a. Infection Preventionist - utilizes expertise and data to inform strategies to improve antibiotic use to include tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections, and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistant organisms. Clinical justification for the use of an antibiotic beyond the initial duration ordered such as a review of laboratory reports/cultures in order to determine if the antibiotic remains indicated or if adjustments to therapy should be made. 1. From 1/27/26 to 1/28/26, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had diagnoses including osteomyelitis of vertebra, lymphedema, and methicillin-resistant Staphylococcus aureus (MRSA) infection. R13's Minimum Data Set (MDS) assessment, dated 1/26/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R13 had intact cognition. A care plan, dated 10/31/25, indicated R13 was colonized with MRSA then completed MRSA decolonization with an infectious disease physician. The care plan also indicated R13 was at risk for bladder incontinence related to impaired mobility and contained an intervention to monitor for signs/symptoms of a UTI. R13's medical record included Loeb's criteria for a UTI on a surveillance line list that indicated the date of infection was 10/21/25. The form indicated R13 did not meet Loeb criteria for a UTI without an indwelling catheter to treat with antibiotic therapy. There was not a culture attached to the Loeb criteria and no signs/symptoms of a UTI were identified. R13 received Levaquin/linezolid antibiotic therapy for a UTI according to the line list. The facility did not update the physician that R13 did not meet the criteria for infection and antibiotic use. The UTI was identified at the hospital. On 1/27/26 at 3:18 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility's provider should have been contacted to see if antibiotic therapy for a UTI should have been continued upon R13's return from the hospital. 2. From 1/27/26 to 1/28/26, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including spastic quadriplegic cerebral palsy, depression, anxiety, and obstructive and reflux uropathy. R9's MDS assessment, dated 12/5/25, had a BIMS score of 15 out of 15 which indicated R9 had intact cognition. R9's medical record included a Loeb's criteria form for UTI that indicated R9 met the criteria for infection on 11/3/25. The required culture was not attached to the form which indicated a culture (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was necessary to ensure appropriate antibiotic treatment. R9 was started on Levaquin for treatment of a UTI according to a surveillance line list with the pathogen listed as pending. On 1/27/26 at 3:18 PM, Surveyor interviewed DON-B who indicated staff sometimes call the hospital for culture results. DON-B reviewed R9's hospital record and found the culture related to R9's current UTI treatment. The results on 10/31/25 indicated the culture grew normal flora. DON-B confirmed R9 did not meet the criteria for antibiotic treatment of a UTI. 3. From 1/27/26 to 1/28/26, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, chronic kidney disease, and acute and chronic respiratory failure. R11's MDS assessment, dated 12/24/25, had a BIMS score of 00 out of 15 which indicated R11's cognition was severely limited. R11's medical record included documentation on the December 2025 surveillance line list that indicated beginning on 12/2/25, R11 was treated prophylactically for chest with doxycycline and that R11 met Loeb's criteria for a respiratory infection. Upon review, R11 did not meet the criteria for antibiotic therapy. On 1/27/26 at 2:36 PM, Surveyor interviewed DON-B who indicated R11 had chest X-rays on 11/22/25 and 12/3/25; however, the chest X-rays did not indicate a new infiltrate. DON-B reviewed R11's medical record and identified signs/symptoms, including a decreased oxygen saturation rate (88%), increased cough/wheezing, and the need for more assistance with activities of daily living (ADLs), which were not indicated on R11's Loeb criteria form. DON-B verified R11 did not meet Loeb's criteria without a chest X-ray that identified a new infiltrate consistent with pneumonia. 4. From 1/26/26 to 1/28/26, Surveyor review R2's medical record. R2 was initially admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses including bilateral primary osteoarthritis of knee, lymphedema, and cellulitis to left and right lower limb. R2's MDS assessment, dated 11/14/25, had a BIMS score of 15 out of 15 which indicated R2 had intact cognition. R2 was responsible for R2's healthcare decisions. R2 had an order for cefdinir 300 milligrams (mg) twice daily with a start date of 9/13/25. The indication for use was sepsis of knee/prophylaxis. R2's medical record did not contain a duration for the antibiotic or a plan for periodic re-evaluation to determine if the antibiotic was still necessary. On 1/28/26 at 12:48 PM, Surveyor interviewed DON-B who stated the facility used Loeb criteria for antibiotic use, but would be switching to McGeer's criteria. DON-B confirmed an assessment was not completed for R2's prophylactic antibiotic therapy and indicated R2 had been on the antibiotic for a long time. DON-B stated the facility's provider addresses the need for the prophylactic medication in visit notes. A provider visit note, dated 1/13/26, indicated R2 had chronic lymphedema with recurrent bilateral cellulitis and was taking bumex, potassium and chronic cefdinir. No additional information or justification for antibiotic use was indicated in the provider note.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure proper physician or Power of Attorney for Healthcare (POAHC) notification for 3 residents (R) (R36, R22, and R5) of 12 sampled residents. R36's physician was not notified of an elevated blood pressure on 1/28/26. R36's physician was not notified when R36's pulse was less than 50 on 1/27/25, 1/22/26, 1/21/26, 1/20/26, 1/19/26, 1/17/25, and 1/16/26. In addition, R36's physician was not notified when R36's anti-hypertensive medication was held. R22's physician was not notified when R22's anti-hypertensive medication was held. R5 tested positive for Influenza A on 1/23/26. R5's POAHC was not notified of the positive test or that R5 started Tamiflu. Findings include: The facility's Notification of Change policy, revised 8/27/24, indicates: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Changes of condition require an evaluation, using the SBAR communication form and progress note evaluation and ensures proper documentation notification has been made. Definitions: .Clinical Complications. Need to alter treatment significantly means, a need to stop a form of treatment because of adverse consequences (such as an adverse drug reaction), or commence a new form of treatment to deal with a problem (for example, the use of a medical procedure or therapy that has not been used on that resident before) .Compliance guidelines: The facility must inform the resident, consult with the resident's physician, and or notify the resident, family member, or legal representative when there is a change requiring such notification. Circumstances requiring notification include: 1. Accidents .2. Significant change in the resident's physical, mental, or psychosocial conditions, such as deterioration in health, mental, or psychosocial status .3. Circumstances that require a need to alter treatment. This may include a. new treatment .b. Discontinuation of current treatment due to: .i. Adverse consequences; ii. Acute condition; iii. Exacerbation of a chronic condition. 1. From 1/26/26 to 1/28/26, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE] and had diagnoses including essential hypertension, syndrome of inappropriate secretion of antidiuretic hormone, hypo-osmolality and hyponatremia, hyperlipemia, abdominal aortic aneurysm-not ruptured, and unspecified dementia. R36's Minimum Data Set (MDS) assessment, dated 1/8/26, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R36 had moderate cognitive impairment. On 1/28/26, Surveyor reviewed R36's January 2026 Medication Administration Record (MAR) and noted the following orders: ~ Lisinopril oral tablet 40 milligrams (mg) Give 40 mg by mouth once daily for hypertension (dated 1/1/25) ~ Clonidine HCl oral tablet 0.2 mg Give 0.2 mg by mouth two times daily for hypertension Hold for systolic blood pressure (SBP) <100 diastolic blood pressure (DBP) <60 or pulse <50. If held update physician (dated 11/5/25) ~ Metoprolol tartrate oral tablet 37.5 mg Give 37.5 mg by mouth two times daily related to essential hypertension (dated 12/19/25) (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ Amlodipine besylate oral tablet 10 mg Give 10 mg by mouth once daily for hypertension (dated 1/14/26) ~ Hydrochlorothiazide oral tablet 25 mg Give 25 mg by mouth once daily related to essential hypertension (dated 1/14/26) On 1/28/26 at 1:34 PM, Surveyor reviewed the facility's standing orders with Director of Nursing (DON)-B. The facility had a standing order to hold blood pressure (BP) medication if systolic BP is less than 100, diastolic BP is less than 60, or pulse is less than 50 and to update the provider if the resident is symptomatic or after the first missed dose. On 1/28/26 Surveyor reviewed R36's MAR, administration notes, vital signs, and progress notes and noted there was no documentation that the provider was notified that R36 had an elevated blood pressure (BP) of 193/105 on 1/28/26. R36's January 2026 MAR indicated the following: ~ R36's 6:00 AM/7:00 AM doses of metoprolol, amlodipine, lisinopril, hydrochlorothiazide, and clonidine were held on 1/27/26 due to a low pulse of 48. ~ R36's 6:00 PM doses of metoprolol and clonidine were administered on 1/22/26; however, R36's pulse was 44. ~ R36's 6:00 PM doses of metoprolol and clonidine were administered on 1/21/26; however, R36's pulse was 46. ~ R36's 6:00 PM doses of metoprolol and clonidine were administered on 1/20/26; however, R36's pulse was 45. ~ R36's 6:00 PM doses of metoprolol and clonidine were administered on 1/19/26; however, R36's pulse was 48. ~ R36's 6:00 AM/7:00 AM doses metoprolol, amlodipine, lisinopril, hydrochlorothiazide, and clonidine were held on 1/17/26 for a low pulse of 47. ~ R36's 6:00 PM dose of clonidine was administered on 1/16/26; however. R36's pulse was 46. R36's medical record did not indicate the physician was notified when R36's pulse was below 50 and the medications were held or when the medications were administered despite R36's low pulse. On 1/28/26 at 1:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-F who verified LPN-F did not notify the physician when R36's medications were held on 1/27/26. On 1/28/26 at 1:34 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated nurses should notify the provider if medications are held and/or vital signs are outside the parameters for administration. DON-B reviewed R36's held medications for 1/27/26 and elevated BP on 1/28/26 and indicated the provider should have been notified regarding the held medications and diastolic BP reading greater than 100. DON-B stated the facility has standing orders to hold BP medication if systolic BP is less than 100, diastolic BP is less than 60, or pulse is less than 50, and to update the (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provider if the resident is symptomatic or after the first missed dose of medication. DON-B stated if a resident's pulse is less than 50, BP medication should be held and the provider should be updated immediately. 2. From 1/26/26 to 1/28/26, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] and had diagnoses including hypertension, type 2 diabetes, and right lower leg fracture. R22's MDS assessment, dated 12/20/25, had a BIMS score of 15 out of 15 which indicated R22 had intact cognition. On 1/27/26 at 8:30 AM, Surveyor observed LPN-F administer medication to R22. LPN-F stated LPN-F obtained R22's BP earlier that morning which was low so LPN-F held R22's hydrochlorothiazide and lisinopril. R22's medical record contained the following orders: ~ Hydrochlorothiazide oral tablet 12.5 milligrams (mg) Give 1 tablet by mouth once daily related to essential (primary) hypertension (dated 9/23/25) ~ Lisinopril oral tablet 20 mg Give 20 mg by mouth once daily related to essential (primary) hypertension. Hold for systolic (BP) less than 100 (dated 11/3/25) On 1/28/26 at 1:34 PM, Surveyor reviewed the facility's standing orders with DON-B. The facility had a standing order to hold BP medication if systolic BP is less than 100, diastolic BP is less than 60, or pulse is less than 50, and update the provider if symptomatic or after the first missed dose. R22's MAR indicated the following: ~ R22's hydrochlorothiazide was held on 1/27/26 at 8:34 AM due to a BP of 110/57. ~ R22's lisinopril was held on 1/27/26 at 8:34 AM due to a BP of 110/57. ~ R22's lisinopril was held on 1/28/26 at 8:31 AM due to a BP of 106/53. R22's medical record contained the following vital signs: ~ On 1/27/26 at 7:32 AM, R22's BP was 110/57 as documented by LPN-F. (Of note: R22's systolic BP was greater than 100.) ~ On 1/28/26 at 6:58 AM, R22's BP was 106/53 as documented by LPN-F. (Of note: R22's systolic BP was greater than 100.) R22's medical record did not indicate the provider was notified when R22's medications were held on 1/27/26 and 1/28/26. On 1/27/26 at 8:30 AM, Surveyor interviewed LPN-F who verified LPN-F did not administer lisinopril or hydrochlorothiazide on 1/27/26 or 1/28/26 because R22's BP was outside the parameters to administer the medication. LPN-F confirmed LPN-F did not notify the provider. On 1/28/26 at 1:34 PM, Surveyor interviewed DON-B who stated R22 did not have an order to hold BP (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication for a BP of 110/57 or 106/53. DON-B indicated hydrochlorothiazide and lisinopril should have been administered because R22's systolic BP was greater than 100. DON-B stated the facility has standing orders to hold BP medication if a resident's systolic BP is less than 100, diastolic BP is less than 60, or pulse is less than 50 and to update the provider if the resident is symptomatic or after the first missed dose of the medication. DON-B confirmed LPN-F did not notify the physician when the medications were held on 1/27/26 and 1/28/26. 3. From 1/26/26 to 1/28/26, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including Influenza A, cerebral infarction, and dysphagia. R5's MDS assessment, dated 11/19/25, had a BIMS score of 13 out of 15 which indicated R5 had intact cognition. R5 had an activated POAHC ((POAHC)-G). A progress note to the physician, dated 1/22/26 at 4:07 PM, indicated R5 started not feeling well on the night of 1/21/26. R5 had a fever of 101.5 degrees on the morning of 1/22/26 and complained of a runny nose and feeling tired. R5 was COVID-19 negative on the morning of 1/22/26 and was put on isolation precautions. R5 was on a wing with active influenza. The provider recommended a respiratory panel. A progress note, dated 1/23/26 at 7:09 PM, indicated R5's respiratory panel was positive for Influenza A. R5 had an order for Tamiflu two times daily for 5 days. On 1/26/26 at 11:01 AM, Surveyor interviewed POAHC-G via phone. POAHC-G knew the facility tested for COVID-19 the week prior but had not heard anything. POAHC-G was not aware that R5 had Influenza A. On 1/27/25 at 2:34 PM, Family Member (FM)-H approached Surveyor and stated POAHC-G received a call last week that the facility was going to test R5 for COVID-19 and was then told they were testing for Influenza; however, they were not updated with the results. FM-H was in the facility and was not told that R5 was ill or on isolation precautions. On 1/28/26 at 11:54 AM, Surveyor interviewed DON-B who confirmed POAHC-G was not notified when R5 tested positive for Influenza A.		

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a written Notice of Medicare Non-Coverage (NOMNC) form (which is used to inform residents of their final day of Medicare Part A insurance coverage and standard claim appeal rights and instructions) was thoroughly completed when provided to 3 residents (R) (R57, R58, and R59) of 3 sampled residents. R57, R58, and R59 were issued written NOMNC forms when their Medicare Part A services were ending. The facility did not ensure the forms included all of the required information. Findings include: Notice Instructions for Notice of Medicare Non-Coverage (NOMNC) (a Centers for Medicare and Medicaid Services (CMS)-10123 form) indicates a Medicare provider/plan .must deliver a completed copy of this notice to beneficiaries/enrollees receiving covered skilled nursing services. The CMS-10123 form requires providers to manually or electronically enter coverage type, effective date, and a Quality Improvement Organization (QIO) name and number. 1. From 1/26/26 to 1/28/26, Surveyor reviewed R57's medical record. R57 was admitted to the facility on [DATE] and had a diagnosis of cellulitis. R57's Minimum Data Set (MDS) assessment, dated 12/20/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R57 had intact cognition. R57's had an activated Power of Attorney for Healthcare (POAHC) who was responsible for assisting R57 with healthcare decisions. R57's medical record indicated R57's Medicare Part A coverage ended on 12/20/25 and R57 was discharged from the facility on 12/20/25. Surveyor reviewed R57's NOMNC form which was signed on 12/17/25. Fields on the form were incomplete, including the coverage type, effective date, and the required QIO name and contact information for an appeal. (See interviews under example 3.) 2. From 1/26/26 to 1/28/26, Surveyor reviewed R58's medical record. R58 was admitted to the facility on [DATE] and had diagnoses including overactive bladder and asthma. R58's MDS assessment, dated 9/25/25, had a BIMS score of 15 out of 15 which indicated R58 had intact cognition. R58 was responsible for R58's healthcare decisions. R58's medical record indicated R58's Medicare Part A coverage ended on 9/25/25 and R58 was discharged from the facility on 9/25/25. Surveyor reviewed R58's NOMNC form which was signed on 9/22/25. Fields on the form were incomplete, including the coverage type, effective date, and the required QIO name and contact information for an appeal. (See interviews under example 3.) 3. From 1/26/26 to 1/28/26, Surveyor reviewed R59's medical record. R59 was admitted to the facility on [DATE] and had a diagnosis of cellulitis of the right upper limb. R59's MDS assessment, dated 7/9/25, had a BIMS score of 15 out of 15 which indicated R59 had intact cognition. R59 was responsible for R59's healthcare decisions. R59's medical record indicated R59's Medicare Part A coverage ended on 7/9/25 and R59 was discharged from the facility on 7/9/25. Surveyor reviewed R59's NOMNC form which was signed on 7/3/25. Fields on the form were incomplete, including the coverage type, effective date, and required QIO name and contact information for an appeal. On 1/28/26 at 11:11 AM, Surveyor interviewed Social Service Designee (SSD)-M who issues NOMNC forms. SSD-M indicated SSD-M receives a last cover date (LCD) from therapy, completes the forms on a computer, prints the forms, and issues the forms to residents. SSD-M indicated the NOMNC form is used to inform residents when Medicare services are ending and what the resident's appeal rights are. SSD-M was not aware of the name and contact information for the QIO or where to find it. SSD-M acknowledged R57, R58, and R59's NOMNC forms were incomplete. On 1/28/26 at 11:51 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated Medicare Part A NOMNC forms are completed by therapy. NHA-A stated SSD-M only completes managed care NOMNC forms. NHA-A stated if a resident is not in therapy, the Business Office issues the NOMNC form. NHA-A was confused why SSD-M thought SSD-M was responsible for issuing Medicare Part A NOMNC forms. NHA-A acknowledged R57, R58, and R59's forms were not thoroughly completed.		

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NAME OF PROVIDER OR SUPPLIER Suring Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Manor Dr Suring, WI 54174	
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff, resident, and family interview, and record review, the facility did not ensure adaptive equipment to maintain the current level of function and prevent contracture was provided for 1 resident (R) (R6) of 1 sampled resident. R6 did not have rolled towels placed in the left hand and elbow crease and as ordered. In addition, R6's care plan contained an intervention for a left hand splint to be worn at all times. The splint was not consistently applied. Findings Include: The facility's Restorative policy, revised 2/5/25, indicates: It is the guideline of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining all physical, mental, and psychosocial functioning. 3. Nursing personnel are trained in basic maintenance nursing care that does not require the use of a qualified therapist or licensed nurse oversight. This training may include, but it is not limited to: a. Maintaining proper positioning and body alignment. 6. Residents, as identified during the comprehensive assessment process, will receive services from restorative aids when they are assessed to have a need for restorative services. The services may include .splint or brace assistance. From 1/26/26 to 1/28/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including multiple sclerosis, hemiplegia, chronic pain, osteoarthritis, schizoaffective disorder, bipolar disorder, and anxiety. R6's Minimum Data Set (MDS) assessment, dated 1/18/26, had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R6 had severely impaired cognition. A care plan, initiated 4/29/21 and revised 1/4/26, indicated R6 had an activities of daily living (ADL) self care performance deficit related to multiple sclerosis and impaired mobility. The care plan contained a goal is to maintain current level of function through the review date (3/10/26). The care plan contained interventions (dated 7/24/25) to wear a left hand splint for contracture/management at all times or as tolerated, monitor every shift, and document when R6 chooses not to wear the brace. A care plan, initiated 3/30/23 and revised 1/4/26, indicated R6 had left-sided hemiplegia. The care plan contained a goal to remain free of complications or discomfort related to hemiplegia through 3/10/26. The care plan contained interventions for a left hand splint to be worn at all times or as tolerated to prevent contracture and to monitor skin for signs and symptoms of breakdown. Surveyor reviewed R6's Kardex (an abbreviated care plan used by nursing staff) which contained the following: R6 Dressing/splint therapy: left hand elbow contracture. Place rolled hand towel in elbow crease. Place rolled towel in left hand. R6's medical record contained the following physician orders:~ Therapy: Left hand elbow contractures. (R6) needs to have rolled washcloth in left hand-be sure thumb is on outside of fingers. Rolled hand towel in elbow crease. Certified Nursing Assistants (CNAs) may place; every shift per therapy recommendations (dated 4/7/25).~ Check skin for breakdown every 4 hours while brace is on. Document any skin impairment noted and implement treatment. Update doctor regarding skin impairment and initiated treatment (dated 6/20/23). Surveyor reviewed R6's Treatment Administration Record (TAR) for 12/1/25 to 1/27/26 and noted the following:~ Therapy-left hand elbow contractures. (R6) needs to have rolled washcloth in left hand. Be sure thumb is on outside of fingers. Rolled hand towel in elbow crease (dated 4/7/25) was documented as completed 3 shifts per day except the 1/11/26 night shift (blank) and the 12/27/25 AM shift (documented as other). On 1/26/26 at 11:03 AM, Surveyor observed R6 in a wheelchair in R6's room without a rolled towel in the left hand or elbow crease. Surveyor did not observe a brace or splint on R6's left upper extremity (as indicated in R6's care plan). On 1/26/26 at 3:10 PM, Surveyor interviewed R6 and R6's Family Member ((FM)-S). Surveyor noted R6 did not have a rolled towel in the left hand or elbow crease. R6 and FM-S indicated staff do not provide a rolled (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	towel for R6's left hand and elbow crease. FM-S indicated R6 had previous hand lacerations because R6's nails dug into the palm of R6's left hand. FM-S stated R6 had worn a splint on the left wrist/hand. R6 and FM-S were not aware where the splint was kept and said they had not seen it in months. On 1/27/26 at 10:05 AM, Surveyor observed R6 in a wheelchair in the community room visiting with a therapy dog without a rolled towel in the left hand or elbow crease. Surveyor did not observe a brace or splint on R6's left upper extremity. On 1/27/26 at 1:19 PM, Surveyor observed R6 in a wheelchair in the community room during an activity without a rolled towel in the left hand or elbow crease. Surveyor did not observe a brace or splint on R6's left upper extremity. On 1/28/26 at 11:00 AM, Surveyor observed R6 in a wheelchair in the community room without a rolled towel in the left hand or elbow crease. Surveyor did not observe a brace or splint on R6's left upper extremity. On 1/27/26 at 1:23 PM, Surveyor interviewed CNA-D who indicated staff attempt to put a rolled towel in R6's left hand and elbow crease, however, R6 prefers to go without. CNA-D indicated CNA-D did not think a rolled towel helped R6 in any way and would not change the contraction to R6's left hand. On 1/28/26 at 1:34 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R6's left arm and hand were contracted. DON-B indicated staff put a rolled towel in R6's left hand and elbow crease to prevent yeast growth and skin breakdown. DON-B indicated staff move R6's left arm during cares but R6 currently did not have a restorative therapy program. DON-B indicated R6 refused the rolled towel at times. DON-B indicated staff should document refusals on R6's TAR and stated nurses chart placement of the rolled towel each shift.		

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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, staff and resident interview, and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible for 1 resident (R) (R20) of 3 sampled residents. Staff did not ensure R20's cigarettes, lighter, and e-cigarette were kept in a secure location. In addition, a smoking evaluation completed for R20 was not accurate and indicated R20 could store smoking materials independently. Findings include: The facility's Smoking policy, dated 10/25/22, indicates: Facilities may permit residents to smoke tobacco products. In these facilities, assessment of capabilities and deficits determines whether or not supervision is required. If the facility identifies that the resident needs assistance and supervision for smoking, the facility includes this information in the care plan, and reviews and revises the plan periodically as needed. The facility must ensure precautions are taken for residents' individual safety, as well as the safety of others in the facility. Such precautions may include .Supervising residents whose assessments and care plans indicate a need for assistance and supervised smoking; Limiting the accessibility of matches and lighters by residents who need supervision when smoking for safety reasons .Residents who wish to use e-cigarettes should be assessed for their ability to safely manage the device. From 1/26/26 to 1/28/26, Surveyor reviewed R20's medical record. R20 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease, mild cognitive impairment of unknown etiology, osteomyelitis of vertebra, anxiety, multiple left rib fractures, and chronic hepatitis. R20's Minimum Data Set (MDS) assessment, dated 1/8/26, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R20 had intact cognition. R20's facesheet contained the following: Special Instructions: ***SUPERVISED SMOKER: ALL SMOKING MATERIALS MUST BE KEPT LOCKED UP IN MED ROOM. A smoking evaluation, dated 1/3/26, indicated R20 did not need the facility to store R20's cigarettes and lighter but required supervision to smoke. (Of note: The smoking evaluation did not assess the use of e-cigarettes.) A care plan, initiated 1/5/26 and revised 1/22/26, indicated R20 smokes cigarettes. The care plan contained a goal that R20 will not suffer injury from unsafe use of smoking and/or smokeless tobacco. The care plan contained the following interventions: Instruct (R20) regarding the facility policy on smoking/smokeless tobacco: locations, times, safety concerns; Keep cigarettes with staff; Notify charge nurse immediately if it is suspected (R20) has violated facility smoking/smokeless tobacco policy; (R20) requires supervision while smoking. R20's medical record contained the following order: ~ RESIDENT SMOKES: Resident assessed as a SUPERVISED smoker. Observe smoking safety, to include; no smoking materials on person if supervised smoker, no smoking within facility (only in designated smoking areas), no smoking while oxygen is present. Intervene immediately and notify management every shift (dated 1/27/26). On 1/27/26 at 3:54 PM, Surveyor reviewed R20's Kardex (an abbreviated care plan used by nursing staff) that indicated: (R20) is a supervised smoker. All smoking materials must be kept locked up in medication room. Safety: (R20) requires supervision while smoking. On 1/26/26 at 10:40 AM, Surveyor interviewed R20 who stated R20 is not allowed to smoke at 8:00 PM. R20 stated the nurse provides an e-cigarette to use in place of going outside; however, the e-cigarette has a dead battery and no longer works. Surveyor observed an e-cigarette on R20's bedside table. R20 stated R20 had cigarettes and a lighter in a jacket pocket in R20's room. R20 stated staff threaten to take the cigarettes and lighter away but don't because R20 follows the rules. On 1/26/26 at 11:21 AM, Surveyor observed R20 in a wheelchair with cigarettes in hand. R20 stated R20 was waiting for staff to take R20 outside to smoke. On 1/26/26 at 12:15 PM, Surveyor observed Certified Nursing Assistant (CNA)-N wheel R20 outside to smoke and observed R20 smoking outside. CNA-N stayed with R20 and then wheeled R20 back into the facility. On 1/26/26 at 3:05 PM, Surveyor observed an e-cigarette on R20's bedside table. On 1/27/26 at 10:15 AM, Surveyor observed CNA-D and CNA-C transfer R20 from (continued on next page)		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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NAME OF PROVIDER OR SUPPLIER Suring Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Manor Dr Suring, WI 54174	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed to wheelchair via Hoyer lift. CNA-D assisted R20 with donning a jacket. When R20 asked if R20's cigarettes and lighter were in the jacket pocket, CNA-D checked the pocket and told R20 they were not in R20's jacket. When R20 asked CNA-D to check R20's hat, CNA-D retrieved cigarettes and a lighter from the hat and handed them to R20. R20 stated, I don't think I am supposed to have my cigarettes. CNA-D looked at Surveyor and did not respond. On 1/27/26 at 1:23 PM, Surveyor interviewed CNA-D who stated residents who require supervision to smoke should have their smoking supplies stored in the medication room. CNA-D indicated R20 was a supervised smoker and should not have had smoking supplies in the room. On 1/28/26 at 11:25 AM, Surveyor interviewed R20 who stated a staff member took R20's e-cigarette on the 1/27/26 PM shift to charge it. R20 stated R20 prefers to smoke cigarettes. Surveyor observed a box of cigarettes and a lighter in a winter hat on R20's table. On 1/28/26 at 1:34 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R20 required supervision to smoke and confirmed all smoking supplies should be stored in the medication room. DON-B stated supervised smokers are not allowed to keep smoking supplies in their room. Surveyor reviewed R20's 1/3/26 smoking assessment with DON-B who verified the smoking assessment indicated R20 can keep smoking supplies in R20's room which was an error because R20 was a supervised smoker. DON-B indicated the facility's smoking times are 9:00 AM, 1:30 PM, 5:30 PM, and 8:00 PM. DON-B indicated staff take residents outside to smoke at those times and provide supervision while smoking. DON-B was not aware that R20 had an e-cigarette and was not aware that staff provided e-cigarettes to residents.		

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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, staff interview, and record review, the facility did not provide the necessary tube feeding services for 1 resident (R) (R7) of 2 sampled residents. Certified Nursing Assistant (CNA)-D turned off R7's tube feeding before it was complete and without checking with a nurse. Findings include: The facility's Care and Treatment of Tube Feedings policy, revised 8/21/24, indicates: The resident's plan of care will address the use of feeding tube, including strategies to prevent complications. From 1/26/26 to 1/28/26, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had a diagnosis of gastrostomy status. A care plan, revised 1/8/26, indicated R7 had an alteration in nutrition because R7 required tube feeding following a hospital stay. The care plan contained an intervention for Osmolite 1.2 474 milliliters (ml) via gastrostomy (G) tube three times daily .Observe .toleration to tube feeding.On 1/27/26 at 9:38 AM, Surveyor observed CNA-D exit R7's room and tell Licensed Practical Nurse (LPN)-F that R7's tube feeding was done and CNA-D turned the pump off. LPN-F thanked CNA-D and stated CNA-D should not have turned off the pump. LPN-F stated to Surveyor that R7's tube feeding was not complete and indicated the pump only allowed 400 ml to be infused at once. LPN-F indicated R7's tube feeding was 474 ml total and LPN-F needed to add 74 ml to R7's tube feeding. LPN-F stated CNAs should not turn off a tube feeding pump that is beeping since the tube could be clogged or something else could be wrong.On 1/27/26 at 1:23 PM, Surveyor interviewed CNA-D who verified CNA-D should not turn off a tube feeding pump and should instead tell the nurse if a tube feeding pump is beeping. On 1/28/26 at 11:54 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated only licensed staff should manage tube feedings for residents.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not provide pharmaceutical services to ensure the accurate administration of medication for 2 residents (R) (R36 and R22) of 7 sampled residents. R36's vital signs were not completed on 1/27/26 prior to administering metoprolol and clonidine. R36's vital signs were not completed timely on 1/27/26, 1/22/26, 1/21/26, 1/20/26, 1/19/26, 1/18/26, and 1/17/26 prior to administering and/or holding metoprolol, amlodipine, lisinopril, hydrochlorothiazide, and clonidine for a low pulse. R36's physician and standing orders to hold metoprolol and clonidine when R36's pulse was less than 50 were not followed on 1/22/26, 1/21/26, 1/20/26, 1/19/26, and 1/16/26. In addition, R36's metoprolol, amlodipine, lisinopril, hydrochlorothiazide, and clonidine were not administered timely on 1/27/26, 1/22/26, 1/21/26, 1/20/26, 1/18/26, and 1/17/26. R22's physician and standing orders were not followed when staff held lisinopril and hydrochlorothiazide on 1/27/26. Findings include: The facility's Medication Administration policy, revised 11/12/24, indicates: .10. Ensure the six rights of medication administration are followed: .e. Right time .b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. The facility's undated Medication Pass Times document indicates: ~ AM Med Pass: 6:00 AM to 10:30 AM ~ Noon Med Pass: 11:00 AM to 2:00 PM ~ PM Med Pass: 3:00 PM to 6:00 PM ~ Bedtime (HS) Med Pass: 7:00 PM to 10:00 PM 1. From 1/26/26 to 1/28/26, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE] and had diagnoses including essential hypertension, syndrome of inappropriate secretion of antidiuretic hormone, hypo-osmolality and hyponatremia, hyperlipidemia, abdominal aortic aneurysm-not ruptured, and unspecified dementia. R36's Minimum Data Set (MDS) assessment, dated 1/8/26, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R36 had moderately impaired cognition. A care plan, revised 1/27/26, indicated R36 had altered cardiovascular status related to hypertension, high cholesterol, and an abdominal aortic aneurysm-not ruptured. The care plan contained an intervention (dated 1/1/25) to monitor/document/report as needed any signs/symptoms of coronary artery disease. A care plan, initiated on 1/1/25, indicated R36 had potential for altered fluid maintenance related to syndrome of inappropriate secretion of antidiuretic hormone. The care plan contained an intervention (dated 1/22/25) to monitor/document/report as needed any signs/symptoms of fluid overload, including edema, weight gain, crackles in the lungs, and/or increased blood pressure. A physician progress note, dated 1/20/26, indicated hydrochlorothiazide 25 milligrams (mg) daily was added on 1/13/26 due to high blood pressure (BP). The note indicated R36 had resistant hypertension and had been closely monitored due to hypertension. R22's medical record contained the following orders: ~ Lisinopril oral tablet 40 mg Give 40 mg by mouth once daily for hypertension (dated 1/1/25) ~ Clonidine HCl oral tablet 0.2 mg Give 0.2 mg by mouth twice daily for hypertension Hold for systolic blood pressure (SBP) <100 diastolic blood pressure (DBP) <60 or pulse <50. If held update MD (dated 11/5/25) ~ Metoprolol tartrate oral tablet 37.5 mg Give 37.5 mg by mouth twice daily related to essential hypertension (dated 12/19/25) ~ Amlodipine besylate oral tablet 10 mg Give 10 mg by mouth once daily for hypertension (dated 1/14/26) ~ Hydrochlorothiazide oral tablet 25 mg Give 25 mg by mouth once daily related to essential hypertension (dated 1/14/26) On 1/28/26 at 1:34 PM. Surveyor reviewed the facility's standing orders with Director of Nursing (DON)-B. The facility had a standing order to hold blood pressure medication if systolic (BP) is less than 100, diastolic (BP) is less than 60, or pulse is less than 50, and update provider if symptomatic or after first missed dose. On 1/28/26 Surveyor reviewed R36's Medication Administration Record (MAR), administration notes, vital signs, and progress notes which indicated the following: ~ On 1/28/26 at 7:08 AM, R36's BP was 193/105. Clonidine, metoprolol, amlodipine, lisinopril, and hydrochlorothiazide were held on the morning of 1/27/26. ~ On 1/27/26 at 7:04 PM, R36's 6:00 PM doses of clonidine and (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	metoprolol were administered. No evening vital signs were documented. ~ On 1/27/26, R36's 6:00 AM/7:00 AM doses of metoprolol, amlodipine, lisinopril, hydrochlorothiazide, and clonidine were held due to a low pulse. R36 had a pulse of 48 at 7:05 AM.~ On 1/22/26 at 6:45 PM, R36's 6:00 PM doses of metoprolol and clonidine were administered. R36 had a pulse of 44 at 4:35 PM.~ On 1/22/26 at 1:23 PM, R36's 7:00 AM doses of metoprolol, lisonopril, and clonidine were administered. ~ On 1/22/26 at 1:22 PM, R36's 7:00 AM dose of amlodipine was administered. ~ On 1/22/26 at 10:10 AM, R36's 6:00 AM dose of hydrochlorothiazide was administered.~ On 1/21/26 at 6:43 PM, R36's 6:00 PM doses of metoprolol and clonidine were administered. R36's vital signs on 1/21/26 at 5:05 PM were pulse 46, BP 168/80. ~ On 1/21/26 at 10:54 AM, R36's 7:00 AM doses of metoprolol, amlodipine, lisinopril, and clonidine were administered. ~ On 1/21/26 at 10:53 AM, R36's 6:00 AM dose of hydrochlorothiazide was administered.~ On 1/20/26 at 6:36 PM, R36's 6:00 PM doses of metoprolol and clonidine were administered. R36's vital signs on 1/20/26 at 5:13 PM were pulse 45, BP 195/90.~ On 1/20/26 at 10:37 AM, R36's 6:00 AM/7:00 AM doses of metoprolol, clonidine, and hydrochlorothiazide were administered. ~ On 1/20/26 at 10:38 AM, R36's 7:00 AM doses of amlodipine and lisinopril were administered.~ On 1/19/26 at 6:54 PM, R36's 6:00 PM dose of metoprolol and clonidine were administered. R36's vital signs on 1/19/26 at 5:18 PM were pulse 48, BP 198/85.~ On 1/18/26 at 11:35 AM, R36's 7:00 AM doses of metoprolol and clonidine were administered. R36 had a pulse of 62 at 8:14 AM. ~ On 1/18/26 at 11:27 AM, R36's 7:00 AM doses of amlodipine and lisinopril were administered. R36 had a pulse of 62 at 8:14 AM. ~ On 1/18/26 at 11:34 AM, R36's 6:00 AM dose of hydrochlorothiazide was administered. R36 had a pulse of 62 at 8:14 AM.~ On 1/17/26 at 9:14 AM, R36's 6:00 AM/7:00 AM doses of metoprolol, amlodipine, lisinopril, and hydrochlorothiazide were held due to a low pulse. R36 had pulse of 47 at 7:28 AM. ~ On 1/17/26 at 9:14 AM, R36's 7:00 AM dose of clonidine was held due to a low pulse. R36 had a pulse of 47 at 7:28 AM. ~ On 1/16/26 at 5:14 PM, R36's 6:00 PM dose of clonidine HCl was administered. R36 had a pulse of 46 at 5:12 PM. On 1/28/26 at 1:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-F who stated AM medication pass is from 7:00 AM to 10:00 AM. LPN-F stated LPN-F takes residents' vital signs prior to starting medication administration. On 1/28/26 at 1:34 PM, Surveyor interviewed Director of Nursing (DON)-B who stated nurses should obtain vital signs for residents who require vital sign evaluation just prior to medication administration and should contact the provider regarding holding medications and/or vital signs that are outside the parameters for administration. DON-B reviewed R36's held medications on 1/27/26 and elevated BP on 1/28/26. DON-B stated the facility has standing orders to hold blood pressure medication if systolic (BP) is less than 100, diastolic (BP) is less than 60, or pulse is less than 50, and update provider if resident is symptomatic or after the first missed dose of medication. DON-B stated if a resident's pulse is less than 50, BP medication should be held. DON-B stated the facility's medication pass times are posted and medications should be administered within the time frames. DON-B indicated medications should be given within an hour of the ordered time. DON-B stated standing orders are not in a resident's medical record. 2. From 1/26/26 to 1/28/26, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] and had diagnoses including hypertension, type 2 diabetes, and right lower leg fracture. R22's MDS assessment, dated 12/20/25, had a BIMS score of 15 out of 15 which indicated R22 had intact cognition.A care plan, revised 10/9/25, indicated R22 had hypertension. The care plan contained an intervention (dated 10/9/25) to give anti-hypertensives as ordered. On 1/27/26 at 8:30 AM, Surveyor observed LPN-F administer medication to R22. LPN-F stated LPN-F obtained R22's BP earlier that morning which was low so LPN-F held R22's hydrochlorothiazide and lisinopril.R22 had the following medication orders:~ Hydrochlorothiazide oral tablet 12.5 mg Give 1 tablet by mouth once daily related to essential (primary) hypertension (dated 9/23/25)~ Lisinopril oral tablet 20 mg Give 20 mg by mouth once daily related to essential (primary) hypertension. Hold for systolic BP less than 100 (dated 11/3/25)Surveyor reviewed R22's MAR which contained the following information:~ On 1/27/26, R22's hydrochlorothiazide was held due to a low BP of 110/57.~ On 1/27/26, R22's lisinopril was held (continued on next page)		

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Printed: 08/27/2026
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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 01/28/2026
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	due to a low BP of 110/57.~ On 1/28/26, R22's lisinopril was held for a low BP of 106/53. On 1/28/26, Surveyor reviewed R22's vital signs and noted the following:~ On 1/27/26 at 7:32 AM, R22's BP was 110/57 as documented by LPN-F. (Of note: R22's systolic BP was greater than 100.) ~ On 1/28/26 at 6:58 AM, R22's BP was 106/53 as documented by LPN-F. (Of note: R22's systolic BP was greater than 100.) On 1/27/26 at 8:30 AM, Surveyor interviewed LPN-F who verified LPN-F did not administer lisinopril on 1/27/26 or 1/28/26 or hydrochlorothiazide on 1/27/26 because R22's BP was outside the parameters for administration. On 1/28/26 at 1:34 PM, Surveyor interviewed DON-Bw who verified R22 does not have an order to hold BP medication for a BP of 110/57 or 106/53. DON-B confirmed R22's order states to hold BP medication if R22's systolic BP is less than 100. DON-B stated lisinopril and hydrochlorothiazide should have been administered because R22's systolic BP was greater than 100.		

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and record review, the facility did not ensure a stock medication was labeled and administered in accordance with manufacturer's recommendations for 1 resident (R) (R54) and 1 staff (Registered Nurse (RN)-R). On [DATE], the medication room contained Tuberculin Purified Protein Derivative, Mantoux (an injectable solution used for skin testing to diagnose latent tuberculosis (TB) infections) which had a handwritten date of 4/25 or 4/28 on the outer package. Staff confirmed the medication should contain an open date and that once opened, the solution should be used within 30 days. The solution was used to administer TB tests for R54 and RN-R. Findings include: The Centers for Disease Prevention and Control (CDC) Mantoux Tuberculin Skin Test Facilitator Guide 2003 instructs to date the tuberculin vial when opening and discard it after 30 days. The facility's policy Medication Administration policy, with a review date of [DATE], indicates: .13. Identify expiration date. If expired, notify nurse manager. On [DATE] at 1:33 PM, Surveyor observed the facility's medication room refrigerator which contained a clear plastic bag with a brown prescription bottle inside. Inside the brown bottle was a clear vial labeled Mantoux Tuberculin which contained enough solution to cover the bottom of the vial. The vial, the bottle, and the clear bag each contained labels; the label on the bag contained a hand-written date of either 4/25 or 4/28 (the last number was difficult to read due to marker ink blending the lines). The bottle and the vial did not contain hand-written dates. The vial had a manufacturer's expiration date of 4/2028. The vial's lot number was 4CA261. Surveyor noted it was the only Mantoux Tuberculin vial in the medication room refrigerator. On [DATE] at 1:35 PM, Surveyor interviewed RN-I who indicated the hand-written date read 4/25 and the hand-written date on the label would be the date the vial was opened. RN-I indicated once opened, the vial was only good for 30 days. RN-I indicated the vial was past the date it should be used and threw the vial away. On [DATE] at 1:36 PM, RN-R entered the medication room. RN-I stated the facility needed to go through their medications and informed RN-R that the vial of tuberculin was expired and thrown away. On [DATE] at 2:00 PM, Surveyor reviewed Medication Administration Records (MARs) for residents admitted in the past 60 days and noted some of the MARs indicated two step Mantoux Tuberculin was given with a lot number starting with 4CA. The remainder of the lot number was not documented in the MARs. Surveyor reviewed R54's medical record which included an order for two step Mantoux one time only until [DATE], step one now and repeat in 2 weeks. The MAR indicated in the [DATE] box, 04/28 4ca26 with RN-I's initials. On [DATE], R54's MAR indicated the results of the Mantoux Tuberculin were negative. On [DATE] at 3:24 PM, Surveyor interviewed RN-R who stated it is difficult to document the entire lot number on the MAR because there is not enough space. RN-R stated RN-R was made aware that afternoon that the vial of Mantoux Tuberculin in the medication storage room had an incorrect or missing open date. RN-R stated RN-R had just received a TB test from the same vial because RN-R had recently started employment and needed a TB test. RN-R showed Surveyor paperwork for the test which contained the lot number of 4ca261. RN-R verified RN-R used the same vial the evening prior for a newly admitted resident who needed a TB test. RN-R verified it was the only vial the facility had. RN-R stated when opening a new vial, RN-R writes the open date on the vial and puts the vial in a bag or writes the open date on the brown plastic prescription bottle if the vial is stored in the bottle. RN-R stated the solution is only good for 30 days once opened. RN-R confirmed nursing staff should go by the open date when determining efficacy of the solution. RN-R stated RN-R thought the nurse who opened the vial got confused because the manufacturer's expiration date on the vial is good for as long as the hand-written date that was put on the bag's label (4/28). RN-R thought the hand-written date was 4/28 versus 4/25 as indicated by RN-I. RN-R stated RN-R saw nurses label open dates incorrectly or (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	label the bag versus the solution container and then the actual open date was unknown. On [DATE] at 3:29 PM, Surveyor interviewed Director of Nursing (DON)-B who stated Mantoux Tuberculin vials should have a hand-written date on the vial's label when the vial is opened. DON-B indicated the facility has had to throw vials away because nurses put the vial in a brown medication bottle where the open date could not be confirmed. Nursing Home Administrator (NHA)-A was present and indicated the vial of Mantoux Tuberculin thrown away by RN-I was the only vial in the medication room and a new vial would be ordered.		