STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525398	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prescott Nursing and Rehab Community	1505 Orrin Rd Prescott, WI 54021

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 of 5 residents (R) reviewed were free from chemical restraints. (R21)R21 was prescribed a hypnotic medication. There is no indication nonpharmacological interventions were tried prior to initiating the medication. The facility did not complete a sleep assessment, care plan, or monitor R21's sleep. R21 denied insomnia or history of sleep concerns. R21 is not informed that R21 is taking a psychotropic for sleep.Findings:R21 was admitted to the facility on [DATE] and has diagnoses including bipolar disorder, obstructive sleep apnea (adult) (pediatric), acute and chronic respiratory failure with hypoxia, asthma, manic episode, unspecified mood (affective) disorder, and anxiety disorder.R21's Minimum Data Set (MDS) assessment, dated 5/1/26, indicated R21 is dependent for assistance for all transfers and assistance with position changing. R21 can perform most activities of daily living with assistance of setting up the task. R21's Brief Interview of Mental Status scored 15/15, meaning R21 is cognitively intact. R21 is their own person and able to make their own decisions.R21's orders include:Trazodone tablet; 50mg; amt: 25mg; oral Special instructions: Administer 25mg at HS (bedtime) for sleep. Once A Day 07:00PM - 10:00PM Started 02/01/2026- open ended Trazodone tablet; 50mg; amt: 25mg; oral Special instructions: Administer 25mg at HS (bedtime) for sleep. Once A Day 07:00PM - 10:00PM Started 11/07/2025- 02/01/2026 ~ R21 does not have a completed sleep assessment.~ R21's care plan does not address insomnia, sleep disturbance or sleep issues with interventions for monitoring behaviors.~ The facility is not monitoring R21's sleep patterns.~ R21 does not have signed consent for trazadone. On 5/12/26 at 11:36 AM, Surveyor interviewed Certified Nursing Assistant (CNA) F who stated R21 is on her call light a lot but CNA F tries to take care of everything she needs when CNA F is in the room. Surveyor asked CNA F if R21 has difficulty sleeping. CNA F stated CNA F does not work the night shift so is unable to speak to sleep problems. On 5/13/26 at 8:34 AM, Surveyor interviewed Registered Nurse (RN) H who stated if we need an order for a medication, we fill out the form for the doctor and put it in the doctor's book to sign off. RN H reviewed R21's record and could not find a sleep assessment or monitoring of hours slept, nor medication effectiveness. Surveyor interviewed RN H who stated usually we track how many hours a resident sleeps. RN H stated RN H was not sure of the indication for the trazodone, but R21 is up all night and probably needs it. On 5/13/26 at 8:50 AM, Surveyor interviewed Director of Nursing (DON) B who stated DON B has no idea what form RN H is referring to. DON B stated we do consent forms for psychotropics and high-risk meds and pharmacy reviews monthly. DON B stated the facility had to give R21 something to help R21 sleep. DON B stated R21 would not sleep when R21 was first admitted to the facility, and R21 would constantly use the call light. DON B stated nights were rough. On 5/13/26 at 9:06 AM, Surveyor interviewed DON B and asked about documentation for why a resident would require medication or sleep. DON B stated there would be progress notes on why the resident needed it. Surveyor could not find progress notes regarding R21's need for sleep medication and requested DON B provide the documentation. On 5/13/26 at 11:50 AM, Surveyor interviewed R21 who stated that I am a night person. I've always stayed up until 2 or 3 in the morning. Surveyor asked if R21 had difficulty sleeping here at the facility. (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R21 stated not really; I like being a night owl. Surveyor asked R21 if she received medication to help her sleep. R21 stated no, I don't think I get any medication for sleeping. I am falling asleep earlier and getting up earlier. They are changing me. Surveyor asked R21 how that makes R21 feel. R21 stated, I don't know I guess that is how it is here. Facility was unable to provide information regarding the need for Trazodone or any non-pharmacological interventions tried prior to initiating Trazodone.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure the residents remain free of possible accidental hazards. Facility did not determine the correct mechanical full body lift (Hoyer) sling size and ensure staff were applying the correct size Hoyer sling to prevent accidents for 3 of 7 residents (R) reviewed. (R7, R37, R44). Facility developed a plan of care for R37 that listed the use of an xl (x-[NAME] large) Hoyer sling when a large sling should be used per manufacturer's guidelines. Certified Nursing Assistants (CNAs) used a medium Hoyer sling to transfer R37. Facility developed a plan of care for R44 that listed use of an xl sling when a large Hoyer sling should be used per manufacturer's guidelines. CNAs used a medium Hoyer sling to transfer R44. Facility developed a plan of care for R7 that listed use of an xl sling when a large Hoyer sling should be used per manufacturer's guidelines.Findings include:The Direct Supply Slings manufacturer's guidelines, no date, states, With Direct Supply slings, sizing is made simple! Check the trim color on each sling to quickly identify what size it is. In chart from the following is stated: Size x-small 50-100 pounds (lbs.) Black Trim Size small 75-150 lbs. Black Trim Size medium 125-200lbs. Purple Trim Size Large 175-300lbs. [NAME] Size x-large- 275-500 lbs. Blue trim The Direct Supply Website titled, How Do I Determine What Sling My Resident Needs? dated 2009-2026, states: The determination of the correct sling model and size must be done by a licensed clinician. That designated licensed clinician should: . 2. Determine the correct lift/assist device and sling based on the resident assessment and the manufacturer's instructions. 3. Document the specific recommended lift/assist device (make, model and weight capacity) and sling (make, model and size.) https://www.directsupply.com/resources/blogs/how-to-select-and-use-lift-slings The U.S. Food and Drug Administration patient guide titled Patient Lifts, undated, states: A sling too large: a patient may slip out. A sling too small: patient may fall out, it may worsen patient's condition, it may cause skin tears or pressure injuries due to excessive pressure. Example 1 R37's plan of care dated 5/13/26 states: Resident to be A2 (assist of 2) for transfers using Hoyer lift. Started 5/15/23. Full Body Lift: Tollos XL (extra-large). Started 9/18/23. R37's weight on 5/10/26 was 236.8 lbs. Per manufacturer's guidelines a green trim (large) sling should be used with R37. On 5/13/26 at 1:15 PM, Surveyor walked around with Certified Nursing Assistant (CNA) D and observed Hoyer slings used with residents. Surveyor observed that R37 was sitting in his wheelchair with a blue with purple trim Hoyer sling under him. CNA D stated R37 is an assist of 2 transfer using the Hoyer lift. CNA D stated, Yes we would use the sling under him to transfer him into his chair. Example 2 R44's plan of care, dated 5/13/26, states, Transfers: 2 persons assist with [Hoyer] lift, sling size XL. Started 5/7/26. R44's weight on 5/13/26 was 244.2 lbs. Per manufacturer's guidelines a green trim (large) sling should be used with R44. On 5/13/26 at 1:15 PM, Surveyor walked around with CNA D and observed Hoyer slings used with residents. Surveyor observed that R37 was sitting on a blue with purple trim sling under him in his wheelchair. CNA D stated R37 hates to get in the sling, it hurts. We use a sling to transfer R37. Example 3 R7's plan of care dated 5/13/26, states: 2 assist EZ stand (XL) sling for all transfers. Can use Hoyer lift (XL sling) if lethargic and resident cannot participate in EZ stand transfer. Started 1/22/25. R7's weight on 5/12/26 was 230 lbs. Per manufacturer's guidelines a green trim (large) sling should be used with R7. On 5/13/26 at 1:15 PM, Surveyor walked around with CNA D and observed Hoyer slings used with residents. Surveyor observed that a blue sling with green trim was in R7's chair. CNA D stated this is the sling we use with R7. R7 stated slings stay with the residents in their rooms unless they are soiled, then we get one that looks the same. Surveyor asked CNA D what size sling R7 uses. CNA D stated he does not know what size sling to use. Surveyor asked, does that mean that if the wrong size is being used with a resident and a new sling is needed and grabbed based on the same color as the soiled, the use of the wrong size sling is perpetuated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA D stated yeah, I guess so. I see what you are asking. On 5/12/26 at 8:35 AM, Surveyor interviewed CNA D who stated CNA D thinks Hoyer slings are universal in size. CNA D said, well there are different sizes, and this one is definitely one of the smaller ones. (The sling being used was blue with purple trim). CNA D and CNA F tried to find a size on the sling and could not find a size on any of the labels. CNA D stated we aren't told which one to use, we just make sure the resident fits safely and isn't falling out. Each resident has their own sling, and it is kept in their room. Slings are not shared between residents. On 5/12/26 at 11:35 AM, Surveyor interviewed CNA F regarding sling use. CNA F showed Surveyor R6's sling. CNA F stated R6 is smaller, so you use a smaller sling. CNA F showed Surveyor R21's sling. CNA F stated that R21 is larger so we would use a larger sling. CNA F stated there are different sizes, but I don't think they are labeled. CNA F stated the different sizes have different color trim. CNA F states she has no idea what color is what size. CNA F stated there is no chart posted anywhere indicating sling size. CNA F stated the plan of care is how we (CNAs) know how to transfer residents. CNA F stated I don't think the plan of care tells you what size sling to use. CNA F stated I know that the sling should not be lower than this (touched back of head) and it should be down to here (touched the back of her knees). CNA F stated we are kind of just guessing, but we do have different sizes to choose from, and we make sure it is big enough, so they fit right. On 5/12/26 at 12:19 PM, Surveyor interviewed Physical Therapist (PT) J and Physical Therapy Director (PTD) I regarding Hoyer transfer and slings. PT J stated that residents are admitted with transfer orders from the hospital or provider. PT J stated that PT J assesses a new resident within a day or so of admission. PT J determines a resident's ability and how to transfer safely. PT J stated PT J fills out the form with recommendations to communicate with nursing. PT J stated PT J does not determine the sling size nursing does that. PT J stated CNAs would not be doing that. Should not be doing that. Nurses determine the sling size, and it is care planned. On 5/13/26 at 8:43 AM, Surveyor interviewed Registered Nurse (RN) H who stated that residents are admitted with transfers orders when admitted . Physical Therapy sees them a day or two later to assess strength. PT then communicate their recommendations to nursing on the communication form. The doctor or Physical Therapy determines if a resident needs to be transferred by Hoyer and which sling to use. Nursing does not do that. It is placed on the plan of care for the CNA to follow. On 5/13/26 at 11:41 AM, Surveyor interviewed CNA E who stated some residents have the sling size on their plan of care. CNA E stated no, you can't easily tell what size the sling is, but it is on the plan of care. CNA E stated it should say a size on the slings, but they don't. CNA E stated they (slings) do have different color trim. CNA E stated no, there is not a chart posted that tells us what color each size sling is. CNA E stated CNA E knows the slings have to have room on the side to hold them and residents need to be safely lying in the sling. The sling goes from back of head down to the knee. On 5/13/26 at 1:32 PM, Surveyor interviewed Director of Nursing (DON) B who stated that admissions have transfer orders when they are admitted that usually have an order for transfer method. PT assesses residents within a day or two after admission and completes the communication form with their recommendations. DON B stated that everything eventually gets in chart. DON B stated nurses usually determine the sling size, usually it is the MDS Coordinator or DON B. DON B stated we look at the body habitus to determine. CNA might make a recommendation on sling but wouldn't use it until we verify it is the appropriate sling.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents received the appropriate treatment and services to prevent complications for 1 of 1 resident (R) receiving nutrition through tube feedings (enteral nutrition) (R26).The facility did not ensure standards of practice were conducted by ensuring proper gastrostomy tube (G-tube) placement before administering medications via G-tube.The facility policy titled, Care and Treatment of Feeding Tubes, last reviewed 04/03/25 states under the section of Policy Explanation and Compliance Guidelines, .6.licensed nurses, will monitor and check that the feeding tube is in the right location (a). Tube placement will be verified before beginning a feeding and before administering medications.On 05/12/26, Surveyor reviewed R26's medical record. R26 was admitted to the facility on [DATE] with a diagnosis of placement of a gastrostomy tube following surgery for right hemicolectomy.R26's admission Minimum Data Set (MDS) assessment, dated 02/06/2026, indicates having a Brief Interview for Mental Status score of 15/15 (cognitively intact). R26 required 51% of total calories through tube feeding.R26's care plan was updated on 04/10/26 with ability to eat orally.R26's physician orders were updated on 03/10/26 for all medications to be given via G tube or by mouth (patient prefers G-Tube). Flush with 30 cc before and after medication administration.On 05/12/2026 at 9:54 AM, Surveyor observed Licensed Practical Nurse (LPN) C administer R26's medications via G-tube without checking placement prior to administering medication.On 05/12/2026 at 12:43 AM, Surveyor interviewed LPN C regarding expectation of checking gastric content residual prior to medication administration via G-tube. LPN C stated, Are we supposed to do that? Director of Nursing (DON) B was walking down hallway while Surveyor was interviewing LPN C and Surveyor interviewed DON B of expectation of checking residual prior to medication administration. DON B stated the expectation would be to check residual prior to medication administration.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not provide a sanitary environment to help prevent the development and transmission of communicable diseases and infections for 2 of 14 residents. (R4 and R7)-Certified Nursing Assistant (CNA) E did not place barrier between floor and graduate when emptying R4's Foley catheter bag.-CNA D did not sanitize the mechanical lift after transferring R6, nor prior to using mechanical lift to transfer R7. CNA D and CNA E used the EZ stand lift for R4's transfer from bed to wheelchair and did not sanitize after use. The facility policy titled, Cleaning/Disinfecting Resident-Care items and Equipment, reviewed on 01/20225 states, . Reusable items are cleaned and disinfected between residents . The facility procedure titled, Emptying a Urinary Drainage Bag Competency, states, . 4. Place a paper towel on floor next to the drainage bag. 5. Place graduate collection container on top of paper towel. Wisconsin Nursing Assistant Curriculum, Copyright © 2023 by WisTech, section 5.25 Skills Checklist: Emptying Catheter Drainage Bag, states: Procedure Steps: ~Put on gloves. ~Place a barrier (e.g., paper towel or disposable pad) on the floor under the drainage bag. ~Place the graduated cylinder on the barrier. Example 1 On 05/12/26, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] with diagnoses including abnormal gait and mobility, weakness, spinal disc disorder, and urinary retention and obstruction. R4's care plan states: ~ Dated 07/07/25: Resident has a history of UTI (Urinary tract infection). Resident has a catheter increasing infection risk. ~ Dated 03/15/25: Resident requires enhanced barrier precautions related to: Fornier's Gangrene wounds, urinary catheter, and new colostomy. One assist with foley catheter care and emptying. ~ Dated 03/10/25: Self Care Deficit requiring 2 staff assist with EZ stand for transfers. On 05/12/2026 at 9:02 AM, Surveyor observed Certified Nursing Assistant (CNA) D and CNA E provide care for R4. CNA E emptied R4's foley catheter bag. During the process, CNA E placed the urinal directly on the floor then proceeded to empty the foley catheter bag without the barrier in place. CNA D and CNA E then transferred R4 from the bed to the wheelchair using an EZ stand mechanical lift. Following the transfer, R4 was disconnected from the lift, and the lift was placed out in the hallway without being sanitized. On 05/12/2026 at 9:23 AM, Surveyor asked CNA F when lifts are supposed to be sanitized. CNA F said, After every use, but sometimes we have a lack of purple wipes, so we do it when we can. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/12/2026 at 9:29 AM, Surveyor asked CNA D where antimicrobial wipes are located. CNA D led Surveyor to multiple storage rooms in three different areas of the building (two different hallways and central supply closet in the dining room). There were no antimicrobial wipes in any of the areas. CNA D then asked Licensed Practical Nurse (LPN) G where the purple wipes were located. LPN G stated the wipes are on the other hall on the vitals cart. CNA D told and showed Surveyor s/he uses premium adult washcloths (which do not meet the requirements for sanitizing medical equipment) if purple (antimicrobial) wipes are not available. CNA D stated, I am so sorry we forgot to wipe the lift after the transfer for [R4]. CNA D then retrieved antimicrobial wipes and wiped the lift. On 05/12/2026 at 11:14 AM, Surveyor interviewed Director of Nursing (DON) B. Surveyor asked what the expectation is for staff to wipe lifts after use. DON B stated that staff should wipe lifts with antimicrobial wipes after every use in the residents' rooms. DON B also confirmed the facility has 2 Hoyer lifts and 2 sit-to-stand with a total of 14 residents that require the use of mechanical lifts for transfers. Surveyor asked what the expectation is regarding emptying a foley catheter bag. DON B stated, We do not place a barrier on the floor. I was not aware of this. I will educate the staff. Example 2 On 5/12/26 at 8:18 AM, Surveyor observed CNA D use the Hoyer (mechanical full body lift) to transfer R6 to the wheelchair. At 8:37 AM, Surveyor observed CNA D transfer R6 to R6's wheelchair and then take the garbage and Hoyer lift out of R6's room. CNA D parked the Hoyer lift off to the side in the hallway outside R6's room. CNA D then went and discarded the garbage in the dirty utility. CNA D came out of the dirty utility room without performing hand hygiene and went to nurse's station. CNA D did not wipe down the soiled Hoyer lift. Surveyor continued to stand by the Hoyer lift and at 8:52 AM, Surveyor observed CNA D push the soiled Hoyer to R7's room, push the lift inside R7's room, and transfer R7 with the soiled Hoyer lift with assistance of a second CNA. On 5/13/26 at 11:32 AM, Surveyor asked CNA D if CNA D wiped the Hoyer down after using it with R6. CNA D stated CNA D thought it was sanitized but CNA D may have forgotten. CNA D stated the Hoyer lift should have been sanitized after use. On 5/13/26 at 1:38 PM, Surveyor interviewed DON B who stated DON B's expectation is that staff sanitize the Hoyer lift after each use.