STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525389	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Ridge Health and Rehabilitation Center	1445 N 7th St Manitowoc, WI 54220

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47248 Based on staff interview and record review, the facility did not ensure guardianship and protective placement orders were obtained and advance directive wishes were followed for 4 Residents (R) (R31, R43, R39, and R30) of 17 sampled residents. R31 had a legal guardian at the time of admission on 11/4/22. R31's medical record contained petitions for guardianship and protective placement, dated 9/28/22; however, R31's medical record did not contain guardianship or protective placement orders. R43 had a legal guardian at the time of admission on 4/17/24. R43's medical record contained an Order and Notice of Hearing on Guardianship and Protective Placement, dated 3/23/24, with a hearing date of 5/6/24; however R43's medical record did not contain guardianship or protective placement orders. R39 had a legal guardian at the time of admission on 10/13/23. R39's medical record contained petitions for guardianship and protective placement, dated 6/27/23; however, R39's medical record did not contain guardianship or protective placement orders. R30 completed a Power of Attorney for Healthcare (POAHC), dated 10/23/20, prior to admission. R30's advance directive contained no to nursing home placement. R30's choice to not be admitted to a nursing home was not honored. Findings include: State Statue Chapter 154.03(2) indicates: The choices in this document were made by a competent adult. Under the law, the patient's stated desires must be followed unless belief that withholding or withdrawing life-sustaining procedures or feeding tubes would cause the patient pain or reduced comfort and that the pain or discomfort cannot be alleviated through pain relief measures. If the patient's stated desires are that life-sustaining procedures or feeding tubes be used, this directive must be followed. State Statute Chapter 55.03(4) indicates: The law requires a court-ordered protective placement for any resident admitted to a nursing home who has a legal guardian and whose nursing home stay exceeds sixty days only be extended with court approval (State Statute Chapter 55.05(b)). Protective placement is reviewed annually (State Statute Chapter 55.18) to determine if the placement continues to be the least restrictive and in the best interest of the individual. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 8/12/24, Surveyor reviewed R31's medical record. R31 had a court-ordered guardianship and a diagnosis of persistent vegetative state. R31's Minimum Data Set (MDS) assessment, dated 6/28/24, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R31 had severe cognitive impairment. R31's medical record contained petitions for guardianship and protective placement, dated 9/28/22. R31's medical record did not contain guardianship or protective placement orders. 2. On 8/12/24, Surveyor reviewed R43's medical record. R43 had a court-ordered guardianship and a diagnosis of dementia. R43's MDS assessment, dated 7/27/24, had a BIMS score of 0 out of 15 which indicated R43 had severe cognitive impairment. R43's medical record contained an Order and Notice of Hearing on Guardianship and Protective Placement, dated 3/23/24, with a hearing date of 5/6/24. R43's medical record did not contain guardianship or protective placement orders. 3. On 8/12/24, Surveyor reviewed R39's medical record. R39 had a court-ordered guardianship and a diagnosis of anoxic brain injury and persistent vegetative state. R39's MDS assessment, dated 7/12/24, had a BIMS score of 00 out of 15 which indicated R39 had severe cognitive impairment. R39's medical record contained petitions for guardianship and protective placement, dated 6/27/23. R39's medical record did not contain guardianship or protective placement orders. On 8/12/24 at 12:17 PM, Surveyor requested updated and current guardianship and protective placement paperwork for R31, R43, and R39. On 8/13/24 at 9:21 AM, Surveyor received documentation for R31, R43, and R39 from Social Worker (SW)-D and noted the documentation was the same documentation Surveyor observed in R31, R43, and R39's medical records. On 8/13/24 at 1:35 PM, Surveyor interviewed SW-D who stated protective placement paperwork was completed yearly and guardianship paperwork was obtained upon admission. SW-D was unsure who to obtain the paperwork from and stated the facility did not receive or obtain guardianship or protective placement paperwork after the facility was notified by the court that a hearing was scheduled. SW-D stated when notice and order of hearing paperwork is received, the paperwork is scanned into the resident's medical record and no further action is completed by the facility. SW-D stated the facility does not have a process in place to ensure guardianship and protective placement paperwork is obtained and documented in residents' medical records. SW-D confirmed R31 and R43's medical records did not contain orders for guardianship or protective placement and R39's medical record did not contain a current protective placement order. 45942 4. On 8/12/24, Surveyor reviewed R30's medical record. R30 was admitted to the facility on [DATE] with diagnoses including end stage renal disease, congestive heart failure, and dependence on renal dialysis. R30's MDS assessment, dated 6/19/24, had a BIMS score of 12 out of 15 which indicated R30 had moderately impaired cognition. Upon admission to the facility, R30 was R30's own decision maker. R30's POAHC was activated on 5/10/22. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R30's medical record indicated R30 signed POAHC paperwork on 10/23/20 that indicated: My health care agent may admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care. Agent Authority to admit me to a nursing home or community-based residential facility for long-term care. If I check No I cannot be admitted to a Wisconsin long-term care facility without a court order. R30 checked the box that indicated: No, my health care agent does not have the authority to admit me to a nursing home or a community-based residential facility for a long-term stay. On 8/12/24 at 2:21 PM, Surveyor interviewed SW-D who verified R30's POAHC paperwork was marked No for nursing home placement. SW-D stated R30 was admitted to the facility before SW-D was employed by the facility and SW-D had not seen that indicated on a resident's POAHC paperwork. SW-D stated if a resident checks No to nursing home admission on POAHC paperwork, the resident should not be admitted to the facility since that is not the resident's wish. SW-D stated SW-D is not involved in the admission process and the hospital should have fixed it prior to R30's admission to the facility. On 8/12/24 at 2:48 PM, Surveyor interviewed Business Office Staff (BOS)-Q who used to work in admissions when R30 was admitted . BOS-Q stated BOS-Q was unsure what to do if a resident marked No to nursing facility on POAHC paperwork and needed medical care. On 8/12/24 at 2:51 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated if a resident marks No to nursing home admission on POAHC paperwork, the facility would review it and not admit the resident.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563 Based on observation, staff and resident interview, and record review, the facility did not ensure 3 Residents (R) (R11, R16, and R41) of 3 sampled residents were assessed as able to safely and accurately self-administer medication. On 8/12/24, License Practical Nurse (LPN)-U left medication with R11 for R11 to self-administer after breakfast. R11 did not have a physician's order, self-administration of medication assessment, or care plan that indicated R11 could safely and accurately self-administer medication. On 8/12/24, LPN-U left medication at R16's bedside for R16 to self-administer. R16 did not have a physician's order, self-administration of medication assessment, or care plan that indicated R16 could safely and accurately self-administer medication. On 8/12/24, Registered Nurse (RN)-K prepared a nebulizer treatment for R41 to self-administer. R41 did not have a physician's order, self-administration of medication assessment, or care plan that indicated R41 could safely and accurately self-administer medication. Findings include: The facility's Resident Self-Administration of Medication policy, dated 5/1/24, indicates: It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medication after the facility's Interdisciplinary Team has determined which medication may be self-administered safely .4. The results of the Interdisciplinary Team assessment are recorded on the Medication Self-Administration Assessment Form which is placed in the resident's medical record .13. The care plan must reflect resident self-administration and storage arrangements for such medications. The facility's Bedside Medication Storage policy, dated 1/2024, indicates: .2. A written order for the bedside storage of medication is present in the resident's medical record . 1. From 8/12/24 to 8/14/24, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (CHF), chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and ventilator dependency. R11's Minimum Data Set (MDS) assessment, dated 5/31/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R11 had intact cognition. R11's medical record indicated R11 was responsible for R11's healthcare decisions. On 8/12/24 at 9:20 AM, Surveyor observed LPN-U leave a medication cup for R11 that contained two 500 mg (milligram) tablets of calcium carbonate (an antacid medication). LPN-U stated R11 saves the medication for after breakfast. R11's medical record did not contain a physician's order, self-administration of medication assessment, or care plan that indicated R11 could safely and accurately self-administer medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. From 8/12/24 to 8/14/24, Surveyor reviewed R16's medical record. R16 was admitted to the facility on [DATE] with diagnoses including acute and chronic respiratory failure, morbid obesity, asthma, anxiety, tracheostomy, and ventilator dependency. R16's MDS assessment, dated 6/3/24, had a BIMS score of 9 out of 15 which indicated R16 had moderate cogitative impairment. R16's medical record indicated R16 had an activated Power of Attorney for Healthcare (POAHC). On 8/12/24 at 9:35 AM, Surveyor observed LPN-U leave a medication cup with two 250 mg tablets of ethosuximide (an anticonvulsant medication) at R16's bedside. R16's medical record did not contain a physician's order, self-administration of medication assessment, or care plan that indicated R16 could safely and accurately self-administer medication. On 8/12/24 at 12:56 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R11 and R16 did not have physician orders, self-administration of medication assessments, or care plans that indicated R11 and R16 could safely and accurately self-administer medication. 50467 3. From 8/12/24 to 8/14/24, Surveyor reviewed R41's medical record. R41 was admitted to the facility on [DATE] with a history of emphysema (lower respiratory tract disease), acute respiratory failure with hypoxia (lack of oxygen), muscle weakness, and myxedma coma (severe hypothyroidism resulting in a decompensated metabolic state and mental status change). R41's MDS assessment, dated 7/16/24, had a BIMS score of 15 out of 15 which indicated R41 had intact cognition. On 8/12/24 at 9:03 AM, Surveyor observed a nebulizer solution in a nebulizer cup in R41's room. R41 stated RN-K brought the nebulizer solution into R41's room and set up the nebulizer machine for R41 to self-administer the medication. R41's medical record did not contain a physician's order, self-administration of medication assessment, or care plan that indicated R41 could safely and accurately self-administer medication. On 8/12/24 at 9:51 AM, Surveyor interviewed RN-K who confirmed RN-K left the nebulizer solution in R41's room for R41 to self-administer. On 8/13/24 at 1:45 PM, Surveyor interviewed DON-B who confirmed R41 did not have a physician's order, self-administration of medication assessment, or care plan prior to 8/13/24 that indicated R41 could safely and accurately self-administer medication.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50467 Based on observation, staff and resident interview, and record review, the facility did not ensure 1 Resident (R) (R9) of 9 sampled residents had a call light within reach. R9's plan of care contained an intervention to be sure R9's call light was within reach. During an observation on 8/12/24, R9's call light was not within reach. Findings include: The facility's undated Call Lights: Accessibility and Timely Response policy indicates: .4. Staff will ensure the call light is within reach of resident and secured . From 8/12/24 to 8/14/24, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction affecting the right dominant side, type 2 diabetes mellitus, and muscle weakness. R9's Minimum Data Set (MDS) assessment, dated 6/28/24, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R9 had intact cognition. R9's fall care plan indicated R9 was at risk for falls/had potential for falls related to right-sided hemiplegia, a history of falls, gait imbalance, generalized weakness, and incontinence. The care plan contained an intervention to be sure resident's call light is within reach . Surveyor reviewed the facility's grievance file and noted a grievance for R9, dated 7/12/24. The grievance indicated R9 did not have R9's call light within reach after transfers. The grievance indicated the facility added call light placement to R9's care plan and Kardex (an abbreviated care plan used by nursing staff), posted a sign in R9's room for staff to ensure R9's call light was within reach, and provided staff education on 7/16/24. On 8/12/24 at 8:45 AM, Surveyor interviewed R9 in R9's room. R9 was in a Broda chair and R9's call light was attached to the bed rail. Surveyor observed two signs posted on the wall to remind staff to ensure R9's call light was within reach. When Surveyor asked if R9 could reach the call light, R9 confirmed the call light was not within reach. On 8/12/24 at 9:00 AM, Surveyor informed Registered Nurse (RN)-K that R9's call light was not within reach. RN-K entered R9's room and placed R9's call light within reach. On 8/13/24 at 1:45 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed call lights should be within reach for all residents.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff and resident interview and record review, the facility did not ensure the medical record contained advance directives for 1 Resident (R) (R13) of 17 sampled residents. R13 was admitted to the facility on [DATE]. R13's medical record did not contain advance directives, including a Power of Attorney for Healthcare (POAHC) document. Findings include: The facility's Resident's Rights Regarding Treatment and Advance Directive policy, dated on 8/9/24, indicates: It is the policy of this facility to support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatment and to formulate an advance directive .Advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law, relating to the provision of health care when the individual is incapacitated .1) On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive; 2) The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive; 3) Upon admission, should the resident have an advance directive, copies will be made and placed in the chart as well as communicated to staff; 4) The facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities; 5) The facility will identify or arrange for an appropriate representative for the resident to serve as primary decision maker if the resident is assessed as unable to make relevant health care decisions. From 8/12/24 to 8/14/24, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] with diagnoses including congestive heart failure and pulmonary embolism. R13's Minimum Data Set (MDS) assessment, dated on 5/17/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R13 had intact cognition. R13 did not have an activated POAHC. On 8/12/24 at 1:30 PM, Surveyor interviewed R13 who stated R13 was not sure if R13 had POAHC paperwork, but R13's spouse might have a copy. R13 stated it had been a long time since staff asked about POAHC paperwork and R13 did not remember. On 8/13/24 at 9:26 AM, Surveyor interviewed R13 who stated staff spoke with R13 regarding an advance directive and formulating a POAHC after Surveyor interviewed R13 on 8/12/24. R13 stated staff indicated they would work on R13's POAHC paperwork. On 8/13/24 at 9:31 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Social Worker (SW)-D. NHA-A stated R13 had POAHC paperwork that was recently completed after Surveyor's request to review the paperwork on 8/12/24. SW-D stated SW-D had been communicating with R13's spouse and had a hard time getting the POAHC paperwork until it was completed yesterday. Per NHA-A, R13's spouse had the POAHC paperwork, but was unable to find the paperwork. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at 9:49 AM, Surveyor called R13's spouse and left a message. A return call was not received as of this writing. On 8/13/24 at 9:52 AM, Surveyor noted POAHC paperwork in R13's medical record, The paperwork was dated 8/12/24 and scanned on 8/13/24. On 8/13/24 at 1:26 PM, Surveyor interviewed SW-D and Administrator in Training (AIT)-C. When Surveyor asked about the facility's next step if a resident's representative was not able to produce POAHC paperwork for 3 years, SW-D and AIT-C did not indicate if 3 years was a reasonable timeframe to formulate a POAHC. AIT-C stated if there was a concern regarding R13's capacity to make decisions, the facility would address the issue at that time. AIT-C stated the facility's current process is that POAHC paperwork should be completed upon admission. When Surveyor asked if facility's process had recently changed, AIT-C stated AIT-C was unsure and needed to review the facility's admission agreement. SW-D stated communication with R13's spouse regarding POAHC paperwork was documented on 2/1/22, 6/6/22, 1/24/24, and 5/6/24. Surveyor noted the following documentation in R13's medical record: ~ A Social Services note, dated 2/1/22, indicated: Spoke with R13's spouse who had questions about completing a healthcare Power of Attorney (POA) and financial POA. Educated spouse who will try to bring in two people to witness R13's signature and a friend who is a Notary. Referred spouse to resources which might be able to help with tax information and spouse's home deed. ~ A Social Services note, dated 1/24/24, indicated: Left voicemail for R13's spouse for a copy of POA paperwork. ~ A Social Services note, dated 5/6/24, indicated: R13 has an advance directive with spouse who was contacted twice and did not answer. Cannot obtain paperwork at this time. ~ A Social Services note, dated 6/6/22, did not indicate there was communication with R13's spouse regarding POA paperwork

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 47248 Based on staff and resident interview and record review, the facility did not ensure 3 Residents (R) (R12, R23, and R31) of 3 residents reviewed for hospitalization received the proper notice of transfer, reason for transfer, location of transfer, appeal rights, and contact information for the State Long-Term Care Ombudsman. R12 was transferred to the hospital on 7/23/24. R12's activated Power of Attorney for Healthcare (POAHC) did not receive a written transfer notice. R23 was transferred to the hospital on 1/11/24. R23 was not provided with a written transfer notice. R31 was transferred to the hospital on 9/12/23, 10/21/23, 3/8/24, and 4/20/24. R31's court-appointed guardian did not receive written transfer notices. Findings include: The facility's Transfer and Discharge policy, dated 10/26/22, indicates: .4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and way they can understand. The notice will include all the following at the time it is provided: .D. An explanation of the right to appeal the transfer or discharge to the State. E. The name, address (mailing and email) and telephone number of the state entity which receives such appeal hearing requests. F. Information on how to obtain an appeal form. G. Information on obtaining assistance in completing and submitting the appeal hearing request. H. The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman .12. Emergency Transfers/Discharges: .g. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated. 1. From 8/12/24 to 8/14/24, Surveyor reviewed R12's medical record and noted R12 was transferred to the hospital on 7/23/24 due to hypotension and increased lethargy. R12's medical record did not include a copy of the transfer notice given to R12 or R12's POAHC. 2. From 8/12/24 to 8/14/24, Surveyor reviewed R23's medical record and noted R23 was transferred to the hospital on 1/11/24 due to paralysis. R23's medical record did not include a copy of the transfer notice given to R23. On 8/12/24 at 9:44 AM, Surveyor interviewed R23 who verified R23 was transferred to the hospital and did not sign or receive a written transfer notice. 3. On 8/12/24 at 9:47 AM, Surveyor interviewed R31's guardian who stated R31 was transferred to the hospital several times over the last year. R31's guardian stated R31's guardian did not receive any paperwork regarding the transfers. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	From 8/12/24 to 8/14/24, Surveyor reviewed R31's medical record and noted: R31 was transferred to the hospital on 9/12/24 due to abnormal lung sounds, decreased oxygen saturation, and increased secretions; R31 was transferred to the hospital on 10/21/23 due to abnormal lung sounds; R31 was transferred to the hospital on 3/8/24 due to possible infection/sepsis; and R31 was transferred to the hospital on 4/20/24 for seizure activity. R31's medical record did not include copies of transfer notices given to R31 or R31's guardian. On 8/13/24 at 10:55 AM, Surveyor requested transfer notifications for R12, R23, and R31 from Administrator In Training (AIT)-C. On 8/14/24 at 9:15 AM, Surveyor received copies of transfer notifications for R12, R23, and R31 from Social Worker (SW)-D who confirmed SW-D was responsible for ensuring written transfer notices were provided to residents and/or their representatives. Surveyor reviewed the transfer notices and noted the following: ~ A transfer notification, dated 7/23/24, indicated a verbal transfer authorization was obtained from R12's POAHC on 7/23/24. The notice did not contain a signature from R12's POAHC. R12's medical record did not indicate R12's POAHC was provided written notice of the transfer. ~ A transfer notification, dated 1/11/24, indicated a verbal transfer authorization was obtained from R23 on 1/11/24. The transfer notification did not contain R23's signature. ~ A transfer notification, dated 9/12/24, indicated a verbal transfer authorization was obtained from R31's guardian on 9/12/24. A transfer notification, dated 10/21/23, indicated yes with no given date or time. A transfer notification, dated 3/8/24, indicated verbal transfer authorization was obtained on 3/8/24. A transfer notification, dated 4/20/24, indicated verbal authorization was obtained on 4/20/24. The transfer notices did not contain signatures from R31's guardian and R31's medical record did not indicate R31's guardian was provided written notice of the transfers. On 8/14/24 at 9:57 AM, Surveyor interviewed SW-D who stated nursing staff should obtain verbal authorization and sign the completed paperwork when the information is relayed to the resident or their representative at the time of the transfer. SW-D stated SW-D was responsible for ensuring a written copy was provided to the resident or their representative. SW-D confirmed SW-D did not ensure residents or their representatives signed the notices to confirm receipt or document in the resident's medical record that the notice was sent to the resident or their representative.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525389	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Ridge Health and Rehabilitation Center	1445 N 7th St Manitowoc, WI 54220

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 47248 Based on staff and resident interview and record review, the facility did not ensure 3 Residents (R) (R12, R23, and R31) of 3 residents reviewed for hospitalization received written information of the duration of the bed hold policy, the reserve bed payment policy, and the right to return to the facility. R12 was transferred to the hospital on 7/23/24. R12's activated Power of Attorney for Healthcare (POAHC) was not provided with a written notice of the bed hold policy. R23 was transferred to the hospital on 1/11/24. R23 was not provided with a written notice of the bed hold policy. R31 was transferred to the hospital on 9/12/23, 10/21/23, 3/8/24, and 4/20/24. R31's court-appointed guardian was not provided with written notices of the bed hold policy. Findings include: The facility's Transfer and Discharge policy. dated 10/26/22 indicates: .4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and way they can understand. The notice will include all the following at the time it is provided .12. Emergency Transfers/Discharges: .g. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated. 1. From 8/12/24 to 8/14/24, Surveyor reviewed R12's medical record. R12 was transferred to the hospital on 7/23/24 due to hypotension and increased lethargy. R12's medical record did not include a copy of the bed hold notice given to R12 or R12's POAHC. 2. From 8/12/24 to 8/14/24, Surveyor reviewed R23's medical record. R23 was transferred to the hospital on 1/11/24 due to paralysis. R23's medical record did not include a copy of the bed hold notice given to R23. On 8/12/24 at 9:44 AM, Surveyor interviewed R23 who verified R23 was transferred to the hospital and did not sign or receive a bed hold notice. 3. From 8/12/24 to 8/14/24, Surveyor reviewed R31's medical record which indicated: R31 was transferred to the hospital on 9/12/24 due to abnormal lung sounds, decreased oxygen saturation, and increased secretions; R31 was transferred to the hospital on 10/21/23 due to abnormal lung sounds; R31 was transferred to the hospital on 3/8/24 due to possible infection/sepsis; and R31 was transferred to the hospital on 4/20/24 for seizure activity. R31's medical record did not include copies of the bed hold notices given to R31 or R31's guardian. On 8/12/24 at 9:47 AM, Surveyor interviewed R31's guardian who stated R31 was transferred to the hospital several times over the past year. R31's guardian stated R31's guardian did not sign or receive any paperwork regarding the facility's bed hold policy. (continued on next page)

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	525389	A. Building B. Wing	08/14/2024

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at 10:55 AM, Surveyor requested bed hold notifications for R12, R23 and R31 from Administrator In Training (AIT)-C. On 8/14/24 at 9:15 AM, Surveyor received copies of bed hold notifications for R12, R23 and R31 from Social Worker (SW)-D who stated SW-D was responsible for ensuring bed hold notifications were provided to residents and/or their representatives. Surveyor reviewed the bed hold notices and noted the following: ~ A notification, dated 7/23/24, indicated verbal authorization was obtained from R12's POAHC on 7/23/24 and indicated yes for the bed hold. The notice was not signed by R12's POAHC. R12's medical record did not indicate R12 or R12's POAHC were provided notice of the bed hold policy. ~ A notification, dated 1/11/24, indicated verbal authorization was obtained from R23 on 1/11/24 and indicated yes to the bed hold. The notice did not contain R23's signature. ~ A notification, dated 9/12/24, indicated verbal authorization was obtained from R31's guardian on 9/12/24. A notification, dated 10/21/23, indicated yes with no date or time. A notification, dated 3/8/24, indicated verbal authorization was obtained on 3/8/24. A notification, dated 4/20/24, indicated verbal authorization was obtained on 4/20/24. The notifications indicated yes for a bed hold but were not signed by R31's guardian. R31's medical record did not indicate written notice of the bed hold policy was provided to R31 or R31's guardian. On 8/14/24 at 9:57 AM, Surveyor interviewed SW-D who stated nursing staff should obtain verbal authorization and relay verbal information regarding the bed hold policy to a resident or their representative at the time of transfer and sign the completed paperwork. SW-D confirmed SW-D was responsible for ensuring written copies were provided to residents or their representatives. SW-D confirmed R12, R23, and R31's medical records did not indicate bed hold notices were provided to R12, R23, R31 or their representatives and SW-D did not ensure R12, R23, R31 or their representatives signed the written bed hold notices to confirm receipt.

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	525389	A. Building B. Wing	08/14/2024

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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. 47248 Based on observation, staff interview, and record review, the facility did not ensure 1 Resident (R) (R31) of 5 residents reviewed for pressure injuries received the necessary care and services to promote healing and/or prevent pressure injuries from developing. R31 had multiple healed pressure and deep tissue injuries and received wound care to prevent the injuries from re-opening. During observations on 8/12/24, R31's wound care orders and care plan interventions were not implemented as ordered. Findings include: The facility's Pressure Injury Prevention Guidelines, dated 2/14/23, indicate: To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present .1. Individualized interventions will address specific factors identified in the resident's risk assessment, skin assessment, and any pressure injury assessment .8. Compliance with interventions will be documented in the medical record .Preventative Skin Care: 3. Avoid positioning the resident on an area of redness whenever possible .Repositioning techniques: a. Avoid positioning the resident on bony prominences/turning surfaces with existing pressure injuries, including stage 1 .f. Ensure heels are floated off the surface of the bed, using pillows or devices that elevate and offload the heels in such a way as to distribute the weight of the leg along the calf without placing pressure on the Achilles tendon .Pressure re-distribution devices: .3.(b) For stage 3, 4, unstageable, or deep tissue injury: Place the foot and leg into a heel suspension boot that elevates the heel from the surface of the bed, completely offloading the pressure injury. Check skin each shift and as needed for signs of redness or skin breakdown related to the boot. From 8/12/24 to 8/14/24, Surveyor reviewed R31's medical record. R31 had diagnoses including anoxic brain damage, persistent vegetative state, respirator dependent, quadriplegia, left medial ankle deep tissue injury and area of concern (closed and blanchable area), left lateral foot deep tissue injury (closed and blanchable), left lateral malleolus healed stage 4 pressure ulcer, left lateral foot deep tissue injury (closed), and right lateral foot proximal 5th metatarsal area deep tissue injury (healed). R31's Minimum Data Set (MDS) assessment, dated 6/28/24, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R31 had severe cognitive impairment. R31 had a court-appointed guardian for decision making. R31's care plan indicated R31 had the potential for pressure injuries related to persistent vegetative state, tube feeding status, fragile skin, diabetes, and history of pressure injuries to bilateral heels. R31's care plan contained interventions for a hip abductor pillow between the knees, a pillow between the lower legs, legs to be positioned with the ankles not in contact with each other, and soft heel boots. R31's physician and wound care orders included the following: ~ Left medial ankle area of concern: Cleanse with normal saline or wound wash and pat dry. Apply a bordered foam dressing. Change once per week and as needed (PRN). (continued on next page)

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	525389	A. Building B. Wing	08/14/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ Left lateral foot deep tissue injury (DTI): Cleanse with normal saline or wound wash and pat dry. Apply skin prep and cover with bordered foam. Change 3 times per week and PRN. ~ Left lateral malleolus stage 4 pressure ulcer (healed): Apply skin prep to site and cover with bordered foam. Change once per week and PRN for protection. ~ Left lateral malleolus stage 4 pressure injury (healed but fragile): Cover with bordered foam. Change weekly and PRN. Offload area and feet with boots. ~ Right lateral foot proximal 5th metatarsal head area DTI (healed, but fragile): Leave open to air. Offload heels with boots. ~ Left lateral foot DTI: Cleanse area with normal saline. Pat dry. Apply skin prep and bordered foam. Change 3 times per week and PRN. Offloading boots. ~ Left medial ankle area of concern (blanchable reddened area): Cleanse with normal saline or wound wash and pat dry. Apply skin prep and cover with bordered foam. Change 3 times per week and PRN. ~ Soft heel boots on at all times. On 8/12/24 at 8:30 AM and 10:01 AM, Surveyor observed R31 in bed with two bordered foam bandages on the left lateral foot and medial ankle and one bordered foam bandage on the right lateral foot. The bandages were dated 8/7/24. Surveyor noted R31's left foot, ankle, and heel were in direct contact with the mattress. R31's right foot, ankle, and heel touched the top of R31's left foot, ankle, and heel. R31 was on a pressure relieving mattress with no other pressure relieving devices. On 8/12/24 at 10:31 AM, Surveyor observed Certified Nursing Assistant (CNA)-J enter R31's room. Surveyor interviewed CNA-J who stated CNA-J would check R31, provide incontinence care, and reposition R31. On 8/12/24 at 10:34 AM, Surveyor observed Advance Practice Nurse Practitioner (APNP)-G and Registered Nurse (RN)-F in the hallway with a treatment cart. When Surveyor interviewed RN-F regarding wound care for R31, RN-F stated R31 had multiple current and healed areas of concern on R31's feet that RN-F and APNP-G would provide wound care for. On 8/12/24 at 10:45 AM, Surveyor observed R31 in bed with a pillow between R31's knees. R31's right foot, ankle, and heel were in direct contact with the mattress. R31's left foot, ankle, and heel touched the top of R31's right foot, ankle, and heel. R31 was on a pressure relieving mattress. R31's heels were not free-floated and R31 was not wearing heel boots. (continued on next page)

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	525389	A. Building B. Wing	08/14/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/24 at 11:16 AM, Surveyor observed APNP-G and RN-F perform wound care for R31 who was in bed with R31's right foot, ankle, and heel in direct contact with the mattress and R31's left foot, ankle, and heel in contact with R31's right foot, ankle, and heel. R31's heels were not free-floated and R31 was not wearing heel boots. APNP-G stated R31's wounds were not open but wound care orders continued because R31's skin was fragile and R31 was at risk for the wounds to reopen or for new wounds to develop. After wound care was completed, APNP-G asked RN-F if R31 had heel boots. RN-F stated R31 was supposed to have heel boots and pillows that kept R31's knees from resting on each other and floated R31's feet off the bed. RN-F stated the heel boots were possibly soiled and RN-F would obtain new boots for R31. When Surveyor asked RN-F when R31's dressings should be changed, RN-F stated the dressings on R31's left lateral foot and ankle should be changed three times weekly. When Surveyor indicated the dressings on R31's left lateral foot and ankle were dated 8/7/24, RN-F stated 8/7/24 seems to be a long time for the dressings to remained unchanged. Surveyor reviewed R31's Treatment Administration Record (TAR) which indicated the dressings on R31's left lateral foot and ankle were changed on 8/9/24 per staff initials and a check mark that indicated the treatment was completed. On 8/13/24 at 2:07 PM, Surveyor interviewed Director of Nursing (DON)-B who stated R31 had prior healed pressure injuries and current DTIs which were being treated. DON-B stated DON-B expects nurses and CNAs to position pressure relieving pillows, apply heel boots, and float R31's heels. DON-B confirmed R31 had orders for wound care to the left lateral foot and ankle and dressing changes three times weekly. DON-B stated DON-B expects staff to complete wound treatments in accordance with physician orders and date bandages when they are changed. Surveyor asked DON-B the name of the nurse who indicated on R31's TAR that R31's dressings were changed on 8/9/24. DON-B stated the nurse was RN-H. On 8/14/24 at 10:49 AM, Surveyor interviewed RN-H who confirmed RN-H worked on 8/9/24. RN-H stated RN-H completed all documentation during the shift and should have provided wound care if wound care was initialed; however, RN-H did not recall completing wound care for R31.

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	525389	A. Building B. Wing	08/14/2024

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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. 50467 Based on 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) (R38) of 1 resident reviewed for smoking. R38 was known by the facility to smoke cigarettes. The facility did not assess R38's ability to safely smoke on a quarterly basis in accordance with the facility's policy. Findings include: The facility's Smoking Safety policy, with a revision date of 5/13/24, indicates: .1. Residents who smoke tobacco products shall have a smoking assessment completed upon admission, quarterly, and as needed. During the entrance conference on 8/12/24 at 9:10 AM, Nursing Home Administrator (NHA)-A confirmed the facility had 3 residents who smoked. From 8/12/24 to 8/14/24, Surveyor reviewed R38's medical record. R38 was admitted to facility on 6/2/23 and had diagnoses including emphysema and chronic obstructive pulmonary disease (COPD). R38's Minimum Data Set (MDS) assessment, dated 7/17/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R38 had intact cognition. R38's plan of care indicated R38 smoked tobacco-cigarette products. R38 had an admission smoking assessment, dated 6/2/23, and two additional smoking assessments, dated 4/18/24 and 7/8/24. The assessment on 7/28/24 indicated R38 was an unsupervised smoker and the facility stored R38's lighter and cigarettes. The assessment also indicated R38 was educated on the facility's smoking procedure. On 8/12/24 at 11:42 AM, Surveyor interviewed R38 who confirmed R38 smoked cigarettes. On 8/13/24 at 1:45 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed staff completed smoking assessments for R38 on 6/2/23, 4/18/24, and 7/8/24. DON-B verified smoking assessments should be completed quarterly per policy and indicated R38's 9/2023, 12/2023, and 3/2024 quarterly smoking assessments had not been completed and education was not initiated to ensure smoking assessments were completed timely.

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	525389	A. Building B. Wing	08/14/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not ensure vital signs and weights were consistently completed pre- and post-dialysis and communicated to the dialysis facility for 1 Resident (R) (R30) of 1 resident reviewed for dialysis. Staff did not consistently complete R30's dialysis communication sheets and did not consistently obtain R30's pre- and post-dialysis vital signs and weights. Findings include: The facility's Hemodialysis policy, dated 2/15/23, indicates: This facility will provide the necessary care and treatment consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis .The facility will assure that each resident receives care and services for the provision of hemodialysis and peritoneal dialysis consistent with professional standards of practice. This will include: The ongoing evaluation of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility; .2) The facility will coordinate and collaborate with the dialysis facility to assure that .c) Documentation requirements are met to assure treatments are provided as ordered by the nephrologist, attending practitioner, and dialysis team .4) The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form or other form, that will include, but not limit itself to: .b) Physician/treatment orders, laboratory values, and vital signs .d) Nutritional/fluid management including documentation of weights . From 8/12/24 to 8/14/24, Surveyor reviewed R30's medical record. R30 was admitted to the facility on [DATE] with diagnosis including end stage renal disease, congestive heart failure (CHF), and dependence on renal dialysis. R30's Minimum Data Set (MDS) assessment, dated 6/19/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R30 had intact cognition. R30 had an activated Power of Attorney (POA) as of 5/10/22. R30's medical record contained the following physician orders: ~ Dialysis 3 times per week every day shift on Mondays, Wednesdays and Fridays. ~ Weights on Mondays, Wednesdays, and Fridays before dialysis one time a day. ~ Vital signs prior to sending to dialysis every day shift on Mondays, Wednesdays, and Fridays. ~ Vital signs upon returning from dialysis every evening shift on Mondays, Wednesdays, and Fridays. (continued on next page)

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	525389	A. Building B. Wing	08/14/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R30's dialysis communication binder and noted missing documentation on R30's communication form for pre-dialysis weight on the following dates: 7/8/24, 7/10/24, 7/15/24, 7/19/24, 7/24/24, 8/9/24, and 8/12/24. Surveyor noted missing documentation on R30's communication form for post-dialysis weight on the following dates: 7/8/24, 7/10/24, 7/15/24, 7/19/24, 7/24/24, 7/26/24, 7/29/24, 8/2/24, 8/9/24, and 8/12/24. Surveyor noted missing documentation on R30's communication for pre-dialysis vital signs on the following dates: 7/19/24 (missing pain), 7/26/24 (missing pain), 8/2/24 (missing temperature), and 8/12/24 (missing pain). Surveyor reviewed R30's hemodialysis communication forms and noted the communication forms were not consistently completed on 7/12/24, 7/17/24, 7/22/24, 7/31/24, 8/5/24, 8/7/24, and 8/9/24. On 8/13/24 at 11:59 AM, Surveyor interviewed Director of Nursing (DON)-B who stated staff should obtain and document a resident's weight and vital signs prior to and after dialysis. DON-B stated DON-B expects nurses to complete assessments per physician orders. DON-B verified weights and vital signs were missing on dialysis communication forms in R30's medical record and dialysis communication binder. On 8/13/24 at 12:10 PM, Surveyor interviewed Registered Nurse (RN)-N who stated pre- and post-dialysis vital signs and weights should be obtained. RN-N stated two sets of vital signs and weights should be documented on dialysis dates and verified R30's vital signs and weights were missing on multiple dates.

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	525389	A. Building B. Wing	08/14/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793 Based on staff interview and record review, the facility did not ensure monthly medication reviews were completed or followed-up on for 2 Residents (R) (R36 and R39) of 5 residents reviewed for unnecessary medication. R36 had a pharmacist recommendation from R36's October 2023 monthly medication review (MMR). The recommendation was not addressed until 2/5/24. In addition, R36 did not have an MMR documented for March of 2024. R39 had a pharmacist recommendation from R39's November 2023 MMR. The recommendation was not addressed at the time of the annual survey. Findings include: The facility's Medication Regimen Review and Reporting policy, dated 2007, indicates: The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure the medications each resident receives are clinically indicated .Medication Regimen Review recommendations and findings are documented and acted upon by the nursing center within 30 calendar days. 1. On 8/13/24, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE] with diagnoses including anoxic brain injury, persistent vegetative state, anxiety, diabetes, and pressure injuries. R36's most recent Minimum Data Set (MDS) assessment, dated 5/14/24, had a Brief Interview for Mental Status (BIMS) score of 00 out of 15 which indicated R36's cognition was severely impaired. Surveyor reviewed R36's MMRs from October of 2023 through July of 2024. R36's October 2023 MMR included a pharmacy recommendation that R36's as needed (PRN) lorazepam (an antianxiety medication) should be discontinued or a new order created because PRN psychotropic medication orders cannot exceed 14 days unless a rationale and duration is documented by the prescriber. R36's PRN lorazepam was not discontinued until 2/5/24 (122 days after the recommendation). R36 was administered PRN lorazepam 3 times in November of 2023, once in December of 2023, and once in January of 2024. Surveyor also noted R36 did not have an MMR completed in March of 2024. On 8/14/24 at 11:23 AM, Surveyor interviewed Director of Nursing (DON)-B who was unsure why R36's pharmacy recommendation from October of 2023 was not addressed sooner and stated it was before DON-B started as the DON. DON-B agreed pharmacy recommendations should be followed-up on in a timely manner. DON-B stated R36's recommendation from March of 2024 was not completed because R36 was hospitalized from 3/7/24 to 3/12/24 (per pharmacy documentation). DON-B verified R36 was expected to return to the facility and was present in the facility for the rest of March. (continued on next page)

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	525389	A. Building B. Wing	08/14/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 8/13/24, Surveyor reviewed R39's medical record. R39 was admitted to the facility on [DATE] with diagnoses including anoxic brain injury, persistent vegetative state, chronic respiratory failure, and hypertension. R39's MDS assessment, dated 7/12/24, had a BIMS score of 00 out of 15 which indicated R39's cognition was severely impaired. Surveyor reviewed R39's MMRs from November of 2023 through July of 2024. R39's November of 2023 MMR included a pharmacy recommendation to conduct a self-administration assessment for R39's nebulizer treatment to ensure R39's ability to administer the medication appropriately. R39's medical record did not indicate R39's ability to self-administer the nebulizer was assessed. On 8/14/24 at 11:23 AM, Surveyor interviewed DON-B who verified R39 did not have a self-administration of medication assessment completed for the nebulizer treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525389	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Ridge Health and Rehabilitation Center	1445 N 7th St Manitowoc, WI 54220

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49563 Based on observation, staff interview, and record review, the facility did not ensure all drugs and biologicals were stored in accordance with the facility's policy. Three of 4 medication carts were observed unlocked and unattended. In addition, 2 of 2 medication carts and 1 of 2 mediation storage rooms contained expired medication and medical supplies. This practice had the potential to affect multiple residents in the facility. Medication carts on the 500, 600, and 300 wings were unlocked and unattended on 8/12/24 and 8/13/24. Medication carts and the medication storage room on the 200 and 300 wings contained expired medications and medical supplies. Findings include: The facility's Medication Storage policy, dated 1/2024, indicates: Medications and biologicals are stored properly, following manufacturers' or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication .4. Medication rooms, cabinets, and medication supplies should remain locked when not in use or attended to by persons with authorized access .14. Outdated, contaminated, and discontinued medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock . Medication Cart: On 8/12/24 at 8:58 AM, Surveyor observed a medication cart unattended and unlocked on the 500 wing with a computer screen on top of the medication cart that was open to residents' health information. The medication cart faced toward the hallway and exposed the drawers and computer screen while Registered Nurse (RN)-K was in R38's room. On 8/12/24 at 10:05 AM, Surveyor noted the 600 wing medication cart was unlocked in the hallway. On 8/12/24 at 10:07 AM, a Certified Nursing Assistant (CNA) located RN-L in the nursing station. RN-L confirmed the medication cart should be locked when unattended. RN-L locked the cart after the discussion. On 8/12/24 at 12:54 PM, Surveyor noted the 300 wing medication cart was unlocked and unattended. RN-N then exited a resident's room and prepared medication for another resident. At 1:03 PM, RN-N again left the medication cart unlocked and unattended during the administration of medication. Immediately following the observation, Surveyor interviewed RN-N who stated RN-N must have forgotten to lock the cart and verified medication carts should be locked when unattended. (continued on next page)

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	525389	A. Building B. Wing	08/14/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/13/24 at 7:45 AM, Surveyor noted the 500 wing medication cart was unlocked in the hallway. On 8/13/24 at 7:45 AM, Surveyor interviewed RN-K who confirmed the medication cart should be locked. On 8/13/24 at 1:45 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed medication carts and computer screens should be locked when not attended. Expired Medications and Supplies: On 8/12/24 at 2:20 PM, Surveyor observed 2 of 4 medication carts and 1 of 2 medication storage rooms and noted the following: 200 Wing Medication Cart: ~ Two boxes of Smartemp probe covers with an expiration date of 5/4/21 ~ Five 25 g (gram) syringes with expiration dates of 1/5/23 ~ A bottle of stye medication that was opened on 6/30/24 and expired on 7/30/24 ~ Three bottles of Artificial Tears with expiration dates of 7/30/24 ~ A bottle of aspirin with an expiration date of 7/2024 ~ A bottle of Geri-Mox with an expiration date of 7/2024 300 Wing Medication Cart: ~ A bottle of vitamin B6 100 mg (milligrams) with an expiration date of 7/2024 ~ An unlabeled tube of Diclofenac gel with an open date of 7/30/24 ~ An unlabeled tube of PeriGuard ointment with an open date of 7/12/24 ~ An open, unlabeled, and undated tube of lubricating jelly ~ An open, unlabeled, and undated tube of Triple Antibiotic ointment 200/300 Wing Medication Storage Room: ~ A box of self-adhesive dressing retention sheets with expiration dates of 1/2023 ~ A bottle of Geri-Mox with an expiration date of 7/2024 ~ One and a half boxes of 25 g syringes with expiration dates of 1/5/23 ~ Undated pudding for medication pass in the refrigerator (continued on next page)

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	525389	A. Building B. Wing	08/14/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ A tube of stye eye ointment with an expiration date of 6/2023 ~ A bottle of zinc sulfate 220 mg (milligrams) with an expiration date of 3/2024 ~ Five bottles of meclizine 12.5 mg with expiration dates of 7/2024 ~ Two bottles of flaxseed oil 1000 mg with expiration dates of 7/2024 On 8/12/24 at 2:38 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-U and LPN-V who verified the above findings. LPN-V stated night shift nurses should monitor the medication carts and storage rooms for expired medications and supplies. On 8/13/24 at 12:24 PM, Surveyor interviewed DON-B who verified the medication carts and storage rooms contained expired medication and supplies. DON-B stated expiration dates should be reviewed when staff load medication carts and night shift nurses should monitor the medication carts and storage rooms for expired medication and supplies.

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	525389	A. Building B. Wing	08/14/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect 33 of 47 residents residing in the facility. (Fourteen residents received nutrition exclusively via tube feeding.) Kitchen equipment and food service areas were not kept in a clean and sanitary condition to prevent cross contamination. Staff did not perform appropriate hand hygiene and safe food handling practices when cooking and serving food. Staff did not document food holding temperatures. The resident refrigerator and reach-in cooler contained food and beverages that were past the discard date or not labeled with a discard date. Findings include: On [DATE] at 8:55 AM, Surveyor began an initial tour of the kitchen with the Dietary Manager (DM)-E who stated the facility followed the State and Federal Food Codes. Cleanliness: The 2022 Food and Drug Administration (FDA) Food Code documents at ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. The 2022 FDA Food Code documents at ,d+[DATE].13 Nonfood-Contact Surfaces: Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residue. The 2022 FDA Food Code documents at ,d+[DATE].12 Cooking and Baking Equipment: (B) The cavities and door seals of microwave ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning procedure. During an initial kitchen tour that began on [DATE] at 8:55 AM, Surveyor observed the following: ~ Dust, dried food debris, and unidentified substances on the top, bottom, sides, and drawer frames of two plastic storage bins of serving and cooking utensils ~ A broken top on a bin of serving and cooking utensils that exposed the items to air ~ Food debris and spilled liquids on food preparation services, including the tray line conveyor, cooktop, and kitchen floor (continued on next page)

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	525389	A. Building B. Wing	08/14/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ An open Ziploc bag of sausage links on top of visibly soiled scissors and tinfoil ~ Dried yellow food debris on the interior top and sides of the microwave During a follow-up visit to the kitchen on [DATE] at 11:25 AM, Surveyor observed the following: ~ Two visibly soiled oven mitts on the eye wash station next to the handwashing sink ~ Two visibly soiled oven mitts on a shelf with containers of food for resident consumption ~ Three clipboards and a three-ring binder against/on shelves with clean kitchenware ~ Two clipboards and a box of gloves on top of clean water mugs On [DATE] at 1:22 PM, Surveyor interviewed DM-E who stated cleaning tasks were assigned on the daily schedule; however, staff did not complete a cleaning log or sign off when cleaning tasks were completed. DM-E stated DM-E completed a daily checklist that included verifying the completion of cleaning tasks. Hand Hygiene: The 2022 FDA Food Code documents at ,d+[DATE].15 Gloves, Use Limitation: (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. The 2022 FDA Food Code documents at ,d+[DATE].14 When to Wash: Food employees shall clean their hands and exposed portions of their arms as specified under S ,d+[DATE].12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single use articles and: .(E) After handling soiled clean equipment and utensils. On [DATE] at 11:25 AM, Surveyor observed [NAME] (CK)-P prepare lunch in the kitchen and noted the following: ~ On six instances, CK-P touched the conveyor shelf with gloved hands. ~ On ten instances, CK-P touched and served biscuits with gloved hands. ~ On two instances, CK-P touched potatoes with gloved hands. ~ On one instance, CK-P touched steamed vegetables with a gloved hand. During the 42 minute observation, CK-P completed the above tasks with the same pair of gloves and did not change gloves or complete hand hygiene. (continued on next page)

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	525389	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:27 PM, Surveyor interviewed CK-P who stated staff are expected to change gloves and complete hand hygiene whenever they leave the trayline. CK-P stated kitchen staff receive hand hygiene education with nursing staff, but CK-P was uncertain how often the education occurred. On [DATE] at 10:18 AM, Surveyor interviewed DM-E who stated staff are expected to complete hand hygiene if they leave the trayline, touch a contaminated surface (such as opening the oven door), or if a resident has a known allergy. DM-E acknowledged concerns with CK-P's hand hygiene during meal service. Holding Temperatures: The 2022 FDA Food Code documents at ,d+[DATE].16 Time/Temperature Control for Safety Food, for Hot and Cold Holding indicates: Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature Danger Zone of 41 degrees Fahrenheit (F) to 135 degrees F too long. Up to a point, the rate of growth increases with an increase in temperature within this zone. Beyond the upper limit of the optimal temperature range for a particular organism, the rate of growth decreases. Operations requiring heating or cooling of food should be performed as rapidly as possible to avoid the possibility of bacterial growth: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control .(1) At 135 degrees F or above or (2) At 41 degrees F or less. On [DATE] at 10:18 AM, Surveyor interviewed DM-E who stated staff complete one set of temperatures which is done when the food in still in the oven or while cooking to ensure internal temperatures are met. DM-E stated the food is then placed in the steam table and served. DM-E stated staff do not complete holding temps unless an audit is being completed. Open and Undated/Expired Food Items: The 2022 FDA Food Code documents at ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking: .(B) Except as specified in (E)-(G) of this section, refrigerated, Ready-to-Eat Time/Temperature Control for Safety Food Prepared and Packaged by a Food Processing Plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. During an initial kitchen tour that began on [DATE] at 8:55 AM, Surveyor and DM-E observed the following items in the reach-in cooler that were not labeled or discarded by the discard date: ~ A pitcher of mixed pink lemonade with an open date of [DATE] and a discard date of [DATE] ~ A pitcher of mixed pink lemonade with an open date of [DATE] and a discard date of [DATE] ~ Pre-thickened cranberry juice with an open date of [DATE] that did not have a discard date (continued on next page)

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	525389	A. Building B. Wing	08/14/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an initial kitchen tour that began on [DATE] at 8:55 AM, Surveyor and DM-E observed a resident refrigerator that contained the following item that did not have a discard date: ~ A box of one piece of pizza with a date of [DATE] and no discard date

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	525389	A. Building B. Wing	08/14/2024

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47248 Based on staff interview and record review, the facility did not ensure the accurate submission of mandatory staffing information based on payroll data in a uniformed electronic format to the Centers for Medicare & Medicaid Services (CMS). This had the potential to affect all 47 residents residing in the facility. Staffing data for fiscal quarter 1 (date range: 10/1/23-12/31/23) and quarter 2 (date range: 1/1/24-3/31/24) of the Payroll Based Journal (PBJ) were not submitted accurately to CMS. Findings include: The Centers for Medicare & Medicaid Services (CMS) Electronic Staffing Data Submission Payroll-Based Journal, Long-Term Care Facility Policy Manual, dated June 2022, indicates: Chapter 1: .(U) mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS 1.2 Submission Timelines and Accuracy. Direct care staffing and census data will be collected quarterly and is required to be timely and accurately .Report Quarter: staffing and census data will be collected for each fiscal quarter. Staffing data includes the number of hours paid to work by each staff member each day within a quarter. Census data includes the facility's census on the last day of each of the three months in a quarter. The fiscal quarters are as follows: Fiscal quarter, date range: (quarter 1) October 1-December 31, (quarter 2) January 1-March 31, (quarter 3) April 1-June 30, (quarter 4) July 1-September 30. On 8/12/24, Surveyor reviewed the PBJ Staffing Data Report/CASPER Report 1705 D for fiscal year 2024 which indicated quarter 1 of 2024 (October 1-December 31) and quarter 2 of 2024 (January 1-March 31) triggered for excessively low weekend staff. During the entrance conference with Nursing Home Administrator (NHA)-A on 8/12/24, Surveyor requested weekend staff postings and schedules for quarter 2. On 8/12/24 at 11:15 AM, Surveyor received and reviewed the staff postings and schedules and noted staff ratios were appropriate per the Facility Assessment and did not indicate low staffing during weekends. On 8/12/24 at 1:30 PM, Surveyor interviewed NHA-A who stated Corporate Business Office Manager (CBOM)-I submitted all staffing data for the facility. NHA-A stated it was possible the data was not submitted correctly because staff ratios were not low on weekends. Surveyor requested the phone number of CBOM-I who did not work in the facility. On 8/12/24 at 3:09 PM and on 8/13/24 at 12:35 PM, Surveyor called CBOM-I and left voicemail messages requesting a return call. (continued on next page)

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	525389	A. Building B. Wing	08/14/2024

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	On 8/13/24 at 3:30 PM, Surveyor interviewed NHA-A and Administrator In Training (AIT)-C and indicated Surveyor did not receive a return call from CBOM-I regarding the PBJ data. NHA-A and AIT-C stated they would ensure Surveyor received a return call. On 8/14/24 at 11:11 AM, AIT-C approached Surveyor and stated AIT-C worked with CBOM-I via email regarding the staffing data that was submitted. AIT-C stated CBOM-I found that salary employees such as Director of Nursing (DON)-B who worked on weekends did not pull through automatically. AIT-C stated CBOM-I was working on how to fix the issue which occurred with the introduction of a new payroll system in October of 2023. When Surveyor asked AIT-C when the issue was noticed by the facility, AIT-C stated the issue was not noticed by the facility in October of 2023 possibly because no salaried employees worked weekends during that quarter. On 8/14/24 at 11:59 AM, Surveyor obtained and reviewed PBJ data for quarter 1 of 2024 and noted excessively low weekend staffing was indicated on the PBJ report. On 8/14/24 at 12:11 PM, Surveyor interviewed NHA-A and AIT-C and showed NH-A and AIT-C a copy of the quarter 1 PBJ report that indicated excessively low weekend staffing. NHA-A and AIT-C reviewed the PBJ report and confirmed the facility had not begun working on a plan to fix the systems issue for accurately reporting to CMS prior to Surveyor's inquiry. NHA-A and AIT-C confirmed the data was inaccurately transmitted to CMS for quarters 1 and 2 of 2024.

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	525389	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793 Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to help prevent the development and transmission of disease and infection as observed during the provision of care for 7 Residents (R) (R36, R2, R9, R17, R11, R16, and R4) of 10 residents. On 8/12/24, staff did not complete appropriate hand hygiene during wound care for R36. On 8/12/24 and 8/13/24, staff did not wear masks or complete hand hygiene appropriately during the provision of care for R2. On 8/13/24, staff did not wear appropriate personal protective equipment (PPE) during a therapy session with R9 who was on enhanced barrier precautions (EBP). On 8/13/24, staff did not complete appropriate hand hygiene or wear required PPE during a transfer for R17 who was on EBP. On 8/12/24, staff did not complete proper hand hygiene while administering medication to R11, R16, and R4. Findings include: The facility's Hand Hygiene policy, dated October 2022, indicates: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility .2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to the attached hand hygiene table. The hand hygiene table attached to the policy indicated before applying or after removing personal protective equipment, including gloves, staff should either use soap and water or an alcohol-based hand rub. Hand hygiene should be completed before and after handling soiled dressings, after handling items potentially contaminated with bodily fluids, and when moving from a contaminated body site to a clean body site. The facility's Enhanced Barrier Precautions policy, with a copyright of 2024, indicates: .Implementation of Enhanced Barrier Precautions (EBP): .b. Personal protective equipment (PPE) for EBP is only necessary when performing high contact care activities . The facility's COVID-19 Prevention, Response and Reporting policy indicates: .10. Broader use of masking should be determined by the facility as to how and when to implement . 1. From 8/12/24 to 8/14/24, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE] with diagnoses including anoxic brain injury, persistent vegetative state, anxiety, diabetes, and pressure injuries. R36's Minimum Data Set (MDS) assessment, dated 5/14/24, had a Brief Interview for Mental Status (BIMS) score of 00 out of 15 which indicated R36 had severely impaired cognition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525389	A. Building B. Wing	08/14/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/12/24 at 9:33 AM, Surveyor observed Advance Practice Nurse Prescriber (APNP)-G provide wound care for R36's stage 3 coccyx (area at the base of the spine just above the buttocks) pressure injury. APNP-G removed R36's soiled dressing and noted there was a moderate amount of drainage. APNP-G cleansed the wound and surrounding area with gauze and wound wash and noted there was stool present. APNP-G stated the wound measured 0.6 cm (centimeters) x 0.5 cm x 1.8 cm. Surveyor observed APNP-G insert a gloved finger in R36's wound bed to check for tunneling which was 2 cm at the 3-4 o'clock position. APNP-G then packed R36's wound with saline-soaked gauze and covered the wound with a foam border dressing. Without removing gloves and cleansing hands, APNP-G touched R36's pressure-relieving boots, blankets, lift sheet, and feet to conduct a heel check. On 8/12/24 at 11:12 AM, Surveyor interviewed APNP-G who stated if a wound is open or if a resident is incontinent during wound care, APNP-G changes gloves when going from dirty to clean by removing APNP's soiled gloves, completing hand hygiene, and applying new gloves. On 8/13/24 at 9:25 AM, Surveyor interviewed Director of Nursing (DON)-B who verified APNP-G should have removed soiled gloves and completed hand hygiene prior to measuring R36's wound and applying a clean dressing. DON-B also verified APNP-G should have completed hand hygiene and applied clean gloves prior to touching R36's wound bed. 50467 2. On 8/12/24 from 8:39 AM to 8:42 AM, Surveyor noted staff either did not wear masks or did not wear masks appropriately on the 500 and 600 wings. Surveyor noted Certified Nursing Assistant (CNA)-M's mask was below CNA-M's chin while CNA-M assisted R2 with breakfast in R2's room. On 8/12/24 at 9:00 AM, Surveyor observed CNA-M assist R2 with breakfast and noted CNA-M's mask was still below CNA-M's chin. Surveyor confirmed with Registered Nurse (RN)-K that a mask should be worn at all times. RN-K then informed CNA-M that a mask should be worn at all times. During the entrance conference on 8/12/24 at 9:11 AM, Nursing Home Administrator (NHA)-A confirmed masks on the 500 and 600 wings were initiated by DON-B due to a COVID-19 positive resident. On 8/12/24 at 10:05 AM, Surveyor noted CNA-M's mask covered CNA-M's mouth but left CNA-M's nose exposed. On 8/12/24 from 11:47 AM to 11:50 AM, Surveyor observed RN-L in the 600 wing hallway by the medication cart and near residents without a mask. Surveyor also observed CNA-M push a resident in the 500 wing hallway without a mask. On 8/13/24 at 8:32 AM, Surveyor observed CNA-M on the 600 wing and noted CNA-M's mask was below CNA-M's chin while CNA-M was in the hallway with residents present. On 8/13/24 at 10:47 AM, Surveyor noted RN-N and CNA-M's masks were below their chins in the 500 and 600 hallways with residents present. On 8/14/24 at 1:45 PM, Surveyor interviewed DON-B who confirmed surgical masks should be worn at all times on the 500 and 600 wings due to a COVID-19 positive resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525389	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Ridge Health and Rehabilitation Center	1445 N 7th St Manitowoc, WI 54220

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 8/13/24 at 1:23 PM, Surveyor observed RN-K apply cream to a R2's buttock, remove gloves, don clean gloves, and apply powder. RN-K did not complete hand hygiene after RN-K removed soiled gloves and donned clean gloves. On 8/13/24 at 1:45 PM, Surveyor interviewed DON-B who confirmed RN-K should have completed hand hygiene after RN-K removed soiled gloves and before RN-K donned clean gloves. 4. On 8/14/24 at 7:47 AM, Surveyor observed Physical Therapist (PT)-T provide therapy for R9 who was on EBP for carbapenem-resistant Acinetobacter baumannii (CRAB). Surveyor noted an EBP sign on R9's door. PT-T had direct contact with R9 during the therapy session and wore gloves, but did not wear a gown. On 8/14/23 at 9:40 AM, Surveyor interviewed DON-B who confirmed R9 was on EBP and verified PT-T should have worn a gown during the therapy session. On 8/14/24 at 9:51 AM, Surveyor interviewed PT-T who confirmed PT-T did not wear a gown during therapy with R9. 45942 5. From 8/12/24 to 8/14/24, Surveyor reviewed R17's medical record. R17 was admitted to the facility on [DATE] with diagnoses including quadriplegia, diabetes mellitus type 2, pressure ulcer of sacral region stage 4, and extended-spectrum beta lactamase (ESBL) resistance. R17 had an indwelling urinary catheter. R17's MDS assessment, dated 5/10/24, had a BIMS score of 14 out of 15 which indicated R17 had intact cognition. On 8/13/24 at 1:52 PM, Surveyor observed a sign outside R17's room that stated EBP was needed during cares and transfers. Surveyor observed RN-N and CNA-O transfer R17 via Hoyer lift from wheelchair to bed and reposition R17. RN-N and CNA-O wore gloves and a mask during the transfer; however, RN-N and CNA-O did not wear a gown as indicated on the EBP sign. On 8/13/24 at 1:59 PM, Surveyor observed RN-N exit R17's room with the Hoyer lift without removing gloves and cleansing hands. RN-N then re-entered R17's room, removed gloves, and completed hand hygiene. On 8/13/24 at 3:00 PM, Surveyor interviewed RN-N who verified RN-N and CNA-O should have worn gowns during the transfer and RN-N should have removed gloves and completed hand hygiene prior to leaving R17's room with the lift. On 8/13/24 at 3:03 PM, Surveyor interviewed DON-B who stated full PPE should be worn during transfers as indicated on R17's EBP sign. 49563 6. On 8/12/24 at 9:20 AM, Surveyor observed Licensed Practical Nurse (LPN)-U prepare medication for R11. After medication preparation, LPN-U donned gloves without completing hand hygiene. LPN-U administered R11's medication and then prepared to suction R11. LPN-U removed gloves, donned a gown, and donned gloves a second time without completing hand hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525389	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Ridge Health and Rehabilitation Center	1445 N 7th St Manitowoc, WI 54220

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. On 8/12/24 at 9:35 AM, Surveyor observed LPN-U prepare medication for R16. LPN-U did not complete hand hygiene prior to medication preparation. 8. On 8/12/24 at 9:50 AM, Surveyor observed LPN-U prepare medication for R4. LPN-U did not complete hand hygiene prior to donning gloves. On 8/12/24 at 9:59 AM, Surveyor interviewed LPN-U who stated hand hygiene should be completed before medication is prepared and after medication is administered. LPN-U verified LPN-U did not complete hand hygiene after medication preparation and prior to donning gloves. On 8/13/24 at 12:24 PM, Surveyor interviewed DON-B who verified LPN-U did not complete appropriate hand hygiene during medication administration. DON-B stated staff should perform hand hygiene prior to medication preparation, after medication preparation, and after medication administration.