STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not ensure a written transfer notice was provided for 1 resident (R) (R52) of 1 resident reviewed for hospitalization . R52 was transferred to the hospital on 11/5/24. Neither R52 or R52's emergency contact were provided with a written transfer notice. Findings include: The facility did not provide a policy related to transfer/discharge notices. Between 1/26/25 and 1/28/25, Surveyor reviewed R52's medical record. R52 was admitted to the facility on [DATE] and had diagnoses including fracture of unspecified part of neck of femur, type 2 diabetes, protein-calorie malnutrition, and traumatic ischemia of muscle. R52's Minimum Data Set (MDS) assessment, dated 9/22/24, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R52's cognition was moderately impaired. R52's medical record indicated R52 made R52's own healthcare decisions. R52's medical record indicated R52 was hospitalized on [DATE] for a left hip fracture. R52's medical record did not indicate that R52 or R52's emergency contact were provided with a written transfer notice. On 1/28/25 at 4:36 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated the facility provides bed hold notices for residents, but does not provide transfer notices.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51043 Based on staff interview and record review, the facility did not ensure 1 resident (R) (R42) of 2 residents received a bed hold notice when leaving the facility for therapeutic leave. R42 left the facility for therapeutic leave approximately every other week from October 2024 to January 2025. R42 did not receive bed hold notices prior to leaving the facility for therpeutic leave. Findings include: The facility's Therapeutic Leave policy, dated 11/22/23, indicates: .2. The facility will provide the resident and/or representative written information about a bed hold prior to or upon notice of the transfer as per the bed hold policy . From 1/26/25 to 1/28/25, Surveyor reviewed R42's medical record. R42 was admitted to the facility on [DATE] and had diagnoses including septicemia, paraplegia, anxiety, depression, and post-traumatic stress disorder. R42 had an indwelling urinary catheter, a wound vacuum-assisted closure, and a peripherally inserted central catheter line. R42's Minimum Data Set (MDS) assessment, dated 9/23/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R42's cognition was intact. R42's medical record and the facility census indicated R42 had 2 hospital overnight stays, 1 hospitalization , and 4 therapeutic leaves from the facility. According to the facility's census, R42 left the faciity on [DATE], 11/8/24, 11/15/24, 11/29/24, 12/27/24, 1/10/25, and 1/24/25. Surveyor reviewed the MDS list which did not show discharges, entries, or changes in condition to verify the census. R42's medical record did not indicate bed hold notices were provided when R42 left the facility On 1/28/25 at 12:44 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R42 did not have any hospitalization s since R42 was admitted to the facility. DON-B indicated the census was incorrectly documented because R42 had only left the faciity on therapeutic leave. DON-B indicated DON-B did not provide a written bed hold notice to R42 for any of the therapeutic leaves and did not know a therapeutic leave required a bed hold notice since R42 was expected to return to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on observation, staff and resident interview, and record review, the facility did not ensure the appropriate care and treatment for a pressure injury was provided for 1 resident (R) (R207) of 24 sampled residents. R207 was admitted to the facility with a pressure injury on the buttock. The facility did not complete accurate weekly wound assessments or include the pressure injury diagnosis on R207's Minimum Data Set (MDS) assessment and diagnoses list. Findings include: The facility's Wound Care Policy, revised on 2/3/21, indicates: .3. Upon the development of a wound, the wound assessment will be documented on the Initial Wound Assessment Form 7. Any skin impairments, including pressure ulcer wounds, surgical wounds, skin tears, abrasions, etc., should be assessed and documented weekly by the Wound Nurse, or designee, on the Weekly Wound Assessment. From 1/26/25 to 1/28/25, Surveyor reviewed R207's medical record. R207 was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes mellitus with neuropathy, congestive heart failure, chronic respiratory failure with hypoxia, and depression. An initial MDS assessment that was still in progress indicated R207 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 (completed on 1/16/25) which indicated R207 had moderate cognitive impairment. Hospital discharge paperwork, dated 1/15/25, indicated R207 had an active pressure ulcer on the buttock. The paperwork contained an order for Silver Sulfadiazine 1% cream apply twice daily (BID) to open area on buttocks until healed. R207's care plan (initiated on 1/16/25) indicated R207 had potential/actual impairment to skin integrity related to psoriasis, peripheral neuropathy, diabetes mellitus, and history of a pressure ulcer. The care plan contained interventions for a pressure reducing cushion to protect the skin while up in wheelchair, a pressure reducing mattress, and assist to turn and reposition every 2 to 3 hours. R207's January 2025 medication administration record (MAR) contained an order for Silver Sulfadiazine External Cream 1% apply to buttocks topically every morning and at bedtime for open areas (initiated 1/15/25). Surveyor noted the treatment was consistently initialed as administered. An initial admission head-to-toe evaluation skin assessment, dated 1/16/25 and completed by Licensed Practical Nurse (LPN)-R, indicated R207 did not have any skin alterations. A weekly skin assessment, dated 1/18/25 and completed by LPN-S, indicated R207 did not have any skin alterations. Surveyor noted R207's diagnoses list did not contain any open wounds or pressure injuries. Surveyor also noted R207 was not on enhanced barrier precautions (EBP). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/26/25 at 2:09 PM, Surveyor interviewed R207 who indicated R207 had an open sore on the buttocks. R207 stated the wound was painful and staff addressed it daily. On 1/27/25 at 2:48 PM, Surveyor interviewed R207 who was sitting in a recliner and indicated R207 was not offered a cushion in R207's recliner but would like one because R207's wound was painful. On 1/27/25 at 3:37 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R207 was recently admitted to the facility and had an open buttock wound that was present upon admission. DON-B indicated DON-B was behind in charting and R207's wound assessments were not entered yet. DON-B indicated R207's wound diagnosis should be indicated on R207's diagnoses list and MDS assessment. DON-B also indicated R207 should be on EBP for an open wound. When Surveyor asked DON-B why R207 did not have a pressure relieving cushion in R207's recliner, DON-B stated DON-B asked R207 yesterday if R207 wanted one and R207 said no. DON-B indicated DON-B felt R207's wound was moisture-associated and not a pressure injury. DON-B indicated DON-B should have followed up with R207's hospital discharge paperwork and wound diagnosis. DON-B indicated DON-B would provide Surveyor with R207's wound assessments. On 1/27/25 at 3:56 PM, Surveyor interviewed Registered Nurse Manager (RNM)-C who indicated R207 should be on EBP for an open wound and R207's wound diagnosis should be included in R207's diagnoses list. RNM-C printed two wound assessments for R207, including an initial assessment from 1/16/25 and a weekly wound assessment from 1/18/25. RNM-C indicated the assessments were incorrect because each of them indicated R207 did not have an open wound. RNM-C indicated there was no way for staff to appropriately assess the size and condition of R207's wound, including if the wound was improving or worsening, if the assessments were not accurate. RNM-C provided a paper towel from RNM-C's office that listed R207's last name and an initial and indicated: Prox(imal) 1.0 x 1.0, Dist(al) 2.0 x 1.0, 100% gran(ulation), and hydrocolloid. RNM-C indicated the paper towel contained a recent assessment of R207's buttock wound completed by RNM-C and DON-B, however, the paper towel did not contain a date or time. RNM-C indicated the assessment should have been documented on a weekly wound assessment form in R207's medical record. When Surveyor asked RNM-C if R207 should have a pressure relieving cushion in R207's recliner, RNM-C stated R207 should have a cushion if there is an order for one. When Surveyor informed RNM-C that R207 complained of pain and asked Surveyor for a cushion, RNM-C stated RNM-C would get R207 a cushion right away. RNM-C also indicated R207 should be on EBP for the open wound which RNM-C would get started right away. On 1/27/25 at 4:40 PM, Surveyor interviewed DON-B who indicated DON-B wrote the wound assessment on the paper towel and confirmed it was not an appropriate way to document R207's wound assessment. DON-B confirmed weekly wound assessments should be completed on the appropriate form and be included in R207's medical record. DON-B indicated the initial assessment on 1/15/25 and weekly assessment on 1/18/25 were completed by agency staff. DON-B indicated DON-B should have looked at the assessments or had facility staff complete them. DON-B verified there was no way for staff to appropriately assess the size and condition of R207's wound, including whether the wound was improving or worsening, if the assessments were not accurate. DON-B indicated DON-B felt R207's wound looked the same since admission. On 1/28/25 at 10:05 AM, DON-B confirmed with Surveyor that R207 was offered two different pressure relieving cushions and R207 was now using a pressure relieving cushion in the recliner. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 1:26 PM, Surveyor interviewed MDS Coordinator (MDSC)-D who indicated MDSC-D used the facility's assessment (not the hospital discharge paperwork) to create MDS assessments for residents. MDSC-D stated because the initial skin assessment and weekly skin assessment indicated R207 did not have an open wound or pressure injury, there were none added to R207's MDS assessment or diagnoses list. MDSC-D indicated the facility should have a better process. On 1/28/25 at 2:25 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated R207 was admitted with other diagnoses and the wound care information was missed. NHA-A indicated R207's wound assessments should have been accurate and completed appropriately to ensure proper care and follow-up. NHA-A indicated R207 should have been on EBP and indicated the wound should be on R207's diagnoses list.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45943 Based on observation, staff and resident interview, and record review, the facility did not provide appropriate care and services for 1 resident (R) (R19) of 1 sampled resident with an indwelling catheter. On 1/27/25, R19 had dark cherry-colored urine and R19's catheter was flushed without a physician's order. R19's care plan did not include an intervention to flush the catheter. In addition, a description of R19's urine was not documented even though R19's care plan contained an intervention to monitor/record/report blood-tinged urine. Findings include: The National Institute of Health (NIH) National Institute of Diabetes and Digestive Kidney Disease (NIDDK) (12/21/22) indicates: Gross hematuria is when you can see the blood in your urine .Gross hematuria makes your urine look pink, red, or brown .Blood clots can be painful to pass during urination or can cause pain if the clots block the flow of urine. The National Institutes of Health (NIH) National Library of Medicine (5/21/20) states: Severe hematuria can lead to blood clot formation in the bladder cavity and consequent urinary retention. Patients may develop pain if the clots cannot be evacuated in a timely manner. Manual bladder washout using a Foley catheter and syringe is the most common method of removing such blood clots .When severe hematuria occurs, large numbers of blood clots accumulate in the bladder cavity, potentially leading to bladder tamponade and secondary acute urinary retention. Associated symptoms such as lower abdominal pain, restlessness, and elevated blood pressure may also occur. Bladder rupture can occur in rare cases .the blood clots are very adhesive in the early stage and catheters often become blocked .In general, manual bladder irrigation is a simple procedure involving the use of a syringe, a Foley catheter, and saline. From 1/26/25 to 1/28/25, Surveyor reviewed R19's medical record. R19 was admitted to the facility on [DATE] and had diagnoses including benign prostatic hypertrophy (BPH), urinary retention, iron deficiency anemia, and chronic kidney disease. R19's Minimum Data Set (MDS) assessment, dated 1/3/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R19 had intact cognition. R19 was R19's own decision maker. R19's medical record indicated R19 was admitted to the facility with a Foley catheter that was in place since 2018. R19 had two failed voiding trials. R19's care plan (dated 4/23/24) indicated R19 had an indwelling catheter, BPH with urinary retention, and neurogenic bladder. The care plan contained interventions to monitor/record/report to Medical Doctor (MD) for signs/symptoms of urinary tract infection (UTI), pain, burning, blood-tinged urine color, cloudiness, no output, and deepening of urine color. The care plan did not contain an intervention to flush the catheter if obstructed with clots. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A provider note, date 5/22/24, indicated R19 had multiple episodes of gross hematuria. R19's hemoglobin was 6.6 and dropped to 5.1. (A normal hemoglobin level for R19 based on gender and age is 13.6 to 17.7.) R19 agreed to a blood transfusion but refused a urology workup. A provider note, dated 6/11/24, indicated R19's hemoglobin went from 5.1 to 7.2 after the transfusion. R19 refused an anemia and hematuria workup. A hospital discharge summary, dated 12/11/24, indicated R19 had acute blood loss anemia. R19's hemoglobin was 4.2 and raised to 7.4 post transfusion. R19 declined a further workup including an esophagogastroduodenoscopy (EGD)/colonoscopy. On 1/26/25 at 11:20 AM, Surveyor observed R19 and noted R19's catheter tubing and drainage bag contained light pink urine. R19 stated R19 occasionally pulled on the catheter but had no discomfort. On 1/27/25 at 10:41, AM, Surveyor interviewed Certified Nursing Assistant (CNA)-J who indicated R19 had clots in the catheter tubing on the previous night (NOC) shift and the catheter had to be flushed. CNA-J indicated R19's urine was often light cherry-colored because R19 pulled on the catheter. CNA-J also indicated R19's catheter support strap was often readjusted and the cherry color of R19's urine came and went. Surveyor noted there was no documentation in R19's medical record that indicated R19's urine was light pink in color or that R19's catheter was flushed on the 1/27/25 NOC shift. On 1/27/25 at 10:52 AM , Surveyor noted R19's catheter tubing and catheter bag contained dark cherry-colored urine. On 1/27/15 at 10:53 AM, Surveyor interviewed LPN-F who indicated R19's catheter had been flushed twice that day due to clots which caused poor drainage. LPN-F indicated LPN-Q had flushed R19's catheter on the NOC shift and LPN-F had flushed R19's catheter with 10 cubic centimeters (ccs) of normal saline. LPN-F indicated R19's urine started flowing quickly afterward. LPN-F indicated R19's urine was routinely light pink in color since R19 pulled on the catheter tubing. LPN-F verified the tubing was well anchored to R19's left thigh and there was approximately 600 ccs of dark cherry-colored urine in R19's catheter bag. LPN-F indicated LPN-F notified R19's physician. When Surveyor asked LPN-F to review R19's catheter care orders, LPN-F verified R19 did not have an order to flush the catheter. LPN-F also verified R19's medical record did not indicate LPN-Q observed clots in R19's urine, that R19's urine was discolored, or that R19's catheter was flushed. LPN-F received a phone order at 1:39 PM on 1/27/25 that indicated: May flush catheter with (10-20 cc) saline as needed every 4 hours as needed for catheter care. On 1/28/25 at 8:06 AM, Surveyor interviewed Director of Nursing (DON)-B who verified there should have been an order to flush R19's catheter before the intervention was performed. DON-B could not verify whether or not R19's catheter was flushed prior to 1/27/25. DON-B also verified R19's care plan did not contain an intervention (prior to 1/27/25) to flush the catheter if the catheter became obstructed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 11:37 AM, Surveyor again interviewed DON-B. When asked if staff documented R19's urine color daily, DON-B stated stated documented volume but not color. DON-B indicated the CNAs were good at reporting urine color. When asked what staff should do if R19's urine is light pink or dark cherry-colored, DON-B indicated abnormal urine color should be reported and documented and there should follow through. DON-B indicated the facility did not have standing orders for flushing catheters.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff and resident interview and record review, the facility did not ensure 1 resident (R) (R43) of 4 sampled residents received the necessary care and services to monitor weight loss. R43 had an unplanned weight loss of 15.72% between 9/13/24 and 1/1/25 with a 5.26% weight loss between 12/9/24 and 1/1/25. R43's medical record did not contain a current order for weight monitoring. In addition, staff did not monitor R43's weight per the facility's policy. Findings include: The facility's undated Weight Monitoring policy indicates: Based on the resident's comprehensive assessment, the facility will ensure all residents maintain acceptable parameters of nutritional status, such as body weight or desirable weight range .unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise .5. A weight monitoring schedule will be developed upon admission for all residents .c. Residents with weight loss, monitor weight weekly. d. If clinically indicated, monitor weight daily .6. Weight analysis: The newly recorded resident weight should be compared to the previous recorded weight. A significant change in weight is defined as .a. 5% change in weight in 1 month (30 days). b. 7.5% change in weight in 3 months (90 days). c. 10% change in weight in 6 months (180 days). Between 1/26/25 and 1/28/25, Surveyor reviewed R43's medical record. R43 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side, cerebral infarction due to thrombosis of right middle cerebral artery, hyperlipidemia, and diverticulitis. R43's Minimum Data Set (MDS) assessment, dated 12/18/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R43 had intact cognition. R43's medical record indicated R43 was R43's own decision maker. R43 had an order for a gluten-free regular diet and a house supplement once daily. R43 had an order for weekly weights for 4 weeks that was discontinued on 12/9/24. R43's medical record did not include a current order for weight monitoring. R43's medical record indicated R43 had an unplanned weight loss of 15.72% between 9/13/24 and 1/1/25 with a 5.26% weight loss between 12/9/24 and 1/1/25. R43's medical record did not include any additional weights after 1/1/25. A nutritional note, dated 1/3/25, indicated R43 triggered for a significant weight loss of 5.3% in 30 days and 11.3% in 90 days likely due to poor intake. The note indicated R43 received a health shake three times daily and contained recommendations for a house supplement once daily to promote calorie intake and weight maintenance and continue to monitor. A nutritional note, dated 1/10/25, indicated the facility's dietitian met with R43 to review and encourage food and fluid intake and discuss food preferences. The note indicated to continue with R43's current plan of care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly nutritional assessment, dated 1/17/25, indicated R43's nutritional goal was to maintain adequate intake and weight with no signs or symptoms of malnutrition or dehydration. The assessment indicated to continue to monitor intakes, weight, and skin integrity. On 1/28/25 at 10:16 AM, Surveyor interviewed Registered Dietitian (RD)-L who confirmed R43 did not have a current order for weight monitoring. RD-L acknowledged more frequent weights should have been ordered for R43 following R43's significant weight loss in one month. In addition, RD-L confirmed R43 should have a more recent weight than 1/1/25. RD-L stated weekly weights for 4 weeks is typically what is ordered. On 1/28/25 at 10:27 AM, Surveyor interviewed R43 who was aware of the weight loss and indicated R43's goal was to put weight back on, but it had been difficult. R43 indicated R43 did not recall the last time R43 was weighed and was uncertain of R43's current weight. On 1/28/25 at 11:39 AM, Surveyor interviewed Director of Nursing (DON)-B who was aware R43 had weight loss and indicated R43's weight had stabilized. DON-B confirmed R43's 1/1/25 weight was R43's most recent weight. DON-B was unable to provide further information to confirm that R43's weight had stabilized since 1/1/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 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** 51043 Based on observation, staff interview, and record review, the facility did not ensure 1 resident (R) (R306) of 3 sampled residents received the appropriate respiratory care and services for a nebulizer treatment. On 1/26/25 and 1/27/25, R306 self-administered a nebulizer treatment (aerosolized breathing treatment) incorrectly. Findings include: The facility's Policy and Procedure Administering Medications, dated 1/1/14, indicates: .Medications may be self-administered by residents who have been assessed and determined to be safe and upon physician order. The facility's Policy and Procedure Nebulizer Use, dated 1/1/14, indicates: .5. Assist the resident to an upright position. 6. Auscultate the lung sounds. The facility's undated Validation Checklist Nebulizer Therapy indicates: .9. Instructed resident on how to use the nebulizer appropriately as needed. On 1/27/25, Surveyor reviewed R306's medical record. R306 was admitted to the facility on [DATE] and had diagnoses including dementia, chronic obstructive pulmonary disease (COPD), and hypertension. A Minimum Data Set (MDS) assessment was not completed due to R306's recent admission and a Brief Interview for Mental Status (BIMS) score (used to assess a resident's cognition) was not available. R306 had an activated Power of Attorney for Healthcare (POAHC) who made medical decisions for R306. On 1/26/25 at 1:34 PM, Surveyor observed R306 in bed at an approximate 45-degree angle with the mouthpiece of a nebulizer treatment hanging out of R306's mouth as R306 slept. Surveyor noted R306 was not fully inhaling the nebulizer treatment. R306 awoke, indicated R306 fell asleep, and attempted to readjust the mouthpiece. On 1/27/25 at 12:10 PM, Surveyor observed Licensed Practical Nurse (LPN)-F) set up and start R306's nebulizer treatment. LPN-F indicated the treatment would be done in 10 minutes. LPN-F exited the room and left R306 seated in a wheelchair with a bedside table in front of R306. Surveyor observed R306 for 25 minutes during the nebulizer treatment. R306 removed the nebulizer treatment from R306's mouth 20 times to talk to R306's roommate's visitor and repeatedly asked the visitor if the treatment was finished. Surveyor noted R306's call light was within reach and staff delivered R306's lunch tray at 12:12 PM. At 12:35 PM, R306 removed the nebulizer from R306's mouth and placed it on the bedside table with the treatment still running. R306 then attempted to eat pudding from R306's lunch tray, however, R306 was shaky and dropped the spoon. At 12:49 PM, Certified Nursing Assistant (CNA)-H entered the room, turned off the nebulizer treatment, and assisted R306 with lunch. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/25 at 12:57 PM, Surveyor interviewed LPN-F who indicated R306 could self-administer the nebulizer treatment. LPN-F indicated R306 knew to shut off the treatment when it was done and to turn on R306's call light so LPN-F could return and clean up. LPN-F indicated the nebulizer treatment took 10-15 minutes to complete and indicated CNA-H should not have shut off the treatment. On 1/27/25 at 1:37 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated a resident can self-administer a nebulizer treatment if a self-administration of medication evaluation is completed and indicates the resident can perform the task. DON-B indicated R306 was assessed and able to self-administer the nebulizer treatment and indicated a CNA can turn off a nebulizer treatment. DON-B indicated a nurse does not have to complete a respiratory assessment before or after a nebulizer treatment and stated the facility's policy and procedure is incorrect. DON-B indicated if a resident is not able to self-administer a nebulizer treatment, the nurse has to hold the nebulizer mouthpiece, remind the resident to keep the mouthpiece in their mouth, and keep the resident in eyeshot or use a mask with the treatment. DON-B indicated the nurse should check on the resident during the treatment as able. DON-B indicated R306's self-administration of medication evaluation should be re-evaluated. On 1/28/25 at 8:47 AM, Surveyor reviewed R306's self-administration of medication evaluations. The first evaluation, completed on 1/27/25 at 9:44 AM, indicated R306 could not correctly identify the names of medications, could not state the common side effects of each medication, could not state correct times when the medications should be taken, could not state the proper dosage of each medication, but could correctly administer nebulizer medication. (The evaluation was completed after Surveyor observed R306 self-administer a nebulizer treatment on 1/26/25.) A second evaluation, completed on 1/27/25 at 4:28 PM, indicated R306 could not correctly identify the names of medications, could not state the common side effects of each medication, could not state correct times when the medications should be taken, could not state the proper dosage of each medication, could not open and close medication containers or dispense medications from packages, could not correctly administer oral medications, and could not correctly administer inhaled medications, but could correctly administer nebulizer medication. A physician's order for self-administration of nebulizer treatments was obtained upon admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49010 Based on observation, staff and resident interview, and record review, the facility did not ensure safe and accurate administration of medication for 4 residents (R) (R15, R6, R12 and R7) of 24 sampled residents. On 1/26/25 and 1/27/25, medication was left at R15's bedside. R15 did not have a self-administration of medication assessment or a physician's order to self-administer the medication. In addition, medication and treatments were signed out as administered on 1/27/25 but were not completed. On 1/26/25, medication was left at the bedside of R6, R12, and R7. R6, R12, and R7 did not have self-administration of medication assessments or physician orders to self-administer the medication. Findings include: The facility's Administering Medications policy, revised 1/1/14, indicates: .1. Only licensed staff, or permitted by the State may prepare, administer, or record the administration of medication .4. Medications may be self-administered by residents who have been assessed and determined to be safe and upon physician's order .6. Medications should be administered within one hour of the prescribed times .9. Should a drug be withheld, refused, or given other than at the scheduled time, the individual administering the medications shall initial and circle the Medication Administration Record (MAR) space provided for that particular drug and document a rationale. 1. On 1/26/25, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD) with acute exacerbation, acute and chronic respiratory failure with hypoxia, type 2 diabetes with diabetic neuropathy, and anxiety. R15's Minimum Data Set (MDS) assessment, dated 11/28/24, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R15 had intact cognition. On 1/26/25 at 1:32 PM, Surveyor interviewed R15 who indicated R15 had a rash under R15's breasts and was supposed to receive medication daily. R15 indicated R15 had not received the prescribed medication that day or recently and had put powder on R15's breasts. R15 also indicated R15 was supposed to have pillowcases under R15's breasts, however, R15 was not given any pillow cases by staff. R15 showed Surveyor a bottle of miconazole nitrate 2% powder on R15's bedside table and the area under R15's breasts. The area appeared inflamed, raised, and wine-colored and contained caked powder. R15 indicated R15 had a similar rash in R15's groin. Surveyor also noted R15 did not have pillowcases to put under R15's breasts. R15's medical record contained the following orders: ~ Cleanse under bilateral breasts with soap and water, pat dry, then wash with 50/50 of vinegar and normal saline, pat dry, apply mix of hydrophilic paste and miconazole 2% to affected areas, apply pillowcase under for barrier. Two times daily for redness (dated 1/16/25). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ Nystatin powder apply to affected areas topically two times a day for yeast infection (dated 11/22/24). - R15's medical record did not contain a diagnosis regarding the ongoing rash/fungal yeast issue and did not contain a physician's order for self-administration of the above treatments/medications (hydrophilic paste, miconazole 2%, nystatin, vinegar/saline mix). On 1/27/25 at 10:08 AM, Surveyor interviewed R15 who indicated R15 had not received any medication for the reddened area under R15's breasts yet. R15 indicated staff had not done the treatment since Surveyor and R15 had spoken the day before. R15 once again showed Surveyor the container of miconazole nitrate 2% powder and showed Surveyor the reddened, raised area under R15's breasts. The area appeared inflamed, raised, and red and contained caked white powder. R15 indicated the powder was miconazole powder that R15 applied. Surveyor noted there were no pillowcases present. R15 indicated staff do not wash the area under R15's breasts daily, do not apply the medications, do not mention the rash, and do not bring R15 water so R15 can wash the area. R15 indicated R15 would like staff to wash the area daily and apply the medication, however, R15 continues to apply miconazole powder by R15's self. R15 indicated Hospice staff cleanse the area, apply the medications, and give R15 clean pillowcases as a moisture barrier on Thursdays when they assist with R15's shower. On 1/27/25 at 10:20 AM, Surveyor reviewed R15's medication administration record (MAR) and noted the treatment was documented as administered twice daily since 1/17/25. Surveyor noted Licensed Practical Nurse (LPN)-G documented that the treatment was administered on the morning of 1/27/25. On 1/27/25 at 10:22 AM, Surveyor observed LPN-G speak with residents and staff by the front desk and then put on a jacket and leave the area. On 1/27/25 at 10:45 AM, Surveyor interviewed LPN-G who confirmed LPN-G had just returned from break. LPN-G indicated LPN-G signed out the treatment for R15's breast area that morning but did not administer the treatment because LPN-G got distracted. LPN-G indicated LPN-G was not aware of any medication left at R15's bedside. LPN-G stated R15 should not complete R15's own treatment for the rash and indicated R15 was not assessed as able to self-administer the medications. When asked to locate the medications for the treatment including the vinegar, LPN-G searched the treatment cart but was unable to find the items needed for the treatment. LPN-G indicated the vinegar was in a 16 ounce plastic bottle. On 1/27/25 at 11:08 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated R15 should not have miconazole nitrate 2% at the bedside. DON-B indicated R15 was not assessed as able to self-administer medications or treatments related to R15's rash. DON-B indicated DON-B expects staff to complete and accurately document physician orders for treatments. DON-B indicated staff should not sign out treatments as completed if they are not completed. On 1/27/25 at 11:29 AM, LPN-G brought a 128 ounce container approximately 1/8 full of vinegar as well as hydrophilic paste, miconazole 2%, nystatin, and vinegar/saline mix to Surveyor. LPN-G indicated LPN-G did not know where the small bottles of vinegar that staff usually used were but stated LPN-G would keep looking. LPN-G did not return with any other items. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/28/25 at 2:25 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed a resident should have an order to keep medication at the beside. NHA-A indicated residents who wish to self-administer medications and treatments need to have an assessment in order to do so. NHA-A indicated staff should follow medication and treatment orders as written by the physician. NHA-A indicated if staff are unable to administer medication when they sign it out, they should go back and immediately correct the documentation to reflect that the medication or treatment was not administered. 51043 2. From 1/26/25 to 1/28/25, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including multiple sclerosis, aphasia, dysphagia, cerebral vascular disease, and depression. R6's MDS assessment, dated 1/1/25, had a BIMS score of 9 out of 15 which indicated R6 had moderately impaired cognition. R6's medical record contained legal Guardianship documentation that indicated R6's Guardian was responsible for R6's medical decisions. R6's medical record did not contain an order for medication to be left at the bedside or a self-administration of medication assessment. On 1/26/25 at 9:23 AM, Surveyor observed medication administration for R6 who was in a common area in the facility. In addition to other oral medication, Licensed Practical Nurse (LPN)-M administered polyethylene glycol (used to prevent and treat constipation) 17 grams mixed with 6 ounces of thickened water. LPN-M observed R6 swallow pills and then initialed R6's MAR that all medications had been administered. LPN-M left the polyethylene glycol on R6's wheelchair tray and began medication administration for another resident. On 1/26/25 at 11:20 AM, Surveyor noted R6 was no longer in the common area. Surveyor was unable to determine if R6 finished the polyethylene glycol. On 1/27/25 at 1:53 PM, Surveyor interviewed DON-B who indicated polyethylene glycol should not have been left with R6 because a self-administration of medication assessment was not completed and R6 did not have an order to self-administer medication. 3. From 1/26/25 to 1/28/25, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] and had diagnoses including dementia, hallucinations, and age-related cataracts of the right and left eyes. R12's MDS assessment, dated 12/16/24, had a BIMS score of 10 out of 15 which indicated R12 had moderately impaired cognition. R12's medical record indicated R12 had an activated Power of Attorney for Healthcare (POAHC) who was responsible for R12's medical decisions. R12's medical record did not contain an order for medication to be left at the bedside or a self-administration of medication assessment. R12 had an order to administer medication in applesauce. On 1/26/25 at approximately 9:40 AM, Surveyor observed medication administration for R12 who was in bed. Surveyor observed LPN-M raise the head of R12's bed and administer R12's medications individually in applesauce. LPN-M also provided polyethylene glycol 17 grams mixed with 6 ounces of water. LPN-M observed R12 swallow pills and then documented in R12's MAR that all medications were administered. LPN-M then lowered the head of R12's bed and left the polyethylene glycol on R12's bedside table. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/26/25 at 11:19 AM, Surveyor observed the cup of polyethylene glycol at R12's bedside and noted there was approximately a quarter of the medication still in the cup. On 1/27/25 at 1:53 PM, Surveyor interviewed DON-B who indicated polyethylene glycol should not have been left at R12's bedside because a self-administration of medication assessment was not completed and R12 did not have an order to self-administer medication. 4. From 1/26/25 to 1/28/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including fracture of right femur, anxiety, and malignant neoplasm of lymphoid (blood cancer). R7's MDS assessment, dated 12/16/24, had a BIMS score of 7 out of 15 which indicated R7 had severely impaired cognition. R7's medical record indicated R7 had an activated POAHC who was responsible for R7's medical decisions. R7's medical record did not contain an order for medication to be left at the bedside or a self-administration of medication assessment . On 1/26/25 at approximately 9:50 AM, Surveyor observed LPN-M administer medication to R7 who was in bed. LPN-M raised the head of R7's bed and administered R7's medications which included polyethylene glycol 17 grams mixed with 6 ounces of water. LPN-M observed R7 swallow pills, lowered the head of R7's bed, and encouraged R7 to sip the polyethylene glycol. LPN-M then documented in R7's MAR that all medications were administered and left the polyethylene glycol on R7's bedside table. On 1/26/25 at 11:19 AM, Surveyor observed the cup of polyethylene glycol at R7's bedside and noted there was approximately a quarter of the medication still in the cup. On 1/27/25 at 1:53 PM, Surveyor interviewed DON-B who indicated the polyethylene glycol should not have been left with R7 because a self-administration of medication assessment was not completed and R7 did not have an order to self-administer medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 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. 48794 Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to affect all 52 residents residing in the facility. Staff did not monitor or document cooked food temperatures. Staff did not test or document parts per million (PPM) of the quaternary sanitizing solution per manufacturer's instructions. Food items were not discarded when beyond their expiration or use-by dates and/or not stored in a manner to prevent cross-contamination. Staff did not complete appropriate hand hygiene during meal service. Cold food items were not maintained at a proper temperature during meal service. Findings include: On 1/26/25 at 11:40 AM, Surveyor interviewed Dietary Manager (DM)-N who stated the facility follows the State and Federal Food Codes. Food Temperatures: The 2022 Food and Drug Administration (FDA) Food Code documents at 3-401.11 Raw Animal Foods: Raw animal foods such as eggs, fish, meat, poultry, and foods containing these raw animal foods, shall be cooked to heat all parts of the food to a temperature and for a time that complies with one of the following methods based on the food that is being cooked. The 2022 FDA Food Code documents at 2-103.11 Person in Charge: The person in charge shall ensure that: (G) employees are properly cooking time/temperature control for safety food, being particularly careful in cooking those foods known to cause severe foodborne illness and death, such as eggs and comminuted meats, through daily oversight of employees' routine monitoring of the cooking temperatures using appropriate temperature measuring devices properly scaled and calibrated. The facility's Food Preparation and Storage policy, dated October 2021, indicates food and nutrition service employees shall prepare and serve food in a manner that complies with safe food handling practices .(7) The internal cooking temperatures/times for specific foods must be reached to kill or sufficiently inactivate pathogenic microorganisms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Meal Service-Temperatures policy, dated 2/23/17, indicates to ensure appropriate food temperatures during meal service .(1) The cook shall take temperatures of food (as appropriate) during meal preparation to ensure food is cooked or chilled to the appropriate temperature .(2) Temperatures shall be recorded on the Temperature Report Form or directly on a copy of the week-at-a-glance menu at each meal. On 1/26/25 at 11:40 AM, Surveyor completed an initial tour of the kitchen with DM-N. During the initial tour, DM-N confirmed kitchen staff complete one set of temperatures prior to meal service but do not consistently monitor or document cooking temperatures. DM-N stated DM-N became aware of the requirement last week while at a conference. DM-N stated DM-N was in the process of creating a procedure but had not done so yet. Sanitizing Bucket Logs: The 2022 FDA Food Code documents at 2-103.11 Person in Charge: The person in charge shall ensure that . (L) Employees are properly sanitizing cleaned multi-use equipment and utensils before they are reused, through routine monitoring of solution temperature and exposure time for hot water sanitizing, and chemical concentration, ph, temperature, and exposure time for chemical sanitizing. The 2022 FDA Food Code 2022 documents at 3-304.14 Wiping Cloths, Use Limitation: (B) Cloths in use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified. The 2022 FDA Food Code documents at 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration: Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. The facility did not provide a policy related to monitoring chemical sanitizing solutions. On 1/26/25 at 11:40 AM, Surveyor completed an initial tour of the kitchen with DM-N. During the initial tour, DM-N stated kitchen staff do not use test strips to test the sanitizing solution in the sanitizing buckets (per the manufacturer's instructions). DM-N stated DM-N became aware of the requirement last week while at a conference. DM-N stated DM-N was in the process of creating a procedure but had not done so yet. Food Labeling/Storage: The 2022 FDA Food Code documents at Manufacturer's Use-By Dates: The manufacturer's use-by date is its recommendation for using the product while its quality is at its best. Although it is a guide for quality, it could be based on food safety reasons. It is recommended that food establishments consider the manufacturer's information as good guidance to follow to maintain the quality (taste, smell, and appearance) and salability of the product. If the product becomes inferior quality-wise due to time in storage, it is possible that safety concerns are not far behind. The facility's Food Receiving and Storage policy, revised October 2022, indicates: Food shall be received and stored in a manner that complies with safe food handling practices .(7) Dry foods are stored in bins and removed from the original packaging, labeled, and dated (use by date) .(8) All foods in the refrigerator or freezer are covered, labeled, and dated (use-by date). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/26/25 at 11:40 AM, Surveyor completed an initial tour of the kitchen with DM-N. During the initial tour, Surveyor noted the following: Dry Storage: ~ An open, uncovered, and unsealed box of thickening powder that was exposed to air Refrigerator: ~ Two open containers of sour cream with open dates of 12/10/24 and manufacturer's use-by dates of 1/16/25 ~ Sixteen 1 quart containers of heavy cream with manufacturer's use-by dates of 1/11/25 During the observations, Surveyor interviewed DM-N who stated the facility does not use use-by dates unless they are manufacturer's use-by dates. DM-N indicated kitchen staff puts stickers on items when they come in and write the date on the item when it is opened. DM-N stated staff refer to the Food Storage and Retention Guide for use-by dates. DM-N indicated DM-N intended to throw out the heavy cream containers the previous day but forgot. DM-N removed the heavy cream and sour cream containers during the tour and instructed staff to discard them. On 1/26/25 at 11:40 AM, Surveyor reviewed the facility's undated Food Storage and Retention Guide that indicated sour cream should be stored in the refrigerator and discarded per the manufacture's use-by date. Surveyor noted heavy cream was not listed in the guide. Hand Hygiene: The 2022 FDA Food Code documents at 2-301.14 When to Wash: Employees shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms .(D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue .(E) After handling soiled equipment or utensils; (F) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; .(H) Before donning gloves to initiate a task that involves working with food; and (I) After engaging in other activities that contaminate the hands. The facility's Food Preparation and Service policy, revised October 2021, indicates food and nutrition service employees shall prepare and serve food in a manner that complies with safe food handling practices .(22) Bare hand contact with food is prohibited. Gloves must be worn when handling food directly, however, gloves can also become contaminated and/or soiled and must be changed between tasks. Disposable gloves are single-use items and shall be discarded after each use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/27/25 at 11:33 AM, Surveyor observed [NAME] (CK)-O complete lunch tray line service in the main kitchen. While CK-O served food with gloved hands, Surveyor observed CK-O touch the handles of food utensils, the top of a tray cart, and a countertop. With the same gloved hands, Surveyor also observed CK-O touch ready-to-eat buns on 18 occasions. CK-O also pulled up the waistband of CK-O's pants and touched 4 buns with the same gloved hands. CK-O then asked DM-N for a towel to wipe a food substance off the thumb of CK-O's glove. DM-N provided CK-O with a paper towel. CK-O wipe food debris from CK-O's gloved thumb and continued to serve buns on 7 trays. Surveyor did not observe CK-O change gloves or complete hand hygiene during meal service. Also during lunch service, Surveyor observed Dietary Aide (DA)-P provide tray line assistance with gloved hands and noted DA-P touched the nose/brim of DA-P's glasses and mouth. DA-P then touched trays and residents' plates without completing hand hygiene. DA-P also put carrots from a resident's plate back in a steam table container with DA-P's gloved hand. Without completing hand hygiene, DA-P removed the glove and donned a clean glove. Surveyor also observed DA-P run DA-P's gloved hands along the wheels of the tray line conveyor and then touch buns, plates, and utensils on residents' trays without completing hand hygiene. On 1/28/25 at 2:01 PM, Surveyor reviewed the above concerns with DM-N who verified Surveyor's observations and concerns. Cold Food Temperatures: The 2022 FDA Food code documents at 3-501.16 Time/Temperature Control for Safety Food, for Hot and Cold Holding: Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature danger zone of 41 degrees Fahrenheit (F) to 135 degrees F too long. Up to a point, the rate of growth increases with an increase in temperature within this zone. Beyond the upper limit of the optimal temperature range for a particular organism, the rate of growth decreases. Operations requiring heating or cooling of food should be performed as rapidly as possible to avoid the possibility of bacterial growth (A) Except during preparation, cooking, or cooling, or when time is used as the public health control . (1) At 135 degrees F or above or (2) At 41 degrees F or less. The facility's Food Preparation and Service policy, revised October 2021, indicates food and nutrition service employees shall prepare and serve food in a manner that complies with safe food handling practices .Food Preparation, Cooking and Holding Temperatures and Times: (1) The danger zone for food temperatures is between 41 degrees F and 135 degrees F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. (2) Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt and cheese. (3) The longer foods remain in the danger zone the greater the risk for growth of harmful pathogens. On 1/27/25 at 11:33 AM, Surveyor observed lunch service. Upon entering the kitchen, Surveyor observed butterscotch pudding with whipped topping stacked in a meal cart ready for service. Surveyor noted the holding temperature was 54.1 degrees F at the beginning of tray line service. Surveyor requested DM-N recheck the temperature at the end of service which was 60.8 degrees F at 12:43 PM. DM-N acknowledged the temperature should be at 41 degrees F or less. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Following the observation, Surveyor observed the ingredients on a can of [NAME] Creek Butterscotch Pudding which included skim milk. Information on the can stated to refrigerate the contents in a separate container after opening. Surveyor also observed the ingredients on a container of Rich's On Top Whipped Topping which included cream and skim milk. The package indicated the product was perishable and to keep refrigerated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51043 Based on staff interview and record review, the facility did not ensure 1 resident (R) (R37) of 1 sampled resident had an accurate and complete medical record. R37's pre and post-dialysis communication forms were not retained in R37's medical record. Findings include: The facility's undated Medical Record Release Policies and Procedures indicate: .Results of initial and subsequent health assessments or medical examinations .Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment . Documentation of all other services including rehabilitation services, treatments and therapeutic diets . On 1/28/25, Surveyor reviewed R37's medical record. R37 was admitted to the facility on [DATE] and had diagnoses including end stage renal disease, chronic obstructive pulmonary disease (COPD), type 2 diabetes, hypertension, and anxiety. R37 received dialysis services. R37's Minimum Data Set (MDS) assessment, dated 10/24/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R37 had intact cognition. R37 made R37's own medical decisions. On 1/28/25 at 10:14 AM, Surveyor interviewed Director of Nursing (DON)-B regarding the facility's communication with the dialysis center for residents on dialysis. DON-B indicated nursing staff obtain the resident's blood pressure, pulse, respiration, temperature, oxygen saturation level. and weight pre and post-dialysis which are documented in the resident's medication administration record (MAR). DON-B indicated DON-B knows the person who runs the dialysis center and communicates with them via phone or email. DON-B stated dialysis staff call the facility if the resident has a bad day or something is out of the norm and send the facility a fax or paper with physician orders. DON-B stated if a nurse has concerns, they fax the dialysis clinic. DON-B provided a copy of the facility's Dialysis Pre and Post Communication form to Surveyor. The form contained fillable spaces for the date, resident's name, vital signs, and for new clinical concerns, including falls, loose stools, change in mental status, and abnormal vital signs The form contained the dialysis center's fax number and instruction at the bottom to Forward to (DON-B) after faxed with fax confirmation. On 1/28/25 at 10:18 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-F about the dialysis communication process. LPN-F indicated nurses fax the Dialysis Pre and Post Communication form before and after dialysis sessions with the resident's vital signs, weight, and if there is anything new to report, like a fluctuation in the resident's blood pressure or if the resident's dialysis access port is bleeding in excess. LPN-F indicated nursing staff give the fax or a copy of the form to DON-B or place them in DON-B's mailbox. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 10:20 AM, Surveyor interviewed DON-B who indicated DON-B reviews the Dialysis Pre and Post Communication forms and keeps them for a short period of time. When Surveyor requested to view the forms, DON-B indicated DON-B threw the forms away yesterday. When Surveyor asked what DON-B does with the forms when DON-B receives them, DON-B indicated DON-B reviews the forms and follows up with the dialysis center, resident, or nursing staff if something is not normal such as an abnormal blood pressure, an alteration in mentation, abnormal access site bleeding, and anything updated by the nurse to the dialysis center. When Surveyor asked if the information contained on the Dialysis Pre and Post Communication form is entered in a resident's medical record, DON-B stated, Only if I had to do something.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 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 4 residents (R) (R207, R42, R12, and R7) of 5 sampled residents. R207 had a open wound but did have an order or care plan for enhanced barrier precautions (EBP). R42 was not noted on the facility's infection control line list for antibiotics, intravenous (IV) therapy, a peripherally inserted central catheter (PICC) line, or infectious wounds. Licensed Practical Nurse (LPN)-M did not complete hand hygiene prior to administering medication to R12 and R7. Findings include: The facility's Enhanced Barrier Precautions policy, dated 12/22/22, indicates: It is the policy of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms (MDROs). Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with an MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) .C. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves .An order for enhanced barrier precautions will be obtained for residents with any of the following: .i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) .4. High-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of a device (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes), wound care, any skin opening requiring a dressing .7. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device is removed. The facility's Infection Surveillance policy, revised 6/27/24, indicates: .9. All residents and infections will be tracked. Separate, site-specific measures may be tracked as prioritized from the infection control risk assessment . The facility's Policy and Procedure Administering Medications, dated 1/1/14, indicates: .12. Adherence to established facility infection control procedures shall be followed during the administration of medications. Hand hygiene shall be required between residents . From 1/26/25 to 1/28/25, Surveyor reviewed R207's medical record. R207 was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes mellitus with neuropathy, chronic respiratory failure with hypoxia, and depression. R207's Minimum Data Set (MDS) assessment from an in process initial MDS stated R207 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R207 had moderate cognitive impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R207's medical record contained daily wound care orders for a buttocks wound. R207's medical record did not contain an order for EBP. On 1/26/25 at 2:09 PM, Surveyor interviewed R207 who indicated R207 had an open sore on the buttocks. R207 stated the wound was painful and staff addressed the wound daily. R207 indicated staff did not wear gowns during cares. On 1/26/25 at 2:16 PM and on 1/27/25 at 10:23 AM, Surveyor noted there was not an EBP sign located on the door or near the entrance to R207's room. On 1/27/25 at 2:52 PM, Surveyor interviewed Registered Nurse (RN)-E who indicated R207 was not on EBP. RN-E then double checked paperwork on the med cart and confirmed R207 was not on EBP. On 1/27/25 at 3:37 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R207 had an open wound on the buttocks that was being addressed with wound care orders and medication. DON-B confirmed R207 should be on EBP. On 1/27/25 at 3:56 PM, Surveyor interviewed RN Manager (RNM)-C who confirmed R207 had an open wound on the buttocks. RNM-C confirmed R207 should be on EBP. On 1/28/25 at 2:25 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated R207 should be on EBP if R207 has an open wound. 50467 2. From 1/26/25 to 1/28/25, Surveyor reviewed R42's medical record. R42 was admitted to the facility on [DATE] and had diagnoses including traumatic spinal cord dysfunction, necrotizing fasciitis (bacterial infection that effects deep layers of the skin fascia/flesh eating disease), stage 4 pressure ulcer sacral region, stage 4 pressure ulcer right buttock, stage 4 pressure ulcer right hip, cutaneous diphtheria (infection of the skin by Corynebacterium), methicillin- resistant Staphylococcus aureus unspecified site (a bacterium that is resistant to several antibiotics), and elevated white blood cell count unspecified. R42's MDS assessment, dated 12/11/24, had a BIMS score of 15 out of 15 which indicated R42 had intact cognition. R42's medical record indicated R42 was on Flagyl oral tablet 500 milligrams (mg), vancomycin 1250 mg IV, and cefepime 2 grams/100 milliliters. On 1/26/25, Surveyor reviewed the facility's infection control line list and noted R42 was not on the line list even though R42's medical record indicated R42 was on IV antibiotics and had open wounds. On 1/27/25 at 9:45 AM, Surveyor interviewed Infection Preventionist (IP)-K who confirmed R42 was not on the line line and it appeared R42 was missed. IP-K indicated R42 was on contact precautions related to an open wound and treated with antibiotics which were finished last week. IP-K indicated R42's PICC line was removed after R42's antibiotics were completed on 1/24/25. IP-K confirmed R42 had a sign on R42's door that indicated R42 was on contact precautions. 51043 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 1/26/25 at 9:23 AM, Surveyor observed LPN-M administer medication to R34. Without completing hand hygiene, LPN-M then administered medication to R12. Without completing hand hygiene, LPN-M then administered medication to R7. On 1/27/25 at 1:53 PM, Surveyor interviewed DON-B who indicated hand hygiene should be completed between residents prior to administering medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50467 Based on staff interview and record review, the facility did not ensure their antibiotic stewardship program was consistently followed. On 1/28/25, Surveyor reviewed R207's medication administration record (MAR) which indicated R207 was on an antibiotic since admission on 1/15/25. There was no stop date indicated for the antibiotic. Findings include: The facility's Antibiotic Stewardship Protocol, dated October 2024, indicates: Antibiotic Stewardship is the process of optimizing the treatment of infections while reducing adverse events associated with antibiotic use. Using the right antibiotic for the right reason for the right amount of time .Reviewing the effectiveness of antibiotic therapy by the Medical Doctor (MD)/Nurse Practitioner (NP) approximately 48 hours after the start is encouraged . From 1/26/25 to 1/28/25, Surveyor reviewed R207's medical record. R207 was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes mellitus with neuropathy, congestive heart failure, and chronic respiratory failure with hypoxia. R207's Minimum Data Set (MDS) assessment, dated 1/17/25, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R207 had intact cognition. An order provided to Surveyor by Director of Nursing (DON)-B (dated 1/11/25) indicated R207 was prescribed azithromycin 250 milligrams (mg) one tablet by mouth three times weekly on Monday, Wednesday, and Friday. R207's MAR did not contain a stop date or duration for the medication. On 1/28/25 at 11:44 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A was not aware of a stop date for R207's antibiotic and Surveyor should speak to DON-B. On 1/28/25 at 11:48 AM, Surveyor interviewed DON-B who confirmed R207 was admitted to the facility on an antibiotic without a duration. DON-B indicated nursing staff should have contacted R207's physician for clarification when R207 was admitted . On 1/28/25 at 3:41 PM, Surveyor interviewed Infection Preventionist (IP)-K who verified R207's antibiotic order did not contain a stop date and indicated antibiotics should have stop dates. IP-K stated IP-K spoke to an MD on 1/28/25 who stated to continue R207's antibiotic once a day three times a week for maintenance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50467 Based on staff interview and record review, the facility did not ensure vaccinations were reviewed, offered, or administered for 2 residents (R) (R24 and R34) of 5 sampled residents. Staff did not offer R24 or R34 the PCV20 (Prevnar 20(R)) vaccine. Findings include: Abbreviations (www.cdc.gov): PCV13: 13-valent pneumococcal conjugate vaccine (Prevnar13(R)) PCV15: 15-valent pneumococcal conjugate vaccine (Vaxneuvance(R)) PCV20: 20-valent pneumococcal conjugate vaccine (Prevnar 20(R)) PPSV23: 23-valent pneumococcal polysaccharide vaccine (Pneumovax23(R)) The most recent Centers for Disease Control and Prevention (CDC) recommendations for pneumococcal vaccinations indicate: For adults [AGE] years or older who have only received PPSV23, the CDC recommends: Give 1 dose of PCV15 or PCV20. The PCV15 or PCV20 dose should be administered at least 1 year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For those who have received PCV13 and 1 dose of PPSV23, the CDC recommends you give 1 dose of PCV20 at least 5 years after the last pneumococcal vaccine. For adults [AGE] years or older who have received PCV13, give 1 dose of PCV20 or PPSV23 at least 1 year after PCV13. Regardless of vaccine used, their vaccines are then complete. The CDC recommendation for adults [AGE] years or older who have no pneumococcal vaccinations is to give 1 dose of PCV15, PCV20, or PCV21. If PCV20 or PCV21 is used, their pneumococcal vaccinations are complete. If PCV15 is used, follow with one dose of PPSV23 to complete their pneumococcal vaccinations. The recommended interval between PCV15 and PPSV23 is at least 1 year. The minimum interval is 8 weeks and can be considered in adults with immunocompromising conditions, cochlear implants, or cerebrospinal fluid leaks. Findings include: The facility's Infection Prevention and Control Program policy, revised 6/27/24, indicates: .Residents will be offered the pneumococcal vaccines recommended by the CDC upon admission, unless contraindicated or received the vaccines elsewhere .C. Education will be provided to the residents and/or representatives regarding the benefits and potential side effects of the immunizations prior to offering the vaccines. D. Residents will have the opportunity to refuse the immunizations. E. Documentation will reflect the education provided and details regarding whether or not the resident received the immunizations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	01/28/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/25, Surveyor reviewed vaccines for 5 sampled residents, including R24 and R34. Surveyor noted R24 and R34's medical records did not contain declination forms for pneumococcal vaccines in 2024 or 2025 and did not indicate the risks and benefits of the vaccines were discussed. In accordance with CDC guidelines, R34 should have been offered the PCV20 vaccine in 2020, five years after the last dose which was on 11/13/15 (PVC13). R24 should have been offered the PCV20 vaccine in 2022, five years after the last dose which was on 5/11/17 (PPSV23). On 1/27/25 at 11:30 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated Infection Preventionist (IP)-K took care of the vaccines and Surveyor should check with IP-K. On 1/27/25 at 12:03 PM, Surveyor interviewed Infection Preventionist (IP)-K who indicated IP-K composed a list of residents that were due or past due for the PCV20 vaccine and presented it to Medical Director (MD)-T on 10/17/23. IP-K indicated MD-T noted no to all of them for the vaccines. When Surveyor asked IP-K if the residents on the list (or their representatives) were offered the vaccine, IP-K indicated no. IP-K indicated IP-K asked MD-T who indicated not to administer the vaccines so the residents were not given the option to receive the vaccine.