STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525391	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wisconsin Dells Health Services	300 Race St Wisconsin Dells, WI 53965

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on observation, interview, and record review, the facility did not ensure that the residents environment remained free of accidents and hazards for 1 of 3 (R25) reviewed for falls and 1 of 1 (R7) reviewed for accidents and hazards. R25 did not have fall interventions in place after 2 falls. Surveyor observed R7's motorized wheelchair charging in the hallway and not behind a fire safe door. This is evidenced by: The facility's policy titled Fall Prevention and Management Guidelines, revised 7/18/24, states in part: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls or reduce the possibility/severity of injury. Provide interventions that address unique risk factors measured by the risk assessment tool. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. Interventions will be monitored for effectiveness. The plan of care will be revised as needed and should be communicated to the staff, resident and resident's family/responsible party. When any resident experiences a fall, the facility will: .review the resident's care plan and update with any new interventions put in place to try to prevent additional falls. Review ach fall/fall investigation during the next morning meeting/clinical meeting with the interdisciplinary Team (IDT). Actions of the IDT may include: .Review of fall risk care plan and any updates to plan of care completed post-fall. Education of staff as to any care plan revisions. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Comprehensive Care Plan, revised 9/23/22, states in part: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Resident specific interventions that reflect the resident's needs and preferences . Staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the intervention, initially and when changes are made. Example 1 R7 admitted to the facility on [DATE]. He relies on a motorized wheelchair for mobility. On 3/9/25 at 10:51 AM Surveyor viewed R7's motorized wheelchair charging outside of his doorway, in the hallway. On 3/9/25 at 11:10 AM CNA I (Certified Nursing Assistant) indicated she was told by a member of the facility's corporation that she should charge the wheelchair there. CNA I indicated she has not received education on storing motorized wheelchairs. On 3/9/25 LPN F (Licensed Practical Nurse) indicated she was unaware that motorized wheelchairs should be charged behind a fire safe door. LPN F indicated she did not receive education regarding where to store motorized wheelchairs. On 3/9/25 at 11:15 AM DON B (Director of Nursing) indicated she was unsure if motorized wheelchairs are ok to charge in the hallway. On 3/9/25 at 12:00 PM NHA A (Nursing Home Administrator) indicated motorized wheelchairs need to charge behind a fire safe door. 49436 Example 2 R25 admitted to the facility on [DATE] with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning) and unsteadiness on feet. R25's Brief Interview for Mental Status (BIMS) on 12/26/24 has a score of 5, indicating R25 has severe cognitive impairment. R25's Minimum Data Set (MDS) comprehensive admission assessment indicates R25 is at risk for falls and falls would be added to R25's care plan. R25's Mobility/Fall Risk assessment dated [DATE] indicates R25 is at risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25 had a fall on 10/8/24. R25's fall reports for 10/8/24 states: Intervention: PT (Physical Therapy) to assess walker and brakes, provide education on brakes and assess for other risks. R25's IDT (Interdisciplinary Team) Clinical Review note states in part: Root cause analysis: .Brake was reported to not be locked on walker. R25's Post Event Observation dated 10/9/24 states in part: Reminders to lock both breaks on walker when in use. R25 had a fall on 2/12/25. R25's fall report states in part: IDT (Interdisciplinary Team) team met to discuss resident. Resident is forgetful but is independent in her room . resident to keep walker by her bed to remind her more to use the walker with ambulating or transferring. R25's Nurses note on 2/12/25 at 9:25 PM states in part: Staff to remind resident to use walker all the time. R25's Post Fall assessment dated [DATE] states in part: New interventions: Staff to remind resident to use her walker all the time. R25's CNA's (Certified Nursing Assistant) Kardex, printed 3/7/25, includes the following: Safety: Ensure that the Resident is wearing appropriate footwear: Gripper socks or shoes on at all times when up OOB (Out of Bed). Place call light or communication device within reach. R25's Comprehensive Care Plan, printed 3/11/25, includes the following: Focus: Resident is at risk for falls r/t (Related to) cognition - unaware of safety needs. Deconditioning/weakness, medication use. Date initiated: 7/5/22 Goal: Fall related injuries will be minimized through care plan review date. Interventions/Tasks: Reminders to lock brakes on walker, initiated 3/11/25. Resident to keep walker by her bed to remind her more to use the walker with ambulating and transferring, initiated 3/11/25. Signs in room for reminder to use walker, initiated 3/11/25. Of note, the 3/11/25 interventions were added to the care plan after Surveyor made DON B (Director of Nursing) aware that R25's fall care plan had not been updated since 2022. On 3/11/25 at 8:50 AM, Surveyor interviewed CNA N (Certified Nursing Assistant) regarding interventions for falls. CNA N indicated any interventions for falls would be on the Kardex. CNA N reviewed R25's Kardex with Surveyor. CNA N indicated the only interventions for R25 was to ensure R25 is wearing proper footwear and the call light is in reach. Surveyor asked CNA N if there were any other interventions for R25 and CNA N indicated there were not. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 8:55 AM, Surveyor interviewed RN C (Registered Nurse) regarding interventions for falls. RN C indicated he would review the resident's physician orders for fall interventions. RN C also indicated there is a sign on the outside of the room for residents at risk for falls. RN C indicated R25 has an alarm mat on the floor when she is in bed and her bed is in the low position. On 3/11/25 at 9:00 AM, Surveyor observed R25's room. R25 did not have an alarm mat in her room. On 3/11/25 at 9:45 AM, Surveyor interviewed DON B (Director of Nursing) regarding fall interventions. DON B indicated if a resident falls and new interventions are put in place, the resident's care plan would be updated with the new interventions and the interventions would be communicated to staff. DON B indicated the Kardex would also be updated with the new interventions. DON B indicated the facility does not place signs outside of the resident's room indicating they are a fall risk. DON B indicated the facility does not put fall interventions in the physician orders. DON B indicated the primary place to look for fall interventions would be the resident's care plan. DON B indicated R25's care plan should have been updated with the new interventions and was not.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 49436 Based on observation, interview, and record review, the facility did not ensure residents who are fed and receive medication by G-tube (Gastrostomy tube, a thin flexible tube inserted through a small incision in the abdomen and into the stomach, used to provide nutrition and fluids) receive the appropriate treatment and services. This affects 1 of 2 residents (R22) reviewed for tube feedings. The facility did not properly check placement of R22's G-tube prior to administering tube feeding. This is evidenced by: The facility's policy titled Verifying Placement of Tube Feeding, revised 8/10/22, states in part: It is the practice of this facility to ensure proper placement of feeding tubes prior to beginning a feeding, flushing the tube, or before administering medications via feeding tube. Before beginning a feeding, flushing the tube, or administering a medication via the feeding tube, proper placement and functioning will be verified. Verify tube placement: For gastrostomy tubes, check that the enteral retention device is properly approximated to the abdominal wall by gently tugging on the tube and taking note of the marking on the tube. Measure length of tube from insertion site to tip upon new admission to facility or with a new/change in the tube and record the length. Check and record the length of the tube prior to feeing as per facility policy. On 3/10/25 at 8:53 AM, Surveyor observed RN C (Registered Nurse) administer R22's tube feeding. RN C stated I had checked placement this morning, We check with air. RN C indicated he was not going to check with air at this time because R22 does not like air being pushed into his stomach. RN C proceeded to use his stethoscope to listen to R22's abdomen while flushing the G-tube with 60 ml of water. Of note, RN C did not verify placement prior to using R22's G-tube. On 3/11/25 at 8:13 AM, Surveyor interviewed RN E regarding verifying G-tube placement. RN E indicated she instills air and listens for bubbles to ensure the G-tube is correctly placed. On 3/11/15 at 8:15 AM, Surveyor interviewed LPN D (Licensed Practical Nurse) regarding verifying G-tube placement. LPN D indicated she uses a little air and listens for the bubbles and will also check residual by aspirating any stomach contents. On 3/11/25 at 8:48 AM, Surveyor interviewed DON B (Director of Nursing) regarding verifying G-tube placement. DON B indicated staff can verify placement by instilling air, watching the site, and assess that the resident is not in pain or discomfort. DON B also indicated staff can aspirate and see if there is residual. Of note, the facility is not following current standards of practice to verify G-tube placement.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on observation, interview, and record review the facility did not ensure that a resident who needs respiratory care is provided such care consistent with professional standards of practice for 1 of 2 residents (R39) reviewed for oxygen. R39 did not have oxygen tubing changed on a weekly basis. Evidenced by: R39 admitted to the facility on [DATE] and has diagnoses that include, in part: pneumonia due to other specified infectious organisms (infection that causes inflammation of the lungs); chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing breathing problems); acute on chronic systolic congestive heart failure (a condition that causes the heart to pump less effectively causing shortness of breath, weakness and fatigue. R39's Minimum Data Set (MDS), dated [DATE], indicates R39's Brief Interview of Mental Status (BIMS) is a 15, indicating that R39 is cognitively intact. R39's Physician Orders state, in part: *Oxygen at 1-4 L/min (liters per minute) via nasal cannula to keep sats (oxygen saturation level) at or above 88% for respiratory distress, as needed Start date 11/20/24 *Change oxygen equipment weekly Tuesday. Start date 3/4/25 Important to note: Surveyor requested oxygen protocol/policy. The facility's Oxygen Concentrator policy, dated 6/27/22 was provided. The policy does not include instruction on when to change oxygen tubing. On 3/9/25 at 9:49 AM, Surveyor observed R39 wearing the nasal cannula with oxygen concentrator set to 4L/min. No labeling with date was noted on oxygen tubing. On 3/11/25 at 10:17 AM, Surveyor interviewed LPN C (Licensed Practical Nurse) and asked about protocols for residents on oxygen. LPN C indicated that tubing is to be labeled with date and changed weekly. On 3/11/24 at 10:24 AM, Surveyor observed R39 wearing the oxygen nasal cannula and no labeling with date noted on the oxygen tubing. At that time, Surveyor asked CNA H (Certified Nursing Assistant) if there was labeling with date on R39's oxygen tubing. CNA H checked the tubing and stated no. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 10:35 AM, Surveyor interviewed DON/IP B (Director of Nursing/Infection Preventionist) and asked about protocols for residents using oxygen. DON/IP B indicated that tubing is to be changed weekly, labeled with the date of change, and documented on the MAR/TAR (medication administration record / treatment administration record). Surveyor asked if this is not documented on the MAR/TAR, do you know if it has been done. DON/IP B stated no. Surveyor asked if it is known when tubing was changed if the tubing is not labeled with a date. DON/IP B stated no. Surveyor reviewed with DON/IP B R39's order for change of oxygen equipment weekly with start date of 3/4/25 and no notation of order prior to this date. Surveyor asked DON/IP B if the facility would be expected to change R39's tubing weekly, label tubing with date of change, and document this change in the MAR/TAR. DON/IP B stated yes.

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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** 50228 Based on observation, interview, and record review the facility did not ensure that a resident who requires dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 2 of 2 residents (R39 and R33) reviewed for dialysis. R39 is receiving dialysis services. R39's care plan does not indicate how to handle an emergency situation with R 39's dialysis port and staff were not able to appropriately verbalize how to handle an emergency situation. R33 is receiving dialysis services. R33's care plan does not indicate how to handle an emergency situation with R33's dialysis port and staff were not able to appropriately verbalize how to handle an emergency situation. Evidenced by: The facility's Hemodialysis policy, dated 9/10/23, states, in part: The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include: The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing assessment and oversight of the resident before and after dialysis treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices. Important to note: the policy does not indicate interventions for implementation in case of a complication/emergency. Example 1 R39 admitted to the facility on [DATE] and has diagnoses that include end stage renal disease (a condition that occurs when the kidneys are no longer able to function adequately to maintain health and survival) and dependence on renal dialysis (relying on a procedure to filter blood and remove waste products when the kidneys are unable to do so). R39's physician orders state, in part: Dialysis scheduled for Mondays, Wednesdays, and Fridays . Order date 11/21/24. R39's care plan states, in part: Renal insufficiencies .date initiated: 3/9/25. Check access site for lack of thrill/bruit (sound and feeling of adequate blood flow), evidence of infection, swelling, or excessive bleeding per facility guidelines. Report abnormalities to MD. Dated 3/9/25. Dialysis (location) Monday-Wednesday-Friday . Dated 3/9/25. Report any dialysis catheter and site evidence of infection, dislodgement, and leaking. Dated 3/9/25. Important to note: R39's care plan does not include interventions related complications/emergencies with catheter site. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/25 at 10:59 AM, Surveyor interviewed CNA I (certified nursing assistant) and asked what would be done if a resident was found bleeding from their dialysis port. CNA I stated the nurse would need to be updated through use of the phone in the hallway. Important to note that CNA I indicated that the resident would need to be left in order to access the phone. On 3/10/25 at 11:13 AM, Surveyor interviewed CNA J and asked what would be done if a resident was found bleeding from their dialysis port. CNA J stated that the nurse would need to be updated. CNA J stated that CNA J would peek into the hall and ask for the nurse, without breaking resident privacy, or would leave the room and use the hall phone to page the nurse. On 3/10/25 at 11:30 AM, Surveyor interviewed LPN F (licensed practical nurse) and asked what would be done if a resident was found bleeding from their dialysis port. LPN F stated that the RN (registered nurse) would need to be alerted. LPN F indicated that the resident would be left while the staff accessed the phone in the hallway. LPN F indicated that after alerting the RN, LPN F would see how bad the bleeding was and put something in place to stop the bleeding. LPN F stated that a dry wipe in the room could be used or could ask someone to bring in gauze. On 3/10/25 at 4:00 PM, Surveyor interviewed DON/IP B (Director of Nursing/Infection Preventionist) and asked what staff is expected to do if a resident is found bleeding from their dialysis port. DON/IP B stated the nurse is to be alerted and there is a bag in the resident's room on their cork board (emergency kit) to help stop bleeding. Surveyor asked if anyone could use the emergency kit. DON/IP B stated yes. Surveyor asked how the nurse would be alerted. DON/IP B stated staff is to stay with the resident, activate the call light, and yell for the nurse. Surveyor asked if emergency procedure is part of the resident care plan and facility policy. DON/IP B reviewed care plan and policy and indicated that they did not say what to do in case of an emergency. Surveyor asked if the resident care plan and facility policy should say what to do in case of an emergency. DON/IP B stated yes. On 3/10/25 at 4:17 PM, Surveyor observed R39's room with DON/IP B. No emergency kit noted on the cork board. Surveyor asked if there should be an emergency kit on the cork board. DON/IP B stated yes. 38882 Example 2 R33 admitted to the facility on [DATE] with the following diagnoses: end stage renal disease and dependence on renal dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R33's Comprehensive Care Plan, initiated 7/29/24, includes Renal insufficiencies . 7/29/24 Check access site for lack of bruit and thrill, evidence of infection/swelling/ or excessive bleeding per facility guidelines. Report abnormalities to R33's Medical Doctor. 7/29/24 Confer with Medical Doctor and/or dialysis treatment center regarding changes in medication administration times/dosage pre-dialysis as needed. 7/29/24 Coordinate dialysis care with dialysis treatment center . Monday, Wednesday, Friday . Send midrin to dialysis with container of applesauce and plastic spoon. Make sure he has blanket and pillow, coat and hat sent with also. Needs to be high back wheelchair with foot pedals, mesh Hoyer sling and Roho cushion under him . 7/29/24 Diet per Medical Doctor orders . 7/29/24 Encourage rest after dialysis treatments . 7/29/24 Hemp dialysis (location- Named Dialysis Center 3 times weekly on Monday, Wednesday, Friday 11:00 AM chair time, 10:45 AM pick up). Obtain labs as ordered and notify Medical Doctor of results. 7/29/24 Record dry weights and report significant changes as ordered . 7/29/24 Report any dialysis catheter and site evidence of infection, dislodgement, and leaking . It is important to note R33's Comprehensive Care Plan does not include goals or interventions related to emergency procedures. On 3/10/25 at 10:54 AM CNA I (Certified Nursing Assistant) indicated if she found R33 bleeding out of his dialysis site she would exit the room to retrieve the nurse. CNA I indicated she would go find the nurse or use the phone hanging halfway down the hallway to call for the nurse. It is important to note CNA I would not apply pressure and would leave R33 alone if R33 had bleeding from dialysis site. On 3/10/25 at 3:22 PM LPN G (Licensed Practicing Nurse) indicated there should be an emergency dialysis kit in R33's room, but she was not able to locate the kit for Surveyor. On 3/11/25 at 11:27 AM NHA A (Nursing Home Administrator) indicated there should be an emergency kit in the rooms of residents who have dialysis and on 3/10/25 she added one to R33's room suspended from his cork board. NHA A indicated the resident's care plan, and the facility policy should contain emergency procedures for all staff related to dialysis care.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50228 Based on observation and interview the facility did not ensure drugs and biologicals are labeled in accordance with currently accepted professional standards 1 of 1 medication carts observed. The medication cart on the 400 hall had two tubes of open and used medicated ointment with no resident names. Evidenced by: Surveyor observed an open, used tube of muscle rub and an open, used tube of hydrocortisone acetate 1% cream in the drawer of the 400 hall medication cart. Surveyor asked LPN G if the tubes were both open and used. LPN G stated yes. Surveyor asked LPN G what resident the tubes were for. LPN G stated no idea, the tubes are not labeled. On 3/11/25 at 10:35 AM, Surveyor interviewed DON/IP B (Director of Nursing/Infection Preventionist) Surveyor asked how long nutritional supplements are good after being opened. DON/IP B stated 3 days. Surveyor asked how staff would know if a supplement is good if there is no use by date. DON/IP B stated there should be a date. Surveyor asked if tubes of ointment are expected to be labeled with a resident's name. DON/IP B stated yes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38882 Based on observation, interview and record review the facility did not maintain a safe and sanitary environment in which food is prepared, stored and distributed. This has the potential to affect all 44 residents who reside in the facility. Surveyor observed the facility's freezer to have frozen condensation attached to the ceiling and fallen pieces of frozen condensation on top of and inside of boxes of unsealed food causing potential for contamination. Surveyor observed a mixer to be stored covered and unclean. Supplements in the medication rooms were not dated. Evidenced by: Example 1 Facility policy, titled Food Storage: Cold Foods, undated, includes: . All . foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of FDA (Food and Drug Administration) Food Code . All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination . On 3/9/25 at 9:04 AM, during initial tour of the facility's kitchen, Surveyor and DM K observed frozen drips suspended from the ceiling in the facility's walk-in freezer. Surveyor and DM K also observed boxes of food to have water damage on them and opened boxes with unsealed food to have shards of ice on and inside of the box. DM K indicated she knocks the drips of ice down with an ice scraper every couple days and it is condensation that builds up and freezes. DM K folded the sides of one of the opened and unsealed boxes out, then Surveyor and DM K observed ice sitting in on the plastic bag inside of the box. DM K indicated she is unsure if the ice got inside of the plastic bag as it is no longer sealed by the manufacturer. DM K indicated she needs to provide a barrier between the frozen dripping and the opened food. DM K indicated she would throw out the egg patties and the potato wedges and other food that could be contaminated by the dislodged ice. On 3/9/25 at 12:19 PM District Manager L indicated the freezer has had this issue for a little while and the facility has tried different things to mitigate the condensation building up. District Manager L indicated there should be a barrier between the food that is no longer sealed by the manufacturer and the frozen dripping condensation to prevent contamination. Example 2 Facility policy, titled Equipment, revised 9/2017, includes: . All food contact equipment will be cleaned and sanitized after every use . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Wisconsin Dells Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Race St Wisconsin Dells, WI 53965	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/9/25 at 9:04 AM Surveyor and DM K (Dietary Manager) observed a mixer to be stored covered and unclean with dried food particles on it. DM K indicated the mixer should have been cleaned before being covered and stored. On 3/9/25 at 12:19 PM District Manager L indicated equipment should be cleaned before being covered in plastic and stored. 50228 Example 3 On 3/10/25 at 4:29 PM, Surveyor observed an open and used 32 ounce box of Imperial Med Plus 2.0 Vanilla Supplement on top of the 400 hall medication cart. Surveyor asked LPN G (Licensed Practical Nurse) if the supplement has been opened and used. LPN G stated yes. Surveyor asked how long the supplement was good. LPN G stated there should be a date on the supplement indicated when it needs to be used by.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on observation, interview and record review the facility did not establish and maintain 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 infection, this has the potential to affect the census (44), 1 of 4 residents (R10) wound care observations with hand hygiene concerns, and 1 of 3 residents (R37) medication pass observations with hand hygiene concerns. The facility is not monitoring the temperature of 2 of their 3 water heaters as part of their control measures for Water Management Program. The facilities Policy and Procedure for Pneumococcal Vaccine is not up to date. The facility did not identify an outbreak on the date it started. There was a breach in infection control for R10 when LPN F did not perform appropriate hand hygiene with wound care. There was a breach in infection control for R37 when LPN F did not perform appropriate hand hygiene with medication pass. This is evidenced by: The facility's Hand Hygiene policy, dated 11/2/22, states, in part: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. 6. Additional considerations: a The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning (applying) gloves, and immediately after removing gloves. The facility's Clean Dressing Change policy, dated 7/20/22, states, in part: It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross contamination.12. Cleanse the wound . 14. Wash hands and put on clean gloves. The facility's Blood Glucose Monitoring policy, dated 8/5/22, states, in part: .4. Perform hand hygiene and don gloves.16. Remove the strip and dispose of it properly.18. Remove and discard gloves and perform hand hygiene. Example 1 Per CDC (Centers for Disease Control and Prevention), 3/15/24 documents, in part: .Cold water guidance: Store and circulate cold water at temperatures below 77 F, although Legionella may grow at temperatures as low as 68 F (20 C). Hot water guidance: Store hot water at temperatures above 140 F (60 C). Ensure hot water in circulation doesn't fall below 120 F (49 C) and recirculate hot water continuously, if possible . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facilities Water Management Plan dated 2/21/25, documents in part: .Our Hot water system is delivered in a loop. The Water enters the building in the boiler room located adjacent to the kitchen and laundry. There are 3 Hot water heaters in the boiler room that heat the water to 154 degrees .Control Measures and Monitoring, Hot water heater temperatures are checked routinely to ensure they remain with in appropriate parameters .: Logbook Documentation from 2025 includes the following, in part: 12/2/25-2/28/25, Monday-Friday documentation reflects a temperature of 165 degrees in the laundry room where the 1st water heater flows to first. There is not documentation for the other two water heaters. On 3/10/25 at 3:22 PM, Surveyor interviewed MD M (Maintenance Director). Surveyor asked MD M are any of the logged temperatures at the water heaters themselves, MD M said just the laundry one. On 3/11/25 at 3:40 PM, Surveyor interviewed MD M. Surveyor asked MD M can you tell me what temperature the water must heat to kill Legionella, MD M said 130 degrees. Surveyor asked MD M is there any documentation of the water heater temperatures, MD M stated only the laundry water heater, not the 2 for rooms. Of note, 140 degrees is the temperature required to prevent Legionella. On 3/11/25 at 3:55 PM, Surveyor interviewed DON/IP B (Director of Nursing/Infection Preventionist). Surveyor asked DON/IP B should the temperatures of the water heaters be documented as part of the Water Management Plan, DON/IP B said I believe so yes. Example 2 The CDC's Pneumococcal Vaccine Recommendations dated 10/26/24 documents in part: .CDC recommends pneumococcal vaccination for children younger than 5 years and adults [AGE] years or older . The Facilities Policy and Procedure entitled Pneumococcal Vaccine (Series) dated 9/18/24, documents in part: .Clinical guidance for implementing pneumococcal vaccine recommendations for adults aged greater than or equal to [AGE] years .Adults aged greater than or equal to [AGE] years old . On 3/11/25 at 3:55 PM, Surveyor interviewed DON/IP B. Surveyor asked DON/IP B if she was aware of the current guidance for pneumococcal vaccines, DON/IP B stated she was not aware of any changes since the addition of the PCV21, PCV 20, and PCV15 (different versions of pneumococcal vaccine). Example 3 According to CDC guidelines and Wisconsin's Department of Health Policy and Procedures date 2/22/23, documents in part: .Acute onset of vomiting and/or diarrhea (3 or more loose stools in 24-hour period) in a resident or staff member and whose symptoms have no other apparent cause . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facilities Policy and Procedure entitled Infection Outbreak Response and Investigation dated 2/21/25 documents in part: .1. Prompt recognition of outbreak .ii. A sudden cluster of infections on a unit or during a short period of time (i.e. three or more cases) . Per the Facilities timeline they identified the Norovirus outbreak as beginning on 1/29/25. January 2025 Norovirus Outbreak Timeline documents the following in part: 1/27/25: 1 resident (R344) on 100 hall with loose stools, placed on contact precautions. 1/28/25: CNA called in with GI (gastrointestinal) upset. This CNA worked 1/27/25 on the 400 hall. Stool sample collected for R344 which was negative for C. difficile (inflammation of the colon caused by the bacteria Clostridium difficile). 1 resident (R41) on 100 hall reports multiple emesis but believes he ate something that didn't agree with him when he was out to eat, placed on contact precautions. 2 residents (R345 and R27) on 400 hall during rounds noted to have loose stools and emesis (R345 with loose stools and emesis) (R27 with emesis), both placed on contact precautions. 1/29/25: Facility called outbreak. Of note, during review of outbreak, the Facility actually had outbreak that started on 1/28/25. On 3/11/25 at 3:55 PM, Surveyor interviewed DON/IP B. Surveyor asked DON/IP B how did you determine when to call the symptoms/issues an outbreak, DON/IP B said when 3 or more people on same hall and/or staff had it. Surveyor asked DON/IP B if the outbreak should have been noted on 1/28/25, DON/IP B stated yes. 50228 Example 4 On 3/10/25 at 11:20 AM, Surveyor observed LPN F (Licensed Practical Nurse) perform wound care for R10. DON/IP B (Director of Nursing/Infection Preventionist) was observing and assisting with positioning of R10 during the dressing change. LPN F removed cleansing packing from R10's wound, then LPN F removed gloves and applied a new set of gloves without performing hand hygiene. LPN F prepared and applied the primary dressing to R10's wound bed, then LPN F removed gloves and applied a new set of gloves without performing hand hygiene. LPN F prepared and applied the secondary dressing. On 3/10/24 at 11:27 AM, Surveyor interviewed LPN F and asked when hand hygiene is needed for wound care. LPN F stated when going into resident room/prior to starting treatment and when done with treatment. Surveyor asked if gloves are contaminated after pulling packing from a resident's wound. LPN F stated yes. Surveyor asked if hand hygiene should be completed with change of gloves. LPN F stated yes. On 3/10/24 at 2:50 PM, Surveyor interviewed DON/IP B (Director of Nursing/Infection Preventionist) and asked when hand hygiene is needed for wound care. DON/IP B stated before treatment, after removing dirty dressing, anytime you go from dirty to clean, and at the end of the treatment. DON/IP B stated that DON/IP B would have expected LPN F to perform hand hygiene after removal of gloves, prior to application of new gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Example 5 On 3/10/25 at 7:57 AM, Surveyor observed LPN F performing medication administration for R37. LPN F gathered oral medications in a medication cup, medication pens for subcutaneous (SQ-under the skin) administration, and a blood sugar test kit and went to R37's bedside. LPN F donned gloves, with no hand hygiene, and performed a finger-stick blood sugar test. Following the test, LPN F touched the following with contaminated gloves: oral medication cup, the bedside table, and the medication pens. Without changing gloves and performing hand hygiene, LPN F administered the SQ injections. LPN F gathered the medication pens, placed them into the blood sugar test kit, and then removed gloves. LPN F then touched the following items prior to performing hand hygiene: resident bed linens, bed remote control, and bedroom door handle. Surveyor asked R37 about infection control with medication administration. LPN F stated that hands should have been cleansed prior to applying gloves and after administration of SQ medication. Surveyor asked if hand hygiene should be performed after performing a blood sugar test, prior to touching resident items. LPN F stated the items belonged to the same resident. Surveyor asked if gloves are contaminated after performing a blood sugar test. LPN F stated yes. Surveyor asked if resident items like a medication cup, bedside table and medication pens should be touched with contaminated gloves. LPN F stated no. Surveyor asked if hand hygiene should be performed after performing a blood sugar test. LPN F stated yes. Surveyor asked if hand hygiene should be performed after SQ administration of medications. LPN F stated yes. On 3/10/24 at 2:50 PM, Surveyor interviewed DON/IP B and asked when hand hygiene is expected with blood sugar testing. DON/IP B stated before and after the test. Surveyor asked if removal of gloves and hand hygiene would be expected after the blood sugar test, prior to any other task/touching resident objects. DON/IP B stated yes. Surveyor asked if DON/IP B would expect staff to remove gloves and perform hand hygiene after SQ administration of medications. DON/IP B stated yes.