STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525370	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Ports Health Services	1612 N 37th St Superior, WI 54880

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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not establish an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 10 of 79 residents (R) observed for infection control practices.Certified Nursing Assistant (CNA) I did not perform proper glove changes and hand hygiene during cares.Staff did not use appropriate infection control practices. No hand hygiene between residents while passing meal trays and the meal trays were placed on dirty Personal Protective Equipment (PPE) container. CNA D served R78 a meal tray and placed it on a contaminated surface. Example 1 Facility policy titled, Hand Hygiene revised 11/02/2022 stated in part: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table . Hand hygiene table .Between resident contacts .Before and after handling clean or soiled dressings, linens, etc . Before performing resident care procedures .Before and after providing care to residents in isolation .When in doubt. On 1/21/2026 at 8:08 AM, Surveyor observed CNA E take a tray into room [ROOM NUMBER] marked with an Enhanced Barrier Precautions (EBP) sign at the door. R71 resides in room [ROOM NUMBER] and has a Foley catheter. CNA E did not perform any hand hygiene when entering or exiting room [ROOM NUMBER]. CNA E then went to the meal tray cart and grabbed a new tray and took it to room [ROOM NUMBER]. room [ROOM NUMBER] is marked with an EBP sign at the door. R69 resides in room [ROOM NUMBER] and has a feeding tube. CNA E did not perform any hand hygiene when entering or exiting room [ROOM NUMBER]. CNA E then took the plate cover back to meal cart, then went back into room [ROOM NUMBER], then back to meal cart without performing hand hygiene. CNA E picked up a new tray from the cart, delivered it to staff person entering room [ROOM NUMBER] with a resident who is on droplet precautions, then went into room [ROOM NUMBER] which had two residents without precautions and after leaving room [ROOM NUMBER] performed hand hygiene. CNA E then took meal tray to room [ROOM NUMBER] marked with an EBP sign. R22 resides in room [ROOM NUMBER] and has Extended-Spectrum Beta-Lactamase (ESBL) (a urinary tract infection (UTI) caused by bacteria (usually E. coli or Klebsiella) that are resistant to common antibiotics like penicillin and cephalosporins) in the urine. CNA E did not perform hand hygiene when entering or exiting room [ROOM NUMBER]. CNA E then went to meal tray cart and picked up a tray for a resident in room [ROOM NUMBER]. R8 resides in room [ROOM NUMBER] and is on EBP for (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 - Some	Methicillin-Resistant Staphylococcus Aureus (MRSA) (a wound typically appears as a painful, red, swollen bump or abscess that may resemble a spider bite or pimple, often accompanied by pus, warmth, and fever). While in room [ROOM NUMBER] CNA E was seen picking up and moving R8's reacher, touching R8's blankets, moving R8's tray table, then removed tray from room [ROOM NUMBER] as R8 was not hungry. No hand hygiene was noted. CNA E went to meal cart to put R8's tray down then answered call light in room [ROOM NUMBER] with an EBP sign on the door. R72 resides in room [ROOM NUMBER] and has a history of MRSA in a wound. CNA E did not perform hand hygiene when entering or leaving room [ROOM NUMBER]. On 01/21/2026 at 8:22 AM, Surveyor interrupted CNA E's meal tray pass as Surveyor felt the observations made were sufficient and resident's safety was now a concern. Surveyor interviewed CNA E regarding no hand hygiene observed with meal tray pass to multiple resident rooms. CNA E replied, Let me check. I don't think that we have to gown up before going into a room when just passing trays. Surveyor responded, It is not the gowning that is my concern, but instead the lack of hand hygiene when entering and exiting rooms with EBPs especially when I saw you touching things in the room like the reacher, blankets and bedside table. CNA E replied, Yes, I will definitely work on the hand hygiene thing. On 01/22/2026 at 7:43 AM, Surveyor interviewed Director of Nursing (DON) B about the observations made of CNA E entering multiple resident' rooms on EBP without performing hand hygiene. DON B replied, Regardless of EBP, staff should utilize standard precautions and should perform hand hygiene when entering and when leaving all resident rooms. Example 2 On 01/21/26 at 9:31 AM, Surveyor observed CNA I provide peri care to R32 while R32 was in bed. CNA I donned gloves and began washing R32 in the genital area. Surveyor observed CNA I clean bowel movement (BM) off R32's bottom. CNA I then rolled R32 from side to side and then placed new brief on R32 with contaminated gloves. CNA D entered into R32's room and assisted CNA I with boosting R32 into bed. Surveyor did not observe CNA I doff contaminated gloves before readjusting R32 into bed, placing blanket over R32, and adjusting R32's pillow with contaminated gloves. On 01/21/26 at 10:01 AM, Surveyor interviewed CNA I and asked what CNA I's process is for providing peri care and hand hygiene. CNA I reported that CNA I should have doffed contaminated gloves before placing any clean items on R32 and touching R32's surfaces that did not pertain to providing peri care. On 01/22/26 at 10:28 AM, Surveyor interviewed DON B and asked DON B's expectation for hand hygiene during peri cares for R32. DON B reported that CNA I should have taken contaminated gloves off after providing peri care, before adjusting blankets and repositioning R32, and then touching all surfaces. DON B reported the expectation is that CNA I complete hand hygiene with washing hands or hand sanitizer after completing peri cares. Example 3 Facility policy, titled Transmission Based (Isolation) Precautions, dated 9/24/2024, states: It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogen's modes of transmission. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Facility staff will apply Transmission -Based Precautions, in addition to standard precautions to residents who are known or suspected of being infected or colonized with certain infectious agent requiring addition control to prevent transmission. R78 was admitted to the facility on [DATE], and has diagnoses of Alzheimer's disease, non-Alzheimer's dementia, renal insufficiency, high blood pressure and anemia. R78's Minimum Data Seta (MDS) assessment, dated 11/25/25, indicated R78 is severely cognitively impaired, and is dependent or requires substantial assistance for movement and activities of daily living; bathing, dressing, hygiene and transferring to toilet. R78's care plan, updated 1/20/26, states infection of respiratory tract for acute respiratory infection. Interventions include hand hygiene prior to entering room and upon removing PPE, implementation of infection control policy and procedures for specific infection/illness. On 1/22/26 at 8:04 AM, Surveyor observed CNA D take a tray out of the food cart located down the hall by room [ROOM NUMBER], which is R29's room. CNA D turned around and put food tray down on top of the isolation precaution contaminated garbage can outside of R29's room. CNA D put on gown, gloves and a mask, picked food tray off the contaminated surface, and took it down to R78. CNA D entered R78's room with contaminated food tray and came out of room with gown, gloves and mask off and contaminated food tray was left in R78's room. R78 is on droplet precautions. R29 is on contact precautions for a different illness than what R78 has. On 1/21/26 at 1:41 PM, Surveyor interviewed CNA D about infection control processes when passing food trays. CNA D stated when passing trays, you need to complete hand hygiene before and after you bring a tray into a room and put on full personal protective equipment (PPE) when going into an isolation room. Surveyor asked CNA D if the PPE cart and trash can outside of a room in the hallway is considered clean or dirty. CNA D initially stated clean. Surveyor clarified is the white can for garbage and soiled PPE. CNA D stated yes. Surveyor asked if CNA D still considers that clean. CNA D stated, Well where should we put it then. Surveyor stated to CNA D that CNA D has to consider if the area is clean or dirty first before setting down something. CNA D stated it holds garbage and agreed it would be dirty. Surveyor asked about observation of putting a food tray on top of a white garbage when putting on her PPE before entering a room. CNA D stated, oh yeah, I did that. I shouldn't have. It is dirty. Normally someone is out here helping us pass trays, holding them while we put on our PPE. CNA D stated CNA D should have put PPE on first. On 1/22/26 at 1:41 AM, Surveyor interviewed Infection Assistant Director of Nursing (ADON) C who is the primary Infection Preventionist (IP) for the facility. ADON C stated the expectation when passing food trays is to sanitize hands (perform hand hygiene) before touching a tray, check what is on the tray, making sure it is correct, provide a hand wipe to residents, deliver tray, and before the next one sanitize hands again and start over. Surveyor asked if anything changes when a room is in isolation or has precautions. ADON C stated that when residents are in isolation or have precautions, staff should put on PPE prior to going into their room, then take it off and sanitize before they leave. They then need to put PPE on again if needed and go retrieve a second tray. Surveyor asked if the white bins outside room doors by PPE carts are considered a clean or dirty space. ADON C stated CNA D told ADON C about that. ADON C stated CNA D shouldn't have taken the tray until CNA D put on her PPE first. We have been trying to bring trays to everyone, so they can put on their PPE first.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility did not provide wound management or diabetic management by professional standards of practice to maintain a resident's highest practicable level of physical well-being for 1 of 3 residents (R32) reviewed.-Staff did not provide wound care dressing as ordered by physician for R32. -R32's air mattress settings were not appropriate per R32's weight based on offloading measures to minimize skin breakdown. -Staff did not administer short acting insulin to R32 when Blood Glucose (BG) was high.Findings include:Facility policy titled Change in Condition of the Resident, last revised 09/20/22, stated in part, .When a resident presents with a possible change of condition or noted changes in mental or physical functioning: 1. Assess the residents need for immediate care medical attention. #2. Assess/evaluate the resident. This assessment/evaluation could include, but is not limited to, the following: a. Vital signs, oxygen saturation, blood glucose level. 3. Notify resident physician. A. Immediate notification for any symptom, sign or apparent discomfort that is: i. Acute or sudden in onset.Surveyor reviewed manufacturing instructions titled, Med Aire Plus 10 Alternating Pressure and Low Air loss Bariatric mattress, states in part, . Page 12, General: This product is designed to provide redistribution while maximizing comfort to patients. Please be sure to operate this equipment as instructed to optimize its value. Page 7, Control unit Figure 1 states, this digital control unit includes intuitive controls for adjusting the air pressure based on the patient's weight and comfort level. Seat inflate increases air pressure for additional sacral support during head of bed elevation. Max firm is available for patient transfers or other patient care procedures. Page 14, Recommended Linen: Deep pocketed fitted or flat sheets are recommended. Multiple layering of linens or under pads beneath the patient should be avoided, when possible, for the prevention and treatment of pressure injuries.R32 was admitted to the facility on [DATE] with readmission on [DATE], with diagnoses in part, metabolic encephalopathy, muscle wasting and atrophy, severe sepsis acute infection, diabetes mellitus type 2, hypertension, congestive heart failure, cerebral infarction, hypothyroidism, and absence of right leg below the knee.R32's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/05/26, indicates R32's cognition is intact with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. R32 has impairment on both upper and lower extremities requiring total dependence on staff assist for personal hygiene, toileting, transferring, and rolling left to right.Surveyor reviewed R32's physician orders:-On 11/05/24 Nursing to check air mattress every shift to assure proper setting of current weight and function. Update maintenance with concerns every shift. -On 09/03/25 Barrier cream to coccyx Q shift and after each incontinent episode. Update provider as needed with concerns every shift to protect skin. -On 12/31/25 Wound care to IAD to thighs. Remove old dressing, cleanse with soap and water, pat dry, apply 6x6 comfort bordered foam dressing.-On 12/31/25 Monitor dressing to thighs for placement. Update provider with concerns every shift.Surveyor reviewed R32's skin integrity care plan which states in part, altered skin integrity non pressure related to history of area to left/right buttocks, redness to groin and coccyx.-Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor notify physician of significant findings-Provide pressure reduction/relieving mattress-Provide thorough skin care after incontinent episodes and apply barrier cream-Treatments as ordered.Surveyor reviewed R32's activities of daily living (ADL) self-care deficit care plan which states in part,-Inspect skin with care. Report reddened areas, rashes, bruising, or open areas to charge nurse.-Toileting: Assist of 2 with check and change every 2-3 hours and as needed.-Transfer: A-2 with Hoyer lift.-Ambulation: non-ambulatory.-Bed mobility: Assist of 1 with repositioning, Assist of 2 with boosting.-Dressing: Assist of 2.Surveyor reviewed R32's potential pressure ulcer development which states in part,-Bolster air mattress provided.-Provide thorough skin care after incontinent episodes and apply barrier cream.-Treatments as ordered.Example 1On 01/20/26 at 2:18 PM, Surveyor observed Certified (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Assistant (CNA) J enter R32's room and provide incontinent care. Surveyor observed no dressings on R32's coccyx gluteal fold thigh area as ordered for dressing to be applied daily. Surveyor observed open areas bilaterally on lower gluteal folds exposed with feces and urine on open wounds.On 01/20/26 at 2:45 PM, Surveyor interviewed CNA J and asked CNA J when CNA J transferred R32 up into the wheelchair for the day, did CNA J observe R32 to have a dressing in place bilaterally on R32's coccyx gluteal folds area. CNA J reported that CNA J is just now getting R32 up for the day. CNA J reported to Surveyor that when CNA J was in R32's room this morning repositioning and changing R32's brief, there were no dressings in place on R32.On 01/21/26 at 6:51 AM, Surveyor entered R32's room and observed Registered Nurse (RN) G pushing medications and fluids through R32's PEG tube. Surveyor observed R32's bed highly inflated and the air mattress at its highest setting. Surveyor observed that the air mattress settings did not match R32's weight of 218 pounds for the air mattress to function appropriately and provide correct off-loading.On 01/21/26 at 7:03 AM, Surveyor observed CNA I use a bath blanket folded 3 times under R32 to reposition R32 in bed. Surveyor observed bath blanket to be wrinkled under R32 on air mattress. Surveyor asked CNA I if it is normal to use a bath blanket under R32 on air mattress versus a chuck. CNA I stated, Sometimes we don't have enough chuck pads to use. On 01/21/26 at 7:41 AM, Surveyor entered R32's room with CNA D and Unit Manager (UM) H to reposition R32. Surveyor observed CNA D and UM H reposition R32. Surveyor observed that the air mattress settings did not match R32's weight of 218 pounds for the air mattress to function appropriately and provide correct off-loading. On 01/21/26 at 8:01 AM, Surveyor interviewed UM H and asked if R32's air mattress was in correct settings to provide off-loading to prevent potential skin breakdown. UM H reported to Surveyor that UM H was unaware R32's settings were not based on R32's weight as physician ordered. UM H reported to Surveyor that UM H would investigate this as it's maintenance that sets the air mattresses upon admission or when implemented.On 01/21/26 at 8:16 AM, Surveyor interviewed RN F and asked if RN F knew the air mattress was inflated beyond R32's weight limit. RN F reported that maintenance usually sets up the air mattress. Surveyor asked RN F about the settings on the air mattress and if staff need to verify the air mattress settings. RN F reported that nurses are to be checking the air mattress on every shift to ensure it is correctly inflated per resident's weight. Surveyor asked RN F about R32's coccyx wounds on lower gluteal folds. RN F reported that RN F is calling them moisture associated due to incontinence and family taking R32 outside the facility and not bringing her back every 2 hours for repositioning. On 01/21/26 at 8:25 AM, Surveyor pulled RN F into R32's room to observe the air mattress inflation settings. RN F reported the settings were between [PHONE NUMBER]lb weight. RN F reported that R32's air mattress settings shouldn't be that high as R32 is only around 218 lbs. Surveyor asked RN F if the air mattress settings were not properly set could it affect R32's pressure off-loading capabilities. RN F reported that it very well could be affecting off-loading. Surveyor asked RN F who is responsible for setting the air mattress settings. RN F reported that maintenance and Unit Manager H usually set the air mattresses up upon admission.On 01/21/26 at 8:29 AM, Surveyor, RN F, and UM H entered R32's room to observe air mattress settings and UM H reported to Surveyor that UM H will fix R32's bed to correct air mattress settings and reach out to maintenance to make sure R32's bed is not broken.On 01/22/2026 at 8:37 AM, Surveyor interviewed Director of Nursing (DON) B and reported to DON B that Surveyor observed R32 to not have wound dressings on bilaterally to coccyx/gluteal folds area as ordered by physician. Surveyor asked DON B's expectation for dressings not on R32's coccyx/gluteal folds area. DON B reported to Surveyor that DON B had interviewed CNA J about the dressings not being on and if CNA J knew they should be on. DON B reported to Surveyor that CNA J stated CNA J did not know they were supposed to even be on or to report to nurse on duty. Surveyor asked DON B's expectation for linens under R32 while in bed on air mattress. DON B reported that staff usually utilize chucks or a draw sheet under R32 when boosting and changing R32 in bed. Surveyor reported to DON B that Surveyor observed CNA I use a bath blanket folded 3 times under R32 to reposition and use as a chuck pad but that the bath (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blanket was wrinkled under R32 on air mattress. Surveyor asked staff why that was being used instead of a chuck and CNA I stated, Sometimes we don't have enough chuck pads to use. Surveyor asked DON B if using a bath blanket was acceptable practice. DON B reported that staff shouldn't use it if it is wrinkling as Surveyor reported. On 01/22/26 at 8:58 AM, Surveyor interviewed DON B and asked DON B what the expectation is of air mattress settings for R32. DON B reported that R32's order refers to adjusting air mattress settings to R32's weight and every nurse should be checking the settings every shift to make sure R32's air mattress settings are appropriate. Example 2Facility policy titled Continuous Glucose Monitors (CGM), last revised 11/14/23, stated in part, .1. Continuous glucose monitor results are only for the resident and/or residents' representative to monitor glucose levels. 6. CGM use requires a physician order. The order should indicate instructions for use such as a. When periodic finger stick glucose readings may be required (and at what intervals) in addition to the use of the CGM, and b. The frequency in which the nurse is to record the glucose readings in the electronic medical record. #7. Treatment decisions may not be solely based on CGM values. Considerations of how the resident is feeling along with a finger stick to confirm blood glucose value will be used for treatment decisions of hypo/hyperglycemic episodes. #10. Nurse will review the resident's CGM value when doing a finger stick to verify the CGM value id within the acceptable range. If the CGM value is outside of acceptable range, the nurse will instruct the resident to calibrate the device.Surveyor reviewed manufacturing instructions for Freestyle Libre 3 plus sensor which states in part, .C. Glucose readings determine background color at top of phone screen, orange indicates High glucose (above 250 mg/dL). D. Trend arrows show where your glucose levels are headed. Arrow pointing straight up is Glucose is rising quickly more than 2mg/dL per minute. CGM and Blood Glucose Monitoring (BGM) readings differ as BGM is measuring the glucose directly from the blood and then CGM measures glucose in the interstitial fluid. Glucose enters the blood stream first then diffuse into the interstitial fluid. As a result, changes in the blood glucose levels whether they are increasing or decreasing will be reflected in the BGM readings before they appear in the CGM readings. This is known as a lag.Surveyor reviewed R32's physician orders:-On 07/21/25, Monitor Libre every shift and use reader to retrieve Blood Glucose [BG] checks every shift.-On 10/10/25, Insulin regular Human injection solution, inject 6 units subcutaneously three times a day for diabetes. Hold if BG is less than 120. Update provider if BG is less than 70 or greater than 400.-On 10/10/25, Insulin regular Human injection solution, inject as per sliding scale: if 150-199= 3 units; 200-249= 6 units; 250-299= 9 units; 300-349= 12 units; 350= 15 units. Update provider if blood sugar is greater than 400, subcutaneously three times a day for diabetes.-On 12/19/25, Apply Libre 3. Change every 15 days. Needs calibration upon application every shift.-On 01/01/26, Lantus Solo Star subcutaneous solution pen injector 100Unit/ML, inject 40 units subcutaneous one time a day related to type 2 Diabetes Mellitus, take with breakfast.-On 01/21/26, Insulin Regular Human Injection Solution 100 UNIT/ML (Insulin Regular (Human)) Inject 5 unit subcutaneously one time only for diabetes mellitus for 1 Day.Surveyor reviewed R32's Alteration in BGs with hyperglycemic and hypoglycemic episodes states in part,-Administer medications as ordered.-Report abnormal results per physician parameters and guidelines.Surveyor reviewed R32's BGs from dates ranging 01/01/26-01/22/26.-On 01/21/26 at 11:11 AM, 353 mg/dl.-On 01/21/26 at 11:12 AM, 393 mg/dl.-On 01/21/26 at 1:00 PM, 276 mg/dl.-On 01/21/26 at 4:02 PM, 500 mg/dl.-On 01/21/26 at 4:03 PM, 500 mg/dl.-On 01/22/26 at 7:58 AM, 399 mg/dl.Surveyor reviewed R32's progress notes that indicated,-On 01/21/26 at 12:10 PM, Writer left message for a call back from physician regarding R32 not receiving insulin this morning due to R32 was sleeping and not eating. R32 was 361, 353, 399, and then 281. Waiting on call back.-On 01/21/26 at 3:01 PM, Writer spoke with RN from community care team regarding R32 not receiving insulin this morning due to resident [R32] sleeping and not eating. Provider gave the ok to hold breakfast insulin and lunch if resident is not awake. Writer updated RN that resident [R32] woke after lunch and ate muffin with mountain dew so short acting insulin was given. Will continue plan of care.-On 1/21/2026 at 3:58 PM, Resident BG 500 at 3:30 PM. Contacted provider and provider ordered 5 units regular (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	insulin 1 time dose give now.On 01/21/26 at 7:41 AM, Surveyor entered R32's room with CNA D and UM H to reposition R32. Surveyor observed R32's Libre BG machine alarming on R32's cell phone. Surveyor asked UM H what the alarm was. Unit Manager H reported to Surveyor that the alarm was R32's BG check from Libre machine and it notifies staff on cell phone. Surveyor observed R32's BG to be 399 with arrow pointing upwards. Surveyor asked UM H what the arrow meant on the Libre machine. UM H reported that the arrow meant that R32's BG was still climbing. UM H reported to Surveyor that UM H would ask RN G if RN G has given insulin yet to R32. Surveyor observed UM H walk out of R32's room and approached RN G to let her know R32's BG result of 399. RN G reported to UM H that RN G would be going into R32's room shortly.On 01/21/26 at 11:59 AM, Surveyor interviewed RN G and asked if RN G had received R32's short acting insulin for breakfast. RN G reported that since R32 did not get up for breakfast, RN G held short acting insulin. Surveyor asked RN G how RN G knows to hold R32's insulin since R32 did not get up for breakfast. RN G stated, I just decided to use my judgement and not give her, her short acting insulin. Surveyor asked if RN G notified the provider on call. RN G reported that RN G has not had a chance yet to call the provider. Surveyor asked RN G if it is normal practice to hold a short acting insulin for over 4 hours before notifying the provider on call. RN G reported that RN G should have called earlier right after deciding to hold the short acting insulin for further orders from the provider in case provider wanted R32 to still have the insulin.On 01/22/26 at 8:37 AM, Surveyor interviewed DON B and reported to DON B that Surveyor observed R32's Libre glucose monitor beeping 399 with arrow up relaying that R32's Blood Glucose (BG) was high while in R32's room with Unit Manager H on 01/21/26. Surveyor asked DON B what expectation would be of managing the Libre and R32's BG. DON B reported that if R32's Libre was alarming with an arrow up it meant that R32's BGs was still actively going up. DON B stated to Surveyor, I expect staff to assess [R32] for any symptoms, perform a manual BG check, and notify physician right away. Surveyor asked DON B was DON B aware that R32 did not receive short acting insulin on 01/21/26 in the AM but then had to have additional 5 units given as R32's BG went up to 500 at 3:30 PM on 01/21/26. DON B reported that DON B was unaware of the additional short acting insulin needing to be given hours later but was aware of the hold of short acting insulin. Surveyor asked if DON B wrote this as a significant medication error. DON B reported to Surveyor that RN G should have notified the provider on call within an hour on holding R32's short acting insulin from earlier in the morning on 01/21/26. On 01/22/2026 at 12:43 PM, Surveyor interviewed DON B about the physician order not specifying periodic finger sticks glucose readings and intervals of completion along with the Libre BG machine. Surveyor also notified DON B that Surveyor could not find that the blood sugar result from 01/21/26 at 3:30 PM was taken again with a manual verification BG check and then the machine calibrated. DON B reported that DON B is sure that the staff member from second shift did complete this task but that it was not charted so unsure at this time. DON B reported that once there is a high BG check from 400 and above that all BGs should be rechecked manually.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525370	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Ports Health Services	1612 N 37th St Superior, WI 54880

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility did not implement professional standards of practice to ensure that a resident does not develop pressure injuries (PIs), receives necessary treatment and services to promote healing and prevent new PIs from developing for 1 of 3 resident (R) reviewed. (R44)R44 was admitted to the facility with stage 3 PIs to left trochanter (hip) and left buttock and stage 2 PIs to the right hip and right buttocks. Facility staff did not complete a comprehensive PI assessment to include measurements and description of R44's PIs on admission. Facility staff on the following assessment documented all the PIs only at a stage 2. This is evidenced by:Facility's policy titled Pressure Injuries and Non pressure Injuries with the revised date of 07/20/22 documented in part, The staging of pressure injury is consistent with the recommendations of National Pressure Injury Advisory Panel (NPIAP) and the RAI Manual, Section M.1. Upon admission: a. A head-to-toe body evaluation will be completed on every resident upon admission/readmission and will be documented on the Admission/readmission Evaluation UDA. i. If pressure Injury: Initiate the Pressure Injury Weekly Tracker UDA - one per wound. NPIAP documented in part, Pressure Ulcer Assessment1. Assess the pressure ulcer initially and re-assess it at least weekly. 1.1. Document the results of all wound assessments.3. Assess and document physical characteristics including: location, Category/Stage, size, tissue type(s), color, periwound condition, wound edges, sinus tracts, undermining, tunneling, exudate, and odor.CMS's RAI Version 3.0 Manual October 2025 documented in part, Section M, For each pressure ulcer, determine the deepest anatomical stage. At admission, code based on findings from the first skin assessment that is conducted on or after and as close to the admission as possible. Do not reverse or back stage. Consider current and historical levels of tissue involvement.R44 was admitted to the facility on [DATE]. R4's current diagnoses of severe protein-calorie malnutrition, weakness, adult failure to thrive, pressure ulcer of back, buttock and hip stage 2, PI left hip unstageable, personal history of physical injury and trauma, mild cognitive impairment, pressure ulcer of left buttock stage 3, personal history of traumatic brain injury, and depression.R44's Minimum Data Set (MDS) dated [DATE] admission 5 day assessment documented BIMS score of 14, meaning intact cognition. Moderate assistance needed from staff for toilet hygiene and personal hygiene and independent with bed mobility. R44 is at risk for PI with two stage 2 PIs on admission, one stage 3 present on admission, and one unstageable present on admission.R44's admission evaluation completed on 12/24/25 documented a skin impairment present to the right trochanter (hip) PI stage 2, left trochanter (hip) PI stage 3, right buttock PI stage 2, and left buttock PI stage 3. This assessment did not include measurements and descriptions of the PIs.On 12/31/25, a pressure injury weekly tracker was completed with the left trochanter (hip) as stage 2 and left gluteal fold (buttock) as a stage 2. Note, this stage was back staged from the admission assessment of a stage 3.On 01/21/26 at 2:20 PM, Surveyor interviewed Director of Nursing (DON) B asking for R44's PI assessment on admission. DON B stated R44 had an admission assessment completed with the wounds listed. Surveyor reviewed with DON B the assessment did not include measurements of the wound and only stages. The stages for two of the wounds were at a stage 3 and when the PI were assessed on 12/31/25 the PIs were staged at a 2. DON B stated she will need to review further. Surveyor asked what the expectation of assessment on admission. DON B stated would expect a full assessment with measurements on the day of admission. On 01/21/26 at 2:30 PM, Surveyor interviewed Registered Nurse (RN) F asking if the staging of a PI at a stage 3 would continue at the same stage and not back stage to a stage 2. RN F stated when RN F assessed R44 on 12/31/25 the PIs were at a stage 2. RN F did not assess R44 on the day of admission. On 01/21/26 at 2:38 PM, DON B stated RN G completed the admission assessment and RN G took the stage levels from the hospital notes. RN G could not recall the observation of the wound. DON B stated would expect a documented full assessment of the PI be completed on the day of admission.