STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525408	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middle River Health and Rehabilitation Center	8274 E San Rd South Range, WI 54874

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility did not provide care and treatment by professional standards of practice to maintain a resident's highest practicable level of physical well-being by not assessing and/or treating a post-medication error for 1 out of 3 residents (R) reviewed for medication errors, R8. -R8 was given the wrong medications of Eliquis 5 mg, metoprolol 12.5 mg, and omeprazole 40 mg. R8 was not assessed every 4 hours for 24 hours as per physician order. Findings include: Example 1 R8 was admitted to the facility on [DATE], with diagnoses including Parkinson disease, Alzheimer's disease unspecified, unspecified dementia, irritable bowel syndrome with constipation, essential hypertension, obstructive sleep apnea, and spinal stenosis. Surveyor reviewed medication error, dated 06/14/25, which stated, in part, incident details include R8 was given wrong medications listed as Eliquis 5 mg, metoprolol 12.5 mg, and omeprazole 40 mg. The resolution for this error was that R8's provider gave an order for monitoring R8 every 4 hours for the next 24 hours. Surveyor reviewed vitals and assessments for R8, which states in part, -On 06/15/25 at 4:07 AM, R8 is monitored for medication error. Baseline neurologically, vital signs blood pressure 106/69, heart rate 71, respirations 20, and oxygen 97% on room air. R8 has no complaints at this time and will continue to monitor. Surveyor found no other documentation of vitals and assessments completed every 4 hours for the next 24 hours for R8. On 06/24/25 at 3:40 PM, Surveyor interviewed DON B and asked DON B what the expectation is for staff to monitor R8 after a medication error as provider orders stated monitor every 4 hours for the next 24 hours. DON B reported to Surveyor that the nursing staff should have monitored R8 every 4 hours for 24 hours including vital signs and head to toe assessment. DON B reported to Surveyor that the assessments and vitals were not completed for R8 every 4 hours as ordered.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure medications were administered under professional standards of clinical practices for 3 of 3 residents (R) reviewed for medication errors, R6, R8 and R7. -R6 received ciprofloxacin 500 mg twice a day for 3 days and should have received 250 mg twice a day for 3 days, and ciprofloxacin did not have an expiration label on it. -R8 received the wrong medications, including Eliquis 5 mg, metoprolol 12.5 mg, and omeprazole 40 mg. -R7's self-administration assessment stated R7 required assistance and nurse left Eliquis, melatonin, omeprazole, and metoprolol in a medicine cup at R7's bedside, left the room, and did not ensure R7 took the medications. Example 1 Surveyor reviewed medication error, dated 06/16/25, which stated, in part, R6 received the wrong dose of ciprofloxacin 500mg twice a day on 06/14/25, 06/15/25, and 06/16/25. R6 was supposed to receive ciprofloxacin 250 mg twice a day for 3 days. Incident details include Registered Nurse (RN) I, who transcribed physician orders incorrectly with no expiration date placed in the Electronic Health Record (EHR). Licensed Practical Nurse (LPN) F administered extra doses of ciprofloxacin twice a day on 06/14/25, 06/15/25, and 06/16/25. The resolution for this error was that education was given to RN I and LPN F about residents' rights of medication administration. On 06/24/25 at 10:10 AM, Surveyor interviewed Director of Nursing (DON) B and asked DON B what kind of education RN I received pertaining to R6's medication error of incorrect dose and no expiration label for ciprofloxacin. DON B reported to Surveyor that on the medication error report, DON B noted that resident's rights of medication administration education was given to RN I and LPN F. Surveyor asked DON B if RN I was educated on the transcription error, as it was not documented on the medication incident report form. DON B reported to Surveyor that DON B did not document that transcription education was provided but would go provide education to RN I and document this education. Example 2 Surveyor reviewed medication error, dated 06/14/25, which stated, in part, that R8 received wrong medications. R8 received Eliquis 5 mg, metoprolol 12.5 mg, and omeprazole 40 mg. Incident details include R8 was given the wrong medications but had no effects, vitals stable, and sleeping. The resolution was that R8's provider gave an order for the nurse to monitor R8 every 4 hours for the next 24 hours. Surveyor did not find any documentation of vital signs being monitored every 4 hours for the next 24 hours and any education provided to LPN G after the medication error. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/24/25 at 10:10 AM, Surveyor interviewed DON B and asked DON B if any education was provided to LPN G. DON B reported that documentation of education was not on the medication incident report, but education was completed. On 06/24/25 at 10:19 AM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked NHA A if any education was provided to LPN G. NHA A reported to Surveyor that this event was not the first incident LPN G had, so LPN G was terminated at some point after finding multiple medication errors. Evidence of education was not provided to Surveyor. Example 3 R7 was admitted to the facility on [DATE], with diagnoses including essential hypertension, end stage renal disease, contracture of left and right hand, anxiety disorder, noncompliance with medication regimen, unstable angina, diabetes mellitus type 2, and congestive heart failure. R7's minimum data set (MDS) assessment, completed on 05/20/25, confirmed R7 scored 15/15 during a Brief Interview for Mental Status (BIMS), indicating intact cognition. R7 requires supervision and set-up assistance with eating and oral hygiene. R7 requires substantial maximal assistance with transferring, dressing lower body, putting on/taking off footwear, personal hygiene, showering/bathing, and toileting. Surveyor reviewed R7's self-administration of medication assessment which stated in part, .-On 03/02/25, all questions such as administering of medications answer- b) Assistance required . Surveyor reviewed medication error, dated 06/20/25, which stated, in part, incident details include R7 has order for self-administration of medications, nurse left night medications at bedside, and did not follow up to check that R7 took medications of Eliquis, melatonin, omeprazole, and metoprolol. The resolution was educating nurse on self-administration orders and to follow up in one hour to ensure R7 received medications. On 06/24/25 at 3:40 PM, Surveyor interviewed Director of Nursing (DON) B and asked DON B process for self-administering medications. DON B reported to Surveyor that nurses are supposed to assess residents first to make sure they can safely administer their own medications. Surveyor asked DON B if R7 had a self-administer assessment completed. DON B reported to Surveyor that R7 has a physician order that R7 can self-administer medications, but that DON B would investigate the self-administering further. DON B reviewed self-administer medication assessment completed on 03/02/25 and reported to Surveyor that DON B reviewed and R7 was deemed to require assistance with medications. DON B reported to Surveyor that DON B will have staff re-evaluate self-administering abilities and update R7's chart as needed. DON B reported to Surveyor that staff should have followed up with R7 to make sure R7 did not miss R7's important medications.

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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** Based on observation and interview, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. This had the potential to affect 48 residents (R). Physical Therapy Assistant (PTA) C and Registered Nurse (RN) O entered R5's room without proper Personal Protective Equipment (PPE) who is on airborne precautions for parainfluenza infection. Findings include: Surveyor reviewed facility policy titled, Isolation-Initiating Transmission Based Precautions, states in part, .-Transmission-Based Precautions will be initiated when there is reason to believe that a resident has a communicable infectious disease. Transmission-Based Precautions may include Contact Precautions, Droplet Precautions, or Airborne Precautions. #5. When Transmission-Based Precautions are implemented, the Infection Preventionist (or designee) shall: a. Ensure that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained near the resident's room so that everyone entering the room can access what they need . Surveyor reviewed facility policy titled, Personal Protective Equipment, states in part, .- Objectives: 1. To prevent the spread of infections; 2. To prevent soiling of clothing with infectious material; -Miscellaneous: 1. Use gowns only once and then discard into an appropriate receptacle inside the exam or treatment room. 2. Clean reusable or disposable gowns may be worn in most circumstances. 3. Use gowns only when indicated or as instructed. 4. Follow established handwashing procedures. 6. When use of a gown is indicated, all personnel must put on the gown before treating or touching the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. Gowns shall be large enough to cover all of the wearer's clothing, and they must be tightly cuffed at the sleeves. 8. After completing the treatment or procedure, gowns must be discarded in the appropriate container located in the room. 10. Soiled gowns must not be worn in break rooms, lobbies, or into any area in which contamination of equipment is likely to occur . R5 was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy, polyneuropathy, diabetes mellitus type 2, bacterial infection unspecified, and heart failure. Surveyor reviewed R5's progress notes, which state in part, -On 06/23/25 at 1:26 PM, R5 having a cough this morning, Robitussin administered, COVID tested and negative, DON notified, R5 placed on droplet precautions. -On 06/24/25 at 9:45 AM, Writer obtained nasal swab for respiratory panel ordered per provider, sent to lab. -On 06/24/25 at 6:48 PM, Received respiratory panel back today, parainfluenza 3 virus detected. R5 on droplet precautions and will remain on for 7 days until 07/01/25. On 06/24/25 at 9:17 AM, Surveyor observed PTA C enter R5's room with no PPE on. PTA C started working with R5 in room on Physical Therapy (PT) exercises. On 06/24/25 at 9:28 AM, Surveyor observed RN O standing outside R5's room. Surveyor interviewed RN O and asked RN O what precautions R5 is on. RN O reported to Surveyor that R5 is on droplet precautions. Surveyor informed RN O that PTA C is in R5's room with no PPE on. RN O immediately reported to Surveyor that PTA C is supposed to have PPE on before entering R5's room. RN O called PTA C out of R5's room and explained to PTA C that PTA C needs mask, shield, gown, and gloves on when providing cares in R5's room. PTA C reported to RN O that she did not realize this and PTA C applied PPE and entered back into R5's room. On 06/24/25 at 9:33 AM, Surveyor observed PTA C exit R5's room and doffed gown, face shield, and gloves. Surveyor observed PTA C continue walking down hallway and exited the unit without proper hand hygiene or removing face mask from R5's room. On 06/24/25 at 9:36 AM, Surveyor observed RN O donning a face shield, gown, and gloves. RN O entered R5's room to swab R5 for a respiratory panel. Surveyor did not observe RN O apply a face mask under the face shield before entering R5's room. On 06/24/25 at 9:45 AM, Surveyor observed RN O exit R5's room and doffed PPE. Surveyor did not observe RN O doff a face mask. Surveyor interviewed RN O and asked if RN O was supposed to have placed a mask on under the face shield when in R5's room on droplet precautions. RN O reported to Surveyor that RN O applied face mask while inside R5's room but should have applied outside room before entering R5's room to decrease chances of spreading infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/24/25 at 10:18 AM, Surveyor interviewed Director of Nursing (DON) B and asked DON B what the expectations are for proper PPE usage with R5 on droplet precautions. DON B reported to Surveyor that all staff are to use appropriate PPE such as mask, face shield, gown, and gloves with droplet precautions. Surveyor informed DON B of observation of RN O and PTA C not utilizing appropriate PPE when entering R5's room. DON B reported that staff should have worn the appropriate PPE before entering R5's room and when exiting doffing the PPE entirely and sanitizing hands before walking onto the next task.