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	02/03/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not provide evidence that all alleged violations are thoroughly investigated for an injury of unknown cause.-Facility did not conduct interviews for other staff and residents.-Facility did not complete education in relation to the incident-Facility did not ensure a Registered Nurse (RN) completed an assessment after a Licensed Practical Nurse (LPN) completed the initial assessment.-Facility did not investigate further after becoming aware of fracture.Findings include:R1 was admitted to the facility on [DATE].On 09/30/25, R1 had a Brief Interview for Mentals Status (BIMS) score of 6/15 which indicates severe cognitive impairment.R1's care plan in part includes a focus of self-care deficit related to polyneuropathy, frequent falls, failure to thrive, weakness, and decreased mobility with interventions of high fall risk last revised on 11/22/25. Prior to the incident R1's care plan stated R1 required assist of 1 with the stand aid for transfers and assist of 2 with stand aid for toileting.Surveyor reviewed staff interviews:CNA C stated CNA C was finishing last rounds and went into R1's room and noticed R1 needed to be changed. CNA C got R1 in the stand aid and stated R1 couldn't stand any longer and R1's feet slipped off the stand aid platform. CNA C reported trying to help R1 get R1's feet back on the stand aid platform but was unsuccessful so CNA C eased R1 to the floor. CNA C stated CNA D then came in to help CNA C.CNA D stated CNA D was on the way to change R2 when CNA D noticed R1's room door was shut and stopped to open it. CNA D observed R1 on the floor and CNA C present in the room. CNA D stated CNA C was trying to move R1 before LPN E could assess R1. CNA C stated CNA C stated not to get LPN E because R1 did not fall and did not need blood pressure checked. CNA D went and notified LPN E of the fall.LPN E stated LPN E was notified to go to R1's room. Upon entry to R1's room, LPN E observed R1 sitting upright on the floor. LPN E stated R1 showed no signs of distress and had no complaints of pain. Certified Nursing Assistant (CNA) C reported to LPN E that R1 had been standing on the stand aid when R1's legs/knees became week causing R1 to go down onto R1's knees. CNA C reported CNA C could not hold R1 up and lowered R1 to the floor in a controlled manner. CNA C reported CNA C was in the process of pulling down R1's pants to change R1's brief at the time of the incident. After R1 had been assisted via Hoyer lift and 3 staff, LPN E completed an assessment of R1. LPN E stated R1 did not complain of pain and vitals were stable. DON B was notified, and a voicemail was left for POA.On 02/03/26 at 11:15 AM, Surveyor interviewed R1. R1 is not a good historian. R1 reported falling and breaking her foot but was unable to recall the events or staff present at the time of the incident.On 02/03/26 at 11:41 AM, Surveyor interviewed CNA C. CNA C stated each resident has a care plan which CNAs can access on their charting program in the computer and there is also a book at the desk they can review if unsure about care. CNA C stated they get verbal report when changes are made as well.On 02/03/26 at 11:48 AM, Surveyor observed CNA C talking with R1. CNA C stated, You remembered to tell her how you were glad I was there to help you, right? Because I would never let you fall. R1 replied, I just told her I jumped off the bed.On 02/03/26 at 11:50 AM, (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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NAME OF PROVIDER OR SUPPLIER Middle River Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8274 E San Rd South Range, WI 54874	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor interviewed RN H. RN H stated care plans are updated by nurses or Director of Nursing (DON) as changes occur. RN H showed Surveyor the binder at the nurse's station that includes all resident care plans. RN H stated all CNAs have access to this if they are unsure and also get verbal report of changes to resident care.On 02/03/26, Surveyor reviewed stand aid competency checklist for CNA C which indicates CNA C has demonstrated use of the stand aid and could use it correctly and was dated 01/12/26.On 02/03/26 at 1:23 PM, Surveyor observed CNA C and CNA G transfer R2 with the stand aid. No concerns.On 02/03/26 at 1:30 PM, Surveyor interviewed CNA G. CNA G stated if a resident's care plan stated they were assist of 1 for transfers, but assist of 2 with toileting, CNA G would not use the stand aid alone to change an incontinent resident.On 02/03/26 at 1:32 PM, Surveyor interviewed CNA C. CNA C stated if a resident's care plan stated they were assist of 1 for transfers, but assist of 2 with toileting, CNA C would not use the stand aid alone to change an incontinent resident.On 02/03/26 at 2:51 PM, Surveyor interviewed Rehab Director (RD) J. RD J stated the stand aid is only to be used as a way to transfer a resident and should not be used to stand a resident that requires changing of incontinent products.On 02/03/26 at 3:45 PM, Surveyor interviewed CNA D. CNA D stated CNA D walked into R1's room on 01/18/26 because the door was closed and R1 is a fall risk. CNA D stated R1 was on the floor and CNA C was present. CNA D stated CNA C told CNA D not to get a nurse and R1 did not need a blood pressure check. CNA D stated CNA D went and got LPN E because CNA C was trying to move R1 prior to being assessed by a nurse. CNA D reported not being sure if CNA C would have reported the incident if CNA D had not entered the room. CNA C did not call for assistance. CNA D stated if a resident's care plan stated 1 assist for transfer and 2 assist for toileting, CNA D would not change a resident's incontinence brief alone, as that is considered toileting.LPN E was unavailable for interview.On 02/03/26 at 3:49 PM, Surveyor interviewed DON B. DON B stated DON B's expectations include nurses reporting incidents to management immediately. DON B stated RNs are sometimes hard to come by but DON B would expect an LPN to have an RN assess the resident as soon as possible after the LPN completed their initial assessment. DON B stated DON B is working with staff in knowing their roles and scopes of practice. DON B stated DON B was informed of this incident on 01/18/26 at 5:30 PM that day. DON B acknowledged that CNA C did not follow R1's care plan and further investigating should have been completed. DON B stated no education related to the incident had been completed at this time but DON B was in the process of putting together education for nurses and planned to have a meeting for CNAs this week. DON B acknowledged other potentially affected residents and other staff should have been interviewed after the incident. DON B stated the reporting and investigation process in long term care is new to DON B and acknowledged the need to improve.On 02/03/26 at 4:27 PM, Surveyor interviewed Nursing Home Administrator (NHA) A with Nursing Consultant (NC) I present. NHA A stated the initial report was submitted on 01/20/26 as that was the day the facility was aware of an injury. NHA A stated the facility did not investigate the incident as an abuse allegation as NHA A believed CNA C had followed the care plan. NHA A acknowledged CNA C had followed the care plan for transfers, but not for toileting. NHA A acknowledged from the information in the interview with CNA D, further investigation should have been completed regarding the incident. NHA A acknowledge further interviews and education should also have been completed. NHA A was made aware of conversation between CNA C and R1 on day of survey.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 of 4 residents reviewed (R1) received person-centered care according to the comprehensive care plan.-A facility staff member did not follow R1's care plan for toileting resulting in a fall.Findings include:R1 was admitted to the facility on [DATE].On 09/30/25, R1 had a Brief Interview for Mentals Status (BIMS) score of 6/15 which indicates severe cognitive impairment.Care plan includes in part; Transfers: stand aid assist of 1. Toileting: 2 assist before morning cares, at bedtime, and every 2-3 hours while awake and upon request.On 01/18/26 at 1:45 PM, Certified Nursing Assistant (CNA) C entered R1's room for incontinence care. CNA C assisted R1 to a standing position in the stand aid with no other staff. While R1 was standing in the stand aid, CNA C attempted to pull down R1's pants to change incontinent brief. R1 stated R1 could no longer stand and R1's feet slipped off the stand aid platform. CNA C stated CNA C attempted to assist R1 put R1's feet back on the platform, but was unable to, and had to lower R1 to the floor.On 02/03/26 at 11:15 AM, Surveyor interviewed R1. R1 is not a good historian. R1 reported falling and breaking her foot but was unable to recall the events or staff present at the time of the incident.On 02/03/26 at 11:41 AM, Surveyor interviewed CNA C. CNA C stated each resident has a care plan which CNAs can access on their charting program in the computer and there is also a book at the desk they can review if unsure about care. CNA C stated they get verbal report when changes are made as well.On 02/03/26 at 11:50 AM, Surveyor interviewed Registered Nurse (RN) H. RN H stated care plans are updated by nurses or Director of Nursing (DON) as changes occur. RN H showed Surveyor the binder at the nurse's station that includes all resident care plans. RN H stated all CNAs have access to this if they are unsure and also get verbal report of changes to resident care.On 02/03/26, Surveyor reviewed stand aid competency checklist for CNA C which indicates CNA C has demonstrated use of the stand aid and could use it correctly.On 02/03/26 at 1:23 PM, Surveyor observed CNA C and CNA G transfer R2 with the stand aid. No concerns.On 02/03/26 at 1:30 PM, Surveyor interviewed CNA G. CNA G stated if a resident's care plan stated they were assist of 1 for transfers, but assist of 2 with toileting, CNA G would not use the stand aid alone to change an incontinent resident.On 02/03/26 at 1:32 PM, Surveyor interviewed CNA C. CNA C stated if a resident's care plan stated they were assist of 1 for transfers, but assist of 2 with toileting, CNA C would not use the stand aid alone to change an incontinent resident.On 02/03/26 at 2:51 PM, Surveyor interviewed Rehab Director (RD) J. RD J stated the stand aid is only to be used as a way to transfer a resident and should not be used to stand a resident that requires changing of incontinent products.On 02/03/26 at 4:27 PM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A stated it would be NHA A's expectation staff would follow the resident's plan of care and acknowledged CNA C should have had assistance with incontinent care for R1.

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F 0689 Level of Harm - 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 1 of 4 residents reviewed (R1) received adequate supervision and assistance devices to prevent accidents.Certified Nursing Assistant (CNA) C did not use stand aid correctly causing a fall resulting in R1 sustaining a fracture.Findings include:R1 was admitted to the facility on [DATE].On 09/30/25, R1 had a Brief Interview for Mentals Status (BIMS) score of 6/15, which indicates severe cognitive impairment.Care plan includes in part: a focus of self-care deficit related to polyneuropathy, frequent falls, failure to thrive, weakness, and decreased mobility with interventions of high fall risk last revised on 11/22/25. Transfers: stand aid assist of 1. Toileting: 2 assist before morning cares, at bedtime, and every 2-3 hours while awake and upon request.On 01/18/26 at 1:45 PM, CNA C entered R1's room for incontinence care. CNA C assisted R1 to a standing position in the stand aid with no other staff assistance. While R1 was standing in the stand aid, CNA C attempted to pull down R1's pants to change incontinent brief. R1 stated R1 could no longer stand and R1's feet slipped off the stand aid platform. CNA C stated CNA C attempted to assist R1 by placing R1's feet back on the platform, but was unable to, and CNA C had to lower R1 to the floor. CNA D was walking past room and noticed the door was shut and opened it. CNA D called Licensed Practical Nurse (LPN) E to the room. LPN E assessed R1. CNA C, CNA D, and LPN E assisted R1 back to bed with the use of the Hoyer lift.On 01/18/26 at 7:30 PM, R1 reported pain in the right ankle/foot. Registered Nurse (RN) F assessed R1. Provider ordered x-rays.On 01/20/26, R1 was sent to the emergency room (ER) for x-rays and assessment. R1 was found to have an acute comminuted, minimally displaced, extra-articular fracture of the right posterior calcaneal tuberosity.On 01/20/26, R1 returned to the facility from the hospital. R1 previously was a 1 person assist with the stand aid and 2 assist with stand aid for toileting before the fall, and since return from the hospital, diagnosis of right posterior calcaneal tuberosity fracture, is now non-weight bearing on the right foot and requires the use of a Hoyer lift for all transfers with assist of 2 staff. R1 wears a prevalon protective boot when in bed, and a CAM boot when up out of bed.On 02/03/26 at 11:15 AM, Surveyor interviewed R1. R1 is not a good historian. R1 reported falling and breaking R1's foot but was unable to recall the events or staff present at the time of the incident.On 02/03/26, Surveyor reviewed the stand aid competency checklist for CNA C, which indicates CNA C has demonstrated use of the stand aid and could use it correctly dated 01/12/26.On 02/03/26 at 1:23 PM, Surveyor observed CNA C and CNA G transfer R2 with the stand aid. No concerns.On 02/03/26 at 1:30 PM, Surveyor interviewed CNA G about lift use and toileting. CNA G stated if a resident's care plan stated they were an assist of 1 for transfers, but an assist of 2 with toileting, CNA G would not use the stand aid alone to change an incontinent resident.On 02/03/26 at 1:32 PM, Surveyor interviewed CNA C. CNA C stated if a resident's care plan stated they were assist of 1 for transfers, but assist of 2 with toileting, CNA C would not use the stand aid alone to change an incontinent resident.On 02/03/26 at 2:51 PM, Surveyor interviewed Rehab Director (RD) J. RD J stated the stand aid is only to be used as a way to transfer a resident and should not be used to stand a resident who requires changing their incontinent products.On 02/03/26 at 4:27 PM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A stated it would be NHA A's expectation that the staff would follow the resident's plan of care and acknowledged CNA C should have had assistance with incontinence care for R1.The facility did not provide education for the staff. Facility did not interview any other residents. R1's care was delayed because an RN did not assess R1 after the LPN assessed R1. An RN, RN F, did not assess R1 for 6 hours after the fall had occurred.