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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastview Health and Rehabilitation Center	729 Park St Antigo, WI 54409

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 observation, staff interview and record review, the facility did not ensure care and treatment provided were consistent with professional standards of practice and resident preference for 2 residents (R) (R1 and R2) of 7 sampled residents.R1 sustained a wound on the right knee during a fall on 2/26/26. Staff did not monitor the wound since it was identified.R2 had a U shaped scar on the left back. Staff and R1's family indicated the area was bruised and had drainage in the recent past. R2's medical record did not contain documentation regarding the area.Findings include: The facility's Wound Treatment Management policy, revised 12/3/24, indicates: To promote wound healing of various types of wounds .Treatment decisions will be based on a. etiology of the wound .b. characteristics of the wound .c. location of the wound. d. goals and preferences of the resident/representative .The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include a. Lack of progression towards healing. b. Changes in the characteristics of the wound. The facility's Pressure Injury Prevention and Management policy, revised 4/17/25, indicates: Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. According to the National Institutes of Health (NIH) website (4/6/26), a wound is defined as a disruption of the normal anatomical structure and function of skin or tissue .it involves broken skin or damaged underlying tissue with intact skin . According to the NIH Nursing Fundamentals Open Resources for Nursing book, dated 2021, skin integrity is a medical term that refers to skin health. Impaired skin integrity is a nursing diagnosis the North American Nursing Diagnosis Association ([NAME]) International defines as, altered epidermis/or dermis (outer most layer of skin/tissue below the epidermis). 1. From 3/30/26 to 3/31/26, Surveyor reviewed R1's medical record. R1 had diagnoses including cerebral vascular accident and hemiplegia. R1's Minimum Data Set (MDS) assessment, dated 2/9/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1's cognition was intact. On 3/30/26 at 10:36 AM, Surveyor interviewed R1 who stated R1 had a fall which caused a rug burn on R1's right knee. R1 pulled up R1's skirt and showed Surveyor the wound. Surveyor observed a circular wound in the center of R1's knee with a reddened peri wound. The center of the wound was yellow in color with visible depth and contained red lines that crossed the front of the knee. R1 stated staff looked at the wound when R1 fell but didn't do anything afterward. R1 indicated R1 wanted staff (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 Eastview Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 729 Park St Antigo, WI 54409	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to look at the wound and do something about the wound. Weekly skin assessments for R1 on 2/10/26, 2/15/26, and 2/22/26 identified 2 scabs on top of the scalp that were self-inflicted. Weekly skin assessments for R1 on 3/1/26, 3/8/26, 3/15/26, 3/22/26, and 3/29/26 indicated R1's skin was intact. There was no indication of a right knee abrasion. A fall report on 2/26/26 indicated a right front knee abrasion was observed at the time of the incident. On 3/30/26 at 1:42 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who indicated R1 did not have any wounds or abrasions. LPN-E indicated if a resident had a wound or abrasion, the area would be documented and monitored even if there was no treatment. LPN-E verified R1's medical record did not contain documentation or monitoring for a right knee wound. LPN-E stated LPN-E would observe R1's right knee for a wound. On 3/30/26 at 2:00 PM, Surveyor interviewed Director of Nursing (DON)-B who was not aware R1 had a wound. DON-B reviewed R1's progress notes and stated there was no indication R1 had any wounds. On 3/30/26 at 3:10 PM, Surveyor again interviewed LPN-E who stated R1's right knee wound was related to a fall on 2/26/26 and was previously documented. LPN-E indicated the wound looked newer and stated R1 informed LPN-E that R1 was picking at the wound. LPN-E indicated the plan was to keep the wound open to air and monitor. On 3/31/26 at 11:16 AM, Surveyor interviewed Registered Nurse (RN)-G who indicated if a wound or bruise is identified, nurses monitor the area. RN-G indicated R1 did not have any wounds. RN-G reviewed R1's Medication Administration Record (MAR) and Treatment Administration Record (TAR) and indicated if R1 had a wound, the wound would be on the MAR or TAR for the nurses to monitor until the wound was healed. When Surveyor asked about R1's right knee wound, RN-G indicated RN-G was told in morning report that R1 picked at a scab. RN-G indicated R1's right knee wound should be monitored. On 3/31/26 at 11:21 AM, Surveyor interviewed R1 who confirmed R1 picked at R1's right knee wound. On 3/31/26 at 1:25 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-F who stated if CNA-F observes a new wound or bruise on a resident or observes a change in an existing wound or bruise, CNA-F informs the nurse. CNA-F did not indicate CNA-F actively observes wounds for changes. On 3/31/26 at 2:21 PM, Surveyor interviewed DON-B who indicated nurses are not expected to monitor R1's right knee wound because CNAs observe wounds and update the nurses with changes. DON-B was unsure if R1's wound was larger or smaller than when it was first identified and was not sure if there were any changes to the wound bed. On 3/31/26 at 2:21 PM, Nursing Home Administrator (NHA)-A indicated CNAs are well trained and know to update the nurse if there are any changes in a resident's wound, including R1's right knee wound. NHA-A indicated CNAs observe residents' skin daily with dressing/undressing and bathing. 2. From 3/30/26 to 3/31/26, Surveyor reviewed R2's medical record. R2 was admitted to the facility 11/18/25 and had diagnoses including heart failure and muscle weakness. R2's MDS assessment, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 11/24/25, had a BIMS score of 12 out of 15 which indicated R2's cognition was moderately impaired. R2's care plan indicated R2 had potential/actual impairment to skin integrity related to incontinence, anemia, coronary artery disease, and chronic obstructive pulmonary disease. On 3/30/26 at 1:30 PM, Surveyor interviewed CNA-F who indicated R2 had a scar on the left back that was previously a bruise. CNA-F stated the impaired skin was weeping previous to scar formation and CNA-F reported the impaired skin to the nurse which is CNA-F's usual practice. CNA-F could not recall the nurse's name. CNA-F stated after CNA-F informs the nurse of a skin change, it is the nurse's responsibility to document the change and determine treatment. An Unwitnessed Fall Document, dated 1/14/26 at 11:30 AM, included a summary of an unwitnessed fall that occurred in R2's room. R2 was found on the floor next to wheelchair. The document indicated there were no injuries at the time of the incident and no injuries observed post-incident. A progress note, dated 1/18/26 at 1:40 PM, indicated R2 had a faded bruised area on the left back rib cage with a scant amount of blood related to a recent fall. There was no further documentation of the area in R2's medical record. R2's Weekly Skin Check assessment forms indicated the following: ~11/19/25 at 9:00 AM: Skin Condition: intact, dry and fragile, no open areas ~11/25/25 at 10:00 PM: Right knee (front) scab present on admission; Back of head - bump; Skin Condition: intact, dry and fragile, abrasion/bruise; no open areas ~ 12/2/25 at 12:42 PM (effective date): Right knee (front) scab present on admission; Back of head - bump; Skin Condition: intact, dry and fragile, abrasion/bruise; no open areas ~ 12/9/25 at 12:42 PM (effective date): Skin Condition: intact, dry and fragile; no open areas ~ 12/16/25 at 12:41 PM (effective date): Skin Condition: intact, dry and fragile, abrasion/bruise; no open areas ~ 12/23/25 at 3:00 PM: Top of scalp purple bruise post fall injury; Skin Condition: intact, dry and fragile, abrasion/bruise; no open areas ~ 1/4/26 at 6:00 PM: Skin Condition: intact, dry and fragile; no open areas ~ 1/8/26 at 8:00 PM: Groin redness/rash; Skin Condition: intact, dry and fragile, rash; no open areas ~ 1/19/26 at 12:00 AM: Skin Condition: intact; Open Area not marked yes or no ~ 1/26/26 at 12:40 PM (effective date): Skin Condition: intact; no open areas ~ 2/3/26 at 4:00 PM: Skin Condition: intact; no open areas ~ 2/9/26 at 4:00 PM: Skin Condition: intact, dry and fragile; no open areas (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, staff interview, and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible for 2 residents (R) (R1 and R6) of 7 sampled residents.R1's care plan contained an intervention for the assistance of 2 staff and a manual stand assist lift for transfers. On 2/15/26, Registered Nurse (RN)-C transferred R1 without a second person which resulted in a fall.R6's care plan contained an intervention to use a pivot disc with transfers. On 3/31/26, Certified Nursing Assistant (CNA)-F transferred R6 with a Lumex (manual stand assist lift). R6 used a Lumex to transfer in the past but was not re-assessed for use of the lift. In addition, R6's care plan was not revised to reflect R6's current transfer status.Findings include:The facility's Fall Prevention Program policy, revised 10/1/25, indicates: Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care .The plan of care and Kardex will be revised as needed.The facility's Accidents and Supervision policy, last revised 10/8/24, indicates: Implementation of interventions using specific interventions to try to reduce a resident's risk from hazards in the environment .Documenting interventions (e.g., plans of action developed through the QAA Committee or care plans for the individual resident) .Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of Supervision: .b. Based on the individual resident's assessed needs and identified hazards in the resident environment.The facility's Comprehensive Care Plans policy, revised 5/1/25, indicates: It is the guideline 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 .The comprehensive care plan will be reviewed and revised by the Interdisciplinary Team after each Comprehensive and Quarterly Minimum Data Set (MDS) assessment.1. From 3/30/26 to 3/31/26, Surveyor reviewed R1's medical record. R1 had diagnoses including cerebral vascular accident and hemiplegia. R1's Minimum Data Set (MDS) assessment, dated 2/9/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition.A fall report, dated 2/15/26, indicated R1 was lowered to the ground during a transfer from chair to shower chair using a Lumex because R1 couldn't stand anymore.On 3/31/26 at 9:45 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated it appeared only one staff (RN-C) assisted R1 during the transfer on 2/15/26 when R1 fell. DON-B reviewed R1's Activities of Daily Living (ADL) self-care performance care plan (dated 2/11/26) that indicated R1 transferred with a Lumex and two staff. DON-B indicated there should have been two staff assisting with R1's transfer on 2/15/26.On 3/31/26 at 10:49 AM, Surveyor interviewed RN-C who verified RN-C transferred R1 without a second staff on 2/15/26 when R1 fell. RN-C stated RN-C thought R1 required the assistance of one staff for transfers and was in error if the care plan indicated otherwise.2. From 3/30/26 to 3/31/26, Surveyor reviewed R6's medical record. R6 had diagnoses including multiple sclerosis and cerebral vascular accident. R6's MDS assessment, dated 1/4/26, had a BIMS score of 7 out of 15 which indicated R6 had severely impaired cognition.R6's ADL self-care performance care plan, dated 2/11/26, indicated R6 transferred with a pivot disc and 1 staff.On 3/31/26 at 7:45 AM, Surveyor observed CNA-F transfer R6 from bed to wheelchair with a Lumex. R6 followed CNA-F's verbal cues to successfully transfer from bed to wheelchair.On 3/31/26 at 11:00 AM, Surveyor interviewed DON-B who indicated staff had used the Lumex with R6 for 4 years. DON-B reviewed R6's care plan and verified the care plan indicated R6 transferred with a pivot disc and the assistance of 1 staff. DON-B verified the care plan was incorrect. DON-B stated R6 received a new custom-fit wheelchair and had to use a pivot disc for transfers due to the size of the wheelchair. DON-B indicated R6 had since received a second wheelchair which allowed for use of the Lumex. DON-B could not find therapy notes that indicated R6 was re-assessed for use of the Lumex with (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfers.On 3/31/26 at 12:15 PM, Surveyor interviewed Physical Therapy Assistant (PTA)-I who was not sure how R6 transferred and did not have access to therapy notes.On 3/31/26 at 12:18 PM, Nursing Home Administrator (NHA)-A provided physical therapy notes (dated 12/2/25) that indicated a pivot disc for transfers would be trialed on 12/2/25 related to a feature on R6's custom fit wheelchair that did not allow the Lumex to fit under the wheelchair for toilet transfers. Therapy notes (dated 12/2/25) indicated prior to trial of the pivot disc, R6 used a Lumex to transfer to the toilet. Discharge recommendations on 12/11/25 indicated to continue with the pivot disc for toilet transfers.

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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. Based on observation, staff interview and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 1 resident (R) (R3) of 1 sampled resident.R3 was on enhanced barrier precautions (EBP) due to carbapenem-resistant Pseudomonas aeruginosa (CRPA) colonization. Certified Nursing Assistant (CNA)-D and Nursing Home Administrator (NHA)-A did not wear a gown or gloves while transferring R3 from bed to wheelchair with a mechanical lift.Findings include:The facility's Enhanced Barrier Precautions policy, revised 9/9/25, indicates: EBP refer to an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high-contact resident care activities .High-contact resident care activities include: a. dressing; b. bathing; c. transferring; d. providing hygiene; e. changing linens .EBP should be followed outside the resident's room when performing transfers .examples of MDROs targeted by the Centers for Disease Control and Prevention (CDC) include: .c. carbapenemase-producing carbapenem-resistant Pseudomonas aeruginosa .From 3/30/26 to 3/31/26, Surveyor reviewed R3's medical record. R3 had a diagnosis of stroke with hemiplegia. R3's Minimum Data Set (MDS) assessment, dated 2/20/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R3's cognition was intact.A care plan, dated 2/18/26, indicated R3 had CRPA colonization. The care plan contained an intervention to observe EBP for infection control.On 3/30/26 at 1:17 PM, Surveyor observed an EBP sign on R3's door and a personal protective equipment (PPE) next to R3's room. Surveyor observed CNA-D enter R3's room without donning a gown or gloves and attach a lift sling to a mechanical lift. NHA-A then entered the room without donning a gown or gloves. NHA-A operated the mechanical lift while CNA-D held onto R3 in the sling to maneuver R3 toward a wheelchair. NHA-A held R3's leg to prevent it from hitting the lift while CNA-D positioned the wheelchair underneath R3. CNA-D guided R3 into the wheelchair while NHA-A operated the lift. NHA-A sanitized the lift while CNA-D gave R3 a hat and made R3's bed. NHA-A wheeled the lift out of the room.On 3/30/26 at 1:27 PM, Surveyor interviewed NHA-A who indicated neither NHA-A or CNA-D needed to observe EBP during the transfer because NHA-A and CNA-D did not provide direct care to R3.On 3/30/26 at 1:30 PM, Surveyor interviewed CNA-D who indicated CNA-D did not need to wear a gown or gloves during the transfer because CNA-D did not provide direct care to R3.On 3/30/26 at 2:00 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated DON-B was told EBP was only required for direct care of residents which did not include transfers.