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	04/15/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure the resident environment remains as free of accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents for 1 of 4 residents (R) reviewed (R1.)R1 was repositioned inappropriately by unqualified staff which resulted in right humerus fracture.This is evidenced by:Facility policy titled, Safe Resident Handling/Transfers, with a reviewed date of 05/23/23, states: Policy: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident.Policy Explanation: All resident require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts are a safer alternative and should be used. Compliance Guidelines: 11. Nursing staff will be educated on the use of safe handling/transfer practices to include use of mechanical lift devices.12. Nursing staff must demonstrate competency in the use of mechanical lifts prior to use and annually with documentation of that competency placed in their education file. 14. Resident lifting and transferring will be performed according to the resident's individual plan of care.According to the Department of Health Services/Division of Quality Assurance publication Role of the Non-Certified staff in the Provision of Care dated 11/2021 Guidance: In 2000, the Department approved the following list of tasks that an individual can perform without being listed on the Wisconsin Nurse Aide Registry as a nurse aide to assist long-term care facilities with the implementation of helpers or hospitality aides and to ensure that the facility remains in compliance with nurse aide training requirements. An individual performing the following non-direct care tasks would not need to be a certified nursing aide. Resident rooms: Perform non-direct care tasks-no physical contact with the resident is allowed.R1 was admitted to the facility on [DATE] with diagnoses of spastic quadriplegic cerebral palsy, contracture of left wrist, contracture of left hand, and cervical disc degeneration.R1's annual Minimum Data Set (MDS) assessment, dated 03/23/26, noted a Brief Interview for Mental Status (BIMS) score of 15/15, indicating cognition is intact. R1 had impaired range of motion (ROM) on both sides of upper and lower extremities. R1 is dependent assist with all activities of daily living (ADL).R1's care plan, dated 12/23/24, with a target date of 04/19/26, states: The resident has an ADL self-care performance deficit with a goal resident will improve current level of function in ADLs. Interventions include Bed Mobility: extensive total assist. Transfer: Hoyer total assist.R1's Certified Nursing Assistant (CNA) Kardex, dated 10/01/25, states: Resident Care: Transfers/Ambulation: transfers with total assist and full sling lift.Of note: fireman method lifting technique was not documented as a safe method to boost R1.Surveyor reviewed R1's therapy evaluations and noted no documentation of evaluating a fireman method to use as a safe method to reposition R1.On 02/10/26, at approximately 3:00 PM, R1 was observed by Certified Nursing Assistant (CNA) U sliding downward in the wheelchair. CNA U asked Business Office Manager (BOM) N to assist in repositioning R1. CNA U and BOM N attempted to reposition R1 using the Hoyer sling positioned under R1, but the sling was too far down (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	to safely move R1. CNA U and BOM N then repositioned R1 using a fireman boost to boost R1 by lifting R1 under each arm and pulling up on R1's pants/briefs to a more upright position. As CNA U and BOM N pulled R1 up, they heard a popping sound in R1's right arm. The provider was notified and on 02/11/26, an x-ray was completed showing a fracture of the surgical neck of right humerus. No surgical intervention. Treatment with sling to right arm. Facility completed investigation of incident, noting root cause to be staff being unaware of proper wheelchair device placement. Interventions implemented included therapy screening for wheelchair positioning, staff education, and pictures placed in resident room noting wheelchair positioning.Surveyor reviewed completed staff training after R1's incident, dated 02/10/26 - 02/18/26, and noted in-service training topic was to use Hoyer sling to boost resident and not to lift by the arms.Of note: Surveyor reviewed completed CNA training and competency topics and noted no education regarding use of fireman method for transferring/repositioning residents. BOM N is not a CNA and should not complete hands-on patient care/repositioning.On 04/15/26 at 10:13 AM, Surveyor interviewed Nursing Home Administrator (NHA) A regarding R1's incident. NHA A stated that non-nursing staff are allowed to assist with repositioning as that is not considered a direct-patient care action. R1 was sliding down in the wheelchair and staff could not use the Hoyer lift to reposition, so they used the fireman method to pull R1 up with her arms. Surveyor asked NHA A if this would be an appropriate method to reposition a resident with contractures. NHA A stated that there was not another option if staff couldn't get the Hoyer sling in position.On 04/15/26 at 3:47 PM, Surveyor interviewed BOM N regarding incident. BOM N stated that CNA U had called out to her asking for help in repositioning R1. BOM N stated that she and the CNA had tried to position the Hoyer sling under R1 to use the mechanical lift, but weren't able, so they decided to use the fireman method. BOM N stated she was positioned on R1's left side and the CNA was on R1's right side. BOM N stated she was hesitant to reach under R1's left arm because of the contractures, so instead BOM N positioned her body close to R1's left arm and reached behind R1 grabbing hold of R1's pants and/or briefs. BOM N stated the CNA on R1's right side reached under R1's right arm and grabbed hold of R1's pants/briefs and together they lifted R1 upright and heard a popping sound. Surveyor asked if the fireman pull was a commonly used method to reposition residents. BOM N stated she did not know. Surveyor asked BOM N if she received any training in repositioning residents. BOM N stated not officially, but that the NHA had shown her in the past. Surveyor asked BOM N if she had any CNA training. BOM N stated no. Surveyor asked BOM N if it was common for unlicensed/untrained staff to assist with resident transfers/repositioning. BOM N stated that she doesn't typically help because she is afraid of something like this happening, but non-nursing staff are allowed to help with boosts.On 04/15/26 at 3:57 PM, Surveyor attempted to interview R1. Surveyor asked R1 if she remembered the incident with her arm being injured. After several seconds, R1 was able to move head up and down, indicating yes. Surveyor asked R1 if she could say what happened. R1 looked at Surveyor and was unable to voice words. Surveyor attempted to ask additional questions, but R1 was only able to respond with yes or no answers. No meaningful conversation was made.Surveyor was unable to interview CNA U identified in the incident.R1's plan of care was not followed, R1 was repositioned by a CNA and a non-certified staff. As a result, R1 suffered a fractured humerus.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observation, interview, and record review, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety which had the potential to affect all 53 residents.-Cook Q did not have a hair or beard restraint on while preparing food.-Cook P did not have a beard net on while preparing food.-Unlabeled and undated food items observed in the cooler.-Expired food items observed in the cooler and freezer.-Excessive frost/ice build-up observed in the freezer including directly above food items.Findings include:On 04/13/26 at 9:00 AM, Surveyor entered the facility's kitchen for the initial tour. Surveyor observed [NAME] Q, who had visible hair/stubble on both [NAME] Q's head and face, was not wearing hair restraints of any kind. Surveyor observed [NAME] P wearing a hair restraint on [NAME] P's head but did not have a beard restraint with facial hair present.On 04/13/26 at 9:05 AM, Surveyor observed glasses of liquid with lids on a tray in the cooler that were not labeled or dated. On another tray in the cooler, unlabeled/undated containers of cottage cheese, and a sandwich that was dated 04/11/26 were observed by Surveyor. Surveyor observed two small containers containing unknown food items on the shelf of the cooler, that were not labeled or dated.On 04/13/26 at 9:10 AM, Surveyor entered the freezer and observed a pack of soft tortillas that were past the use by date and the package wide open. Surveyor observed plastic trays on the top shelf directly under the fans in the freezer. Both trays contained white and brown ice that appeared to have dripped from the unit above. The mounds of ice were 3 and 4 inches tall in some areas. Surveyor observed that directly above a pumpkin pie on another shelf was excessive frost and ice build-up on a pipe.On 04/14/2026 at 8:09, AM Surveyor completed a follow up kitchen inspection. Surveyor observed [NAME] Q again with no hair restraints and [NAME] P with no beard restraint.On 04/14/26 at 11:55 AM, Surveyor interviewed Dietary Manager (DM) I. Surveyor informed DM I of the unlabeled and expired food observed in the refrigerator and freezer previous and current day. Surveyor also asked DM I about the frost/ice buildup in the freezer, to which DM I acknowledged that has been an ongoing issue. DM I acknowledged the other concerns.On 04/14/26 at 1:00 PM, Surveyor interviewed DM I about hair restraints. DM I stated the kitchen policy for hair restraints states anything under 1/4 inch in length does not require hair restraints. DM I provided Surveyor with a copy of the policy which was from the facility company and was not dated. DM I did not provide a nationally recognized standard of practice for which the policy is based on.On 04/15/26 at 8:27 AM, Surveyor interviewed DM I. DM I stated the expectations of staff would be to put an open date, label, and use by date on any items placed in the cooler or freezer. DM I stated the kitchen staff should be looking for expired items and disposing of them, but usually DM I does it. DM I stated it was appropriate to place a label just on the tray of drinks and/or cottage cheese as long as they were going to be used that same day. DM I would expect each individual item to be labeled for longer use or placed in a separate pan with a label on it. When asked about the freezer, DM I stated the frost build-up has been like that as long as DM I has been working at the facility, which is 8 years. When asked how often it gets addressed, DM I stated, When someone complains about it. DM I stated Maintenance looks at it all the time, but DM I thinks maybe it's time to get a professional to come look at it. DM I stated at times DM I will go and take the trays full of ice and knock the ice off out the back door. DM I updated on the federal regulations regarding hair restraints and DM I acknowledged all staff should be wearing hair restraints when working in the kitchen with the food.On 04/15/26 at 8:41 AM, Surveyor updated Director of Nursing (DON) B about kitchen concerns. DON B acknowledged.On 04/15/26 at 11:16 AM, Surveyor interviewed Maintenance Director (MD) J. MD J stated about every 28 days the defrosting mechanism in the freezer needs maintenance. MD J stated some of the insulation had come off with the frost and the copper supply needs to be replaced which MD J planned to do that after the defrosting the freezer. MD J stated MD J checks the freezer weekly and the ice builds up in that short time. When asked if it was appropriate (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to store food directly under the ice buildup, MD J stated, Well when I'm done defrosting it would be warranted. MD J stated the facility does have a local outside source that can perform maintenance and possibly come about twice yearly. MD J stated the outside source has never reported any concerns regarding the ice buildup. MD J stated MD J just takes care of it, and it takes about 45 minutes each time.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility did not ensure residents received services by qualified staff with the correct certification and skills for 2 of 15 residents (R) that require mechanical lifts. (R1, R54) Activity Aide H, a non-certified personnel, assisted R54 with a direct care mechanical transferBusiness office manager N, a non-certified personnel, assisted R1 with repositioning in a wheelchair.The facility policy titled, Safe Resident Handling/Transfers, states, .Two staff members must be utilized when transferring residents with a mechanical lift. According to Department of Health Services (DHS) form P-01559 dated 11/2021, titled, Role of non-certified staff in provision of care, states, In 2000, the Department approved the following list of tasks that an individual can perform without being listed on the Wisconsin Nurse Aide Registry as a nurse aide to assist long-term care facilities with the implementation of helpers or hospitality aides and to ensure that the facility remains in compliance with nurse aide training requirements. An individual performing the following non-direct care tasks would not need to be a certified nurse aide.Perform non-direct care tasks - no physical contact with the resident is allowed. According to Wisconsin Department of Health services, Wisconsin.gov website, only trained personnel are authorized to operate sit-to-stand lifts. This includes certified nursing assistants and other healthcare professionals who have received proper training and are qualified to use the equipment safely. The use of powered patient lift assist devices, such as sit-to-stand lifts, is regulated to ensure the safety of both patients and healthcare workers. Example 1 R54 was admitted to the facility on [DATE] with dementia, Parkinson's disease, and degenerative back and neck disorders. On 04/14/2026 at 8:17 AM, Surveyor observed Certified Nursing Assistant (CNA) G and Activity Aide (AA) H transfer R54 on and off the toilet using a sit-to-stand mechanical lift. AA H pushed the button on the lift which changed the position of R54, lifting him on and off the toilet. Surveyor asked AA H if s/he is a CNA or received training using a mechanical lift. AA H stated that s/he was not trained at the nursing home and is not a CNA. Surveyor asked what her role was, and AA H said s/he helps on the floor and does activities. Surveyor asked what the policy is for mechanical transfers. CNA G stated they use 2 staff assist for anything with a button and only one must be a CNA. On 04/14/2026 at 10:46 AM, Surveyor interviewed Director of Nursing (DON) B and asked what the policy is for staff using mechanical lifts. DON B stated they require 2 staff assist for sit-to-stand lifts and anything with a battery or a button. One needs to be qualified, and the other does not. On 04/14/2026 at 1:38 PM, Surveyor requested all yearly training, education, performance evaluations, and competencies for AA H. Surveyor reviewed the information that confirms AA H's job title was an Activity Aide with date of hire as 05/20/25. Surveyor reviewed competencies and none were found regarding training for transfer assistance. Surveyor looked up Wisconsin CNA registry, and no records were found matching AA H's name. On 04/14/2026 at 2:45 PM, Surveyor interviewed DON B who confirmed there are no current staff in a CNA course that are not certified. Surveyor asked what roles AA H performs. DON B stated AA H is an activity aide, helps pass meal trays and transports residents. Surveyor asked if AA H is trained to use the sit-to-stand lift. DON B said no, but s/he needs to be with a CNA and can only press the button. Surveyor asked if DON B would consider pressing the button as part of a transfer process and operating the lift. DON B said, Yes, but they only are pressing a button. Example 2 R1 was admitted to the facility on [DATE] with spastic quadriplegic cerebral palsy, contracture of left wrist, contracture of left hand, and cervical disc degeneration. R1's care plan, dated 12/23/24, with a target date of 04/19/26, states: .Transfer: Hoyer total assist. (Fireman method lifting technique was not documented as a safe method to boost R1.) Surveyor reviewed R1's therapy evaluations and noted no documentation of evaluating a fireman method to use as a safe method to reposition R1. Surveyor reviewed incident report regarding R1 that stated on 02/10/26, at approximately 3:00 PM, R1 was observed by CNA U sliding downward in the wheelchair. CNA U asked Business Office Manager (BOM) N to assist in (continued on next page)

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	525410	A. Building B. Wing	04/15/2026

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	repositioning R1. CNA U and BOM N attempted to reposition R1 using the Hoyer sling positioned under R1, but the sling was too far down to safely move R1. CNA U and BOM N then repositioned R1 using a fireman method to boost R1 by lifting R1 under each arm and pulling up on R1's pants/briefs to a more upright position. As CNA U and BOM N pulled R1 up, they heard a popping sound in R1's right arm. The provider was notified and on 02/11/26 an x-ray was completed showing a fracture of the surgical neck of right humerus. No surgical intervention. Treatment with sling to right arm. On 04/15/26 at 10:13 AM, Surveyor interviewed Nursing Home Administrator (NHA) A regarding R1's incident. NHA A stated that non-nursing staff are allowed to assist with repositioning as that is not considered a direct-patient care action. R1 was sliding down in the wheelchair and staff could not use the Hoyer lift to reposition, so they used the fireman method to pull R1 up with her arms. Surveyor asked NHA A if this would be an appropriate method to reposition a resident with contractures. NHA A stated that there was not another option if staff couldn't get the Hoyer sling in position. On 04/15/26 at 3:47 PM, Surveyor interviewed BOM N regarding incident. BOM N stated that CNA had called out to her asking for help in repositioning R1. BOM N stated that she and the CNA had tried to position the Hoyer sling under R1 to use the mechanical lift, but weren't able, so they decided to use the fireman method. BOM N stated she was positioned on R1's left side and the CNA was on R1's right side. BOM N stated she was hesitant to reach under R1's left arm because of the contractures, so instead BOM N positioned her body close to R1's left arm and reached behind R1 grabbing hold of R1's pants and/or briefs. BOM N stated the CNA on R1's left reached under R1's left arm and grabbed hold of R1's pants/briefs and together they lifted R1 upright and heard a popping sound. Surveyor asked if the firemen method was a commonly used method to reposition residents. BOM N stated she did not know. Surveyor asked BOM N if she received any training in repositioning residents. BOM N stated not officially, but that the NHA had shown her in the past. Surveyor asked BOM N if she had any CNA training. BOM N stated no. Surveyor asked BOM N if it was common for unlicensed/untrained staff to assist with resident transfers/repositioning. BOM N stated that she doesn't typically help because she is afraid of something like this happening, but non-nursing staff are allowed to help with boosts.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility did not ensure residents were correctly positioned to eat meals in bed to promote the highest practical well-being for 2 of 6 residents (R) reviewed. (R7 and R40)R7 was in bed in a lying position the whole time the breakfast tray was provided. R7 was not checked on or repositioned to effectively see and eat the meal.R40 was in bed in a lying position not eating until a family member arrived and asked staff for assistance. R40's position did not allow him/her to adequately see or eat the meal.Example 1 R7 was admitted to the facility on [DATE] with heart disease and rheumatoid arthritis. R7's care plan with a target date of 04/26/26 indicates R7 requires extensive assist of 1-2 and assist as needed and can feed self meals after set-up and to assist as needed. R7's care plan initiated on 02/25/26 notes a nutritional concern related to inability to manage self-care, variable intake and advanced age. R40 was admitted to the facility on [DATE] with heart failure, COPD, and muscle weakness. R40's care plan with a target date of 06/07/26 states R40 is independent with bed mobility and meals. Care plan initiated 04/10/26, indicated that R40 has a terminal prognosis and is to receive comfort care. Care plan initiated 11/25/25 indicates R40 has a nutritional concern related to heart failure, COPD, need for therapeutic diet and variable intake. On 04/14/2026 at 8:14 AM, Surveyor observed Certified Nursing Assistant (CNA) F set up R7 breakfast in bed. CNA F elevated the head of the bed. Tray was placed in front of R7 slightly below eye level. R7's body was at a 40-degree angle and chin is at table height. CNA F told R7 s/he needs to get boosted up. During continuous observation, CNA F then left the room, and the boost did not happen. At 8:25 AM, R7 was still at a 40-degree angle. On 04/14/2026 at 9:24 AM, CNA F returned and removed R7's breakfast tray. R7 only ate most of the hot cereal. Surveyor interviewed R7 and asked if s/he was able to eat breakfast sitting so low in the bed. R7 said it was very difficult. Example 2 On 04/14/2026 at 8:24 AM, Surveyor observed R40 lying in bed sleeping with breakfast not touched but is set up in front of him/her. R40 woke up at 8:50 AM and was holding a coffee cup with straw. Surveyor observed R40's breakfast tray at eye level and the top of table was at R40's upper lip region. R40's body was at a 35-degree angle and diagonal in the bed with R40's feet hanging off the edge off the right side up against the wall. During Surveyors continuous observation, staff did not check on, assist, or correct R40's position. At 9:03 AM, Family member D entered R40's room and requested CNA to help sit him/her up so he can eat. Family member D stated, He can't eat like that. CNA F straightened R40 some and elevated the HOB more where R40 was then able to see the meal and feed self. Family Member D encouraged R40 to eat. R40 then began to eat food. On 04/14/2026 at 1:19 PM, Unit manager C and RN E stated they boosted and set up R40 between 8:15 and 8:30am. On 04/14/2026 at 10:46 AM, Surveyor interviewed DON B and asked what the expectation is regarding the CNA role if a resident eats in their room? DON B said they would expect the CNA to deliver the tray, offer clothing protector, set up the meal, elevate the head of bed at a position of comfort and at an appropriate height to eat. Both R7 and R40 triggered for weight loss and care plans identify nutritional problems. Neither were positioned, checked on, or assisted to ensure needs were acceptable, obtainable, and/or in a timely manner.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 5 of 5 residents reviewed (R20, R29, R32, R1, R34).-The facility staff did not routinely complete R20's ambulation, exercise, and Activities of Daily Living (ADL) programs.-The facility staff did not routinely complete R29's ambulation program.-The facility staff did not routinely complete R32's ambulation, exercise, and range of motion (ROM) programs.-The facility staff did not routinely complete R1's ROM programs.-The facility staff did not routinely complete R34's ROM programs.Findings include: Example 1 R20 was admitted to the facility on [DATE]. On 03/19/26, R20's Minimum Data Set (MDS) assessment showed a Brief Interview for Mental Status (BIMS) score of 11/15 indicating moderate cognitive impairment. R20's diagnoses include cerebral palsy, epilepsy, congenital hydrocephalus, and morbid obesity. On 04/13/26 at 11:45 AM, Surveyor completed an initial interview with R20. R20 along with Family Member (FM) V, voiced concerns that R20 is not getting ambulated as R20 should. There is concern that R20 will decline or lose the ability if R20 isn't doing it on a regular basis. FM V stated depending on which Certified Nursing Assistant (CNA) is working, R20 may get to walk one time here and there but it is not every day and not consistent and R20 confirmed this. R20's annual MDS assessment, dated 03/19/26, section O0500 Restorative Nursing Programs stated, Record the number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily). Range of motion was marked completed 1 day. Surveyor reviewed R20's CNA tasks which include: Ambulation Program: Twice a day ambulate in hallway. Allow time for foot clearance. Wheelchair to follow, distance as tolerates. R20 needs encouragement to ambulate, if refuses re-approach, if still refuses let FM V know and FM V will talk to R20. Surveyor reviewed CNA task documentation and noted the following for February: 12 shifts marked as not applicable (02/01/26, 02/03/26, 02/05/26, 02/06/26, 02/09/26, 02/11/26, 02/12/26, 02/15/26, 02/17/26, 02/18/26, 02/19/26, 02/24/26). 25 shifts no documentation (02/01/26, 02/02/26, 02/03/26, 02/05/26, 02/07/26, 02/08/26, 02/09/26, 02/10/26, 02/11/26, 02/13/26, 02/14/26, 02/15/26, 02/16/26, 02/17/26, 02/18/26, 02/21/26, 02/22/26, 02/25/26, 02/26/26, 02/27/26, 02/28/26). Surveyor reviewed CNA task documentation and noted the following for March: (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	04/15/2026

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2 shifts marked as not applicable (03/22/26, 03/28/26). 45 shifts no documentation (03/01/26, 03/02/26, 03/03/26, 03/04/26, 03/05/26, 03/06/26, 03/07/26, 03/08/26, 03/09/26, 03/10/26, 03/11/26, 03/13/26, 03/14/26, 03/15/26, 03/16/26, 03/17/26, 03/18/26, 03/19/26, 03/20/26, 03/21/26, 03/23/26, 03/24/26, 03/25/26, 03/26/26, 03/27/26, 03/28/26, 03/29/26, 03/30/26, 03/31/26). Surveyor reviewed CNA task documentation and noted the following for April prior to Survey entrance: 1 shift marked as not applicable (04/06/26). 17 of 24 possible shifts had no documentation (04/01/26, 04/02/26, 04/03/26, 04/04/26, 04/05/26, 04/07/26, 04/08/26, 04/09/26, 04/11/26, 04/12/26). DON (Put on) brace to right foot. Ambulate resident with front-wheeled walker. Assist of 1 with gait belt and wheelchair to follow. Surveyor reviewed CNA task documentation and noted the following for February: 13 shifts marked as not applicable (02/01/26, 02/03/26, 02/05/26, 02/06/26, 02/09/26, 02/11/26, 02/12/26, 02/15/26, 02/17/26, 02/18/26, 02/19/26, 02/24/26). Surveyor reviewed CNA task documentation and noted the following for March: 3 shifts marked as not applicable (03/01/26, 03/22/26, 03/28/26). 45 shifts not documentation (03/01/26, 03/02/26, 03/03/26, 03/04/26, 03/05/26, 03/06/26, 03/07/26, 03/08/26, 03/09/26, 03/10/26, 03/11/26, 03/13/26, 03/14/26, 03/15/26, 03/16/26, 03/17/26, 03/18/26, 03/19/26, 03/20/26, 03/21/26, 03/23/26, 03/24/26, 03/25/26, 03/26/26, 03/27/26, 03/28/26, 03/29/26, 03/30/26, 03/31/26). Surveyor reviewed CNA task documentation and noted the following for April prior to Survey entrance: 1 shift marked as not applicable (04/06/26). 17 of 24 possible shifts had no documentation (04/01/26, 04/02/26, 04/03/26, 04/04/26, 04/05/26, 04/07/26, 04/08/26, 04/09/26, 04/10/26, 04/11/26, 04/12/26). Restorative Nursing Program/ADLs: sit on the edge of bed and perform upper body bathing/dressing, donning up to knees for lower body. Provide limited assist for standing to wash peri area and adjust clothing over hips. Surveyor reviewed CNA task documentation and noted the following for February: 10 shifts no documentation (02/02/26, 02/07/26, 02/08/26, 02/14/26, 02/16/26, 02/21/26, 02/22/26, 02/23/26, 02/25/26, 02/27/26). Surveyor reviewed CNA task documentation and noted the following for March: (continued on next page)

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	525410	A. Building B. Wing	04/15/2026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Task only completed on 3 shifts (03/01/26, 03/03/26, 03/06/26). No documentation for the rest of the month. Surveyor reviewed CNA task documentation and noted no documentation for April prior to Survey entrance. Sitting bilateral lower extremity exercises 10 reps twice a day. 1. Hip flexion 2. Quadriceps Strengthening 3. Ankle Pumps 4. Hip Abduction/Adduction Surveyor reviewed CNA task documentation and noted the following for February: 9 AM shifts with no documentation (02/02/26, 02/07/26, 02/08/26, 02/14/26, 02/21/26, 02/22/26, 02/23/26, 02/25/26, 02/27/26). Only 1 PM shift with documentation noted (02/23/26). Surveyor reviewed CNA task documentation and noted the following for March: Only 2 AM shifts with documentation of completion (02/03/26, 02/06/26). No documentation noted for any PM shift. Surveyor reviewed CNA task documentation and noted no documentation for April prior to Survey entrance. Example 2 R29 was admitted to the facility on [DATE]. On 04/04/26, R29's Minimum Data Set (MDS) assessment showed a Brief Interview for Mental Status (BIMS) score of 11/15 indicating moderate cognitive impairment. R29's diagnoses include stage 3 chronic kidney disease, major depressive disorder, congestive heart failure, muscle weakness, and peripheral vascular disease. On 04/13/26 at 11:15 AM, Surveyor completed initial interview with R29. R29 is concerned that R29 is not getting walked like scheduled and is afraid of losing the ability. R29 reported that since R29 is no longer eligible for therapy, R29 would like to continue the walking program in hopes to eventually be able to go to an assisted living facility. R29's annual MDS assessment, dated 04/04/26, section O0500 Restorative Nursing Programs stated, Record the number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily). No restorative program listed in the assessment. Surveyor reviewed R20's CNA tasks which include: Ambulate in hallway with walker and 1 assist. Wheelchair to follow. (continued on next page)

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	525410	A. Building B. Wing	04/15/2026

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed CNA task documentation and noted the following for February: 6 AM shifts were marked as not applicable (02/01/26, 02/09/26, 02/12/26, 02/15/26, 02/17/26, 02/19/26). Only 7 AM shifts documented (02/03/26, 02/04/36, 02/05/26, 02/06/26, 02/10/26, 02/23/26, 02/26/26). Only 2 PM shifts documented (02/21/26, 02/23/26). Surveyor reviewed CNA task documentation and noted the following for March: 3 shifts marked as not applicable (02/13/26 PM, 02/22/26 AM, 02/28/26 AM). 1 AM shift documented as complete (02/06/26) No other documentation noted. Surveyor reviewed CNA task documentation and noted the following for April prior to Survey entrance: 2 shifts documented for completion (04/02/26 PM, 04/10/26 AM). 22 of 24 possible shifts were noted to have no documentation. On 04/15/26 at 7:10 AM, Surveyor interviewed Certified Nursing Assistant (CNA) L regarding restorative programs. CNA L stated that any restorative or exercise programs would be found in point of care charting under Q-shift. When asked if the programs always get completed, CNA L replied, Not every time. If we are short staffed or someone just doesn't show up, they don't get done. CNA L stated CNA L believed R20 and R29 are both on walking programs. On 04/15/26 at 7:18 AM, Surveyor interviewed Registered Nurse (RN) M in relation to restorative programs. When asked about where to find if a resident is on a restorative program, RN M stated RN M would look in the care plan. RN M stated that any of the nursing staff can complete the restorative/exercise programs but primarily The CNAs do. When asked if all the restorative programs get done, RN M stated, When we are short staffed, probably not. When asked who follows up to make sure it's getting done, RN M responded with, I don't follow up and ask if they've done it. RN M stated RN M would have to look in R20 and R29's charts and was unsure about restorative programs for both residents. On 04/15/26 at 8:41 AM, Surveyor interviewed Director of Nursing (DON) B regarding restorative program expectations. DON B stated the restorative and exercise programs are located in the point of care charting and in the care plans. DON B stated from the care plan it also forwards to the Kardex. DON B stated the CNAs complete these tasks and document in point of care. When asked if the programs always get done, DON B stated, I know that we have some patients that refuse them. I see them doing ROM. DON B stated that yes, CNAs have the ability to mark refusals in their charting. When asked about who follows up to make sure they are being completed, DON B did not have an exact answer. DON B stated MDS coordinator will at times make changes as a decline occurs. DON B's expectation is that the CNAs complete the tasks and document completion. DON B reported to Surveyor the charting for point of care was entered wrong and it did not populate for the CNAs to (continued on next page)

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	525410	A. Building B. Wing	04/15/2026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	complete on some programs. DON B acknowledged there were multiple holes in the charting indicating the task was not completed. Example 3 R32 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction (stroke) affecting right dominant side. R32's annual Minimum Data Set (MDS) assessment, dated 03/16/26, noted no Restorative Nursing Programs. Surveyor reviewed R32's Certified Nursing Assistant (CNA) tasks and noted: Restorative bilateral lower extremity (BLE) exercise program: 10-15 reps each exercise 1-2 sets: 1. Leg extensions. 2. Marching. 3. Toe raises. 4. Heel raises. 5. Foot press. 6. Knees out. 7. Knees in. Every shift; Restorative right upper extremity (RUE) self-exercise program: 20 reps each exercise 1 set: 1. Shoulder flexion/extension. 2. Shoulder abduction/adduction. 3. Pronation/supination. 4. Wrist flexion/extension. 5. Ulnar/radial deviation. 6. Flex and extend fingers. 7. Elbow flexion/extension. Every shift; Ambulate in hallway using hemi walker, gait belt assist of one with wheelchair to follow every shift; Passive Range of Motion (PROM) fingers right hand: flexion, extension, rotation. PROM wrist right hand: flexion, extension, supination. Complete prior to brace wear. Every shift. Right wrist/hand splint on in am and on all day, off at bedtime every shift. Surveyor reviewed R32's CNA task completion of restorative care and noted: -January 2026: no documentation on at least one shift: 01/03/26, 01/04/26, 01/06/26, 01/08/26, 01/15/26, 01/16/26, 01/19/26, 01/20/26, 01/22/26, 01/23/26, 01/24/26 – 01/31/26. Task documented as not completed on 01/17/26 and 01/18/26. -February 2026: no documentation on at least one shift: 02/01/26 – 02/05/26, 02/07/26 – 02/22/26, 02/24/26 – 02/28/26. -March 2026: no documentation on at least one shift: 03/01/26 – 03/05/26, 03/07/26 – 03/31/26. -April 2026: documentation on at least one shift: 04/01/26 – 04/15/26. On 04/15/26 at 10:26 AM, Surveyor interviewed Director of Nursing (DON) B regarding restorative nursing program. DON B stated that the expectation is for CNAs to complete all restorative cares every shift and to document when completed or if resident refused. Example 4 (continued on next page)

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	525410	A. Building B. Wing	04/15/2026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1 was admitted to the facility on [DATE] with diagnoses of spastic quadriplegic cerebral palsy, contracture of left wrist, contracture of left hand, and cervical disc degeneration. R1's annual Minimum Data Set (MDS) assessment, dated 03/23/26, noted no Restorative Nursing Program. Surveyor reviewed R1's CNA tasks and noted: PROM BLE 15 reps x 1 set 1. HIP PROM-flexion/extension 2. HIP Abduction/adduction 3. Hamstring stretch every shift. PROM: 15 reps x 1 set BUE 1.gentle PROM to elbows, wrist and fingers every shift. Surveyor reviewed R1's CNA task completion of restorative care and noted: -February 2026: no documentation on at least one shift: 02/04/26, 02/05/26, 02/07/26 – 02/22/26, 02/24/26 – 02/28/26. -March 2026: no documentation on at least one shift: 03/19/26 – 03/31/26; marked as 'not applicable' on 03/18/26 and 03/22/26. -April 2026: no documentation on at least one shift: 04/01/26 – 04/15/26. Example 5 R34 was admitted to the facility on [DATE] with bilateral osteoarthritis of hip. R34's quarterly MDS assessment, dated 03/13/26, noted no Restorative Nursing Program. Surveyor reviewed R34's CNA tasks and noted: Active BLE ROM exercises: 15 reps 2 times daily: 1. Leg extensions. 2. Marching. 3. Toe raises. 4. Heel raises. 5. Foot press. 6. Knees out. 7. Knees in. Surveyor reviewed R32's CNA task completion of restorative care and noted: -January 2026: no documentation on at least one shift: 01/05/26, 01/19/26 and 01/23/26. -February 2026: no documentation on at least one shift: 02/10/26, 02/15/26, 02/24/26, 02/28/26. -March 2026: no documentation on at least one shift: 03/01/26, 03/05/26, 03/14/26, 03/15/26, 03/17/26 – 03/19/26, 03/22/26, 03/24/26 – 03/30/26. -April 2026: no documentation on at least one shift: 04/01/26 – 04/15/26.

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	525410	A. Building B. Wing	04/15/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure Minimum Data Set (MDS) assessments were coded correctly for 1 of 16 residents (R32) reviewed for MDS accuracy.The facility did not correctly code R32's dental status as edentulous.This is evidenced by:R32 was admitted to the facility on [DATE].R32's admission Minimum Data Set (MDS) assessment, dated 03/18/23, noted R32 had no natural teeth or tooth fragments. R32's most recent MDS, dated [DATE], noted no dental concerns.On 04/13/26 at 1:52 PM, Surveyor interviewed R32. R32 stated he had no teeth and no dentures since admission to the facility in 2023.On 04/15/26 at 9:41 AM, Surveyor interviewed MDS Coordinator S regarding R32's MDS assessments. MDS Coordinator S stated being aware that R32 had no teeth or dentures and had no idea why the MDS assessments completed after admission were marked incorrectly.

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	525410	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastview Health and Rehabilitation Center	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	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 interview and record review, the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices for 1 of 16 residents reviewed (R20).-Facility staff did not perform post-seizure activity assessments and documentation per care plan.Findings include:Facility policy titled, Seizure Precautions, last revised on 11/26/25, reads, Assess the resident for any injuries, including the oral cavity.document in the medical record.date and time seizure began, duration of the seizure, any precipitating factors.resident's response to the seizure, any medications received, post-seizure vital signs, oxygen saturation, and mental status, any instructions on seizure management and injury prevention, and notification of practitioner and family.Facility policy titled, Comprehensive Care Plans, last revised on 02/05/25, reads, The comprehensive care plan will describe.the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions.R20 was admitted to the facility on [DATE].On 03/19/26, R20's Minimum Data Set (MDS) assessment showed a Brief Interview for Mental Status (BIMS) score of 11/15 indicating moderate cognitive impairment.R20's diagnoses include cerebral palsy, epilepsy, congenital hydrocephalus, and morbid obesity.R20's care plan includes states in part: R20 has a seizure disorder related to epilepsy and hydrocephalus with interventions including post seizure treatment.after seizure take vital signs, and neuro check.seizure documentation.location of seizure activity, type of seizure activity, duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after seizure activity.Physician order from 03/29/25 includes monitor for the following complications related to cerebral palsy: decrease in strength and energy, decreased appetite, swallowing difficulties, increased salivation, changes in continence, seizure activity, difficulty breathing, increased confusion, increased pain, decline in functional mobility one time a day. Document N if monitored and none of the above observed. Document Y if monitored and any of the above observed. Add progress note.On 01/04/26, a progress note states Family Member (FM) V reported small seizure activity after supper in FM's room. R20 states R20 is fine now.On 01/04/26, a progress note states grand mal seizure activity reported by Physical Therapist while in the gym today. Will monitor.On 03/03/26, Nurse Practitioner (NP) W progress note states Seizure disorder: Patient continues having intermittent seizures despite medication adherence. Will obtain Keppra level. Continue Keppra and Lamictal as previously prescribed. Continue following with neurology as previously planned or sooner if seizure activity worsens.On 04/07/26, a progress note states FM V reported to writer that R20 had a seizure at 1910 (7:10 PM). Resident doing well post seizure.Surveyor reviewed R20's electronic health record (EHR) and found the order in the treatment record for seizure monitoring was marked administered and not marked indicating yes or no per instructions. There are no noted neurological checks post-seizure activity per the care plan for the dates reviewed and noted in the progress notes. Surveyor noted there were no assessments or progress notes present in R20's EHR post seizure activity.On 04/15/26 at 7:10 AM, Surveyor interviewed Certified Nursing Assistant (CNA) L in relation to seizures and seizure activity. CNA L stated R20 has not had a seizure that CNA L is aware of since CNA L has been here in December. CNA L stated if CNA L noticed a resident having a seizure, CNA L would roll them on their side and call for help. CNA L would then send that person to get a nurse. CNA L stated the nurse may have CNA L get a set of vitals.On 04/15/26 at 7:18 AM, Surveyor interviewed Registered Nurse (RN) M in relation to seizures and seizure activity. RN M stated if a resident had a seizure or seizure activity, RN M would assess the resident, obtain vitals, make sure they are stable, administer PRN medications (as needed) if appropriate and available, and report to POA (power of attorney)/Guardian. (continued on next page)

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	525410	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastview Health and Rehabilitation Center	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	When asked about what to do if R20 had a seizure, RN M stated he has never had one for RN M so RN M would have to look into it further. RN M stated RN M would then update the provider when the resident is stable. On 04/15/26 at 08:17 AM, Surveyor interviewed Family Member (FM) V. FM V stated that occasionally the nurse or CNA will get a blood pressure when FM V has witnessed R20 having a seizure but has never seen an actual assessment or Neuro checks performed. FM V stated no one checks R20's eyes or has R20 squeeze their hands/fingers. On 04/15/26 at 8:41 AM, Surveyor interviewed Director of Nursing (DON) B in relation to R20's seizure monitoring. DON B stated if a resident had a seizure or seizure activity, DON B would expect CNAs to report it to a nurse. DON B would expect the nurses to complete an assessment, gather information, update NP W, and perform normal monitoring. DON B stated the nurses should also document any abnormal activity. DON B was asked about where to find the information regarding R20's seizure care. DON B stated it is in the care plan and that R20 has a seizure and anticonvulsant care plan. When asked if there is any documentation in the MAR/TAR (medication administration record/treatment administration record) DON B stated, No, it would be in a progress note. When asked if the nurses would obtain neuro checks per the care plan, DON B stated that would part of their gathering of data. Surveyor informed DON B per the care plan, the post seizure directions/assessments were not being followed/completed and DON B acknowledged understanding.

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	525410	A. Building B. Wing	04/15/2026

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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** Based on observation, interview and record review, the facility did not ensure that 2 of 2 residents (R) reviewed for pressure injuries (PI) (R49 and R50) received care consistently with professional standards of practice to prevent further deterioration and promote healing of an existing PI.R49 admitted to the facility with multiple PIs. The facility failed to provide complete admission comprehensive PI assessments.Facility staff did not conduct hand hygiene after removal of gloves during R50's PI care treatment. This is evidenced byThe standard of practice for staging pressure injuries and skin and tissue assessment is based on the NPIAP (National Pressure Injury Advisory Panel) system, which categorizes injuries from Stage 1 to Stage 4, along with Unstageable and Deep Tissue Pressure Injury (DTPI). Staging is based on the anatomical depth of tissue destruction (epidermis, dermis, muscle, bone). Conduct a comprehensive skin and tissue assessment for all individual at risk of pressure injuries as soon as possible after admission/transfer to the healthcare service.Example 1R49 was admitted to the facility on [DATE]. R49's diagnoses include PI of sacral region stage 4, severe protein-calorie malnutrition, methicillin resistant staphylococcus aureus, pressure-induced deep tissue damage, PI of other site stage 3, infection of the skin and subcutaneous tissue, PI part of back, unstageable, PI of other site stage 2, PI of other site unstageable, PI of right heel stage 4, fracture of sacrum, and PI of right heel stage 3.A Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 7/15, meaning severe cognitive impairment. R49 is at risk for PI. Unhealed PIs present on admission were 1 stage 3, 2 stage 4, 5 unstageable, and 1 deep tissue injury (DTI). Initial wound assessments on 03/30/26 documented the following and were not completed.Coccyx, pressure, measurements of 5 cm x 4.5 cm x 0.2 cm, and unstageable.Right heel, pressure, measurements of 3 cm x 2.5 cm x .2 cm, unstageable and no exudate. Mid back, pressure, measurements of 2.5 cm x 1 cm, unstageable, 25% epithelization, and no exudate.The facility provided a QuickShot picture and documented site dated 03/30/26. No comprehensive assessment was completed to include measurement, stage, and complete description of the PIs. The areas documented were right LE (lower extremity) med (medial) pressure, left foot lateral distal pressure, right lower leg shin area scab and pressures, and right bottom foot lateral stage 3.On 04/03/26 wound assessment details report documented PIs were identified on 03/30/26. The facility was unable to provide 03/30/26 admission initial assessments for areas of lt (left) ft (foot) lat (lateral) med - stage 3, lt ft lat prox (proximal) - unstageable, mid upper back - unstageable, RLE (Right Lower Extremity) lat - unstageable, lt shin - unstageable, and rt great toe - stage 3.On 04/15/2026 at 4:04 PM, Surveyor interviewed Director of Nursing (DON) B asking about admission assessment with measurements and staging of PIs. DON B stated R49 came in with all 13 PIs. The nurse only did the three major PIs assessments and did not complete a full assessment of all PIs as instructed. Example 2Facility's policy titled Hand Hygiene dated 03/27/25, documented .The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.R50 was admitted to the facility on [DATE]. R50 had a PI to the left heel.On 04/14/26 at 11:19 AM, Surveyor observed Registered Nurse (RN) R washed hands and turned faucet off with clean hands. RN R applied gloves, placed barrier on side of bed, removed R50's left sock and wound dressing. RN R removed gloves, did not complete hand hygiene, put normal saline on gauze, applied gloves and cleansed left heel. RN R removed gloves, did not complete hand hygiene, opened the gauze wrap and applied gloves. With gloved hands RN R applied betadine pad to wound bed and wrapped foot with the gauze wrap. On 04/15/2026 at 3:51 PM, Surveyor interviewed DON B asking about hand hygiene after glove change during PI wound care. Surveyor reviewed observation with RN R completing R50's wound care and not performing hand hygiene during glove changes. DON B stated hand hygiene is expected with removal of gloves. The clinical manager had just reviewed hand hygiene with RN R prior to wound care. We will continue education.

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	04/15/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure all drugs and biologicals were stored and labeled in accordance with currently accepted professional principles for 1 of 16 residents (R37) reviewed.R37's olanzapine medication label did not match physician's orders.This is evidenced by:Facility policy titled, Labeling of Medications and Biologicals, with a reviewed date of 11/12/2024, states: Policy: All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. Policy Explanation and Compliance Guidelines: .4. Labels for individual drug containers must include: a. the resident's name; b. The prescribing physician's name; c. the medication name; d. the dose, strength, and quantity of the medication; .g. appropriate instructions and precautions.12. The pharmacy must be informed of any order changes or changes in directions for the use of the medication.R37 was admitted to the facility on [DATE].R37's physician orders:01/22/26 olanzapine 2.5 mg tablet Give 1 tablet by mouth one time a day for unprovoked behaviors in dementia with directions: Give a half tablet by mouth daily at noon and give 1 tablet by mouth every evening.Previous orders for olanzapine include:11/25/26 olanzapine 2.5 mg tablet Give 1.25 mg by mouth one time a day for unprovoked behaviors in dementia with directions: Give a half tablet by mouth daily at noon and give 1 tablet by mouth every evening.On 04/14/26 at 1:12 PM, Surveyor interviewed Licensed Practical Nurse (LPN) T for clarification of R37's olanzapine order. LPN T stated the nursing staff use the electronic medical record (EMR) to verify records and pulled up R37's EMR. LPN T showed Surveyor that R37's current olanzapine order was for 2.5 mg given daily at 3 PM. Surveyor asked LPN T what the included directions of giving a half tab at noon and 1 tab in evening meant. LPN T stated that it was part of an old order and the pharmacy must not have corrected it. Surveyor asked LPN T to show Surveyor R37's medication dispensing card provided by the pharmacy. LPN T opened medication cart and pulled out 4 pharmacy labeled medication cards for olanzapine. Two of the olanzapine medication cards contained full tablets and 2 olanzapine medications cards contained half tablets. All of the olanzapine medication cards had the same pharmacy label attached stating, Olanzapine 2.5 mg tab Give 1/2 tab PO daily at noon - Give 1 tab PO every evening. None of the 1/2 tabs were missing from the medication cards. The 1/2 tab medication cards had dispensed dates of 12/13/25 and 03/13/26. Surveyor asked LPN T if the pharmacy label matched the physician orders. LPN T stated yes because staff do not look at the pharmacy label's direction and only go by the order in the resident's EMR.On 04/14/26 at 2:05 PM, Surveyor interviewed Director of Nursing (DON) B regarding medication labeling. DON B stated it does not matter if the medication card does not match because staff are expected to follow orders in EMR. DON B stated that the facility does have labels that can be used to correct errors on the medications, but they frown on that because the label should not be changed.

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	04/15/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents received routine dental services for 1 of 2 residents (R32) reviewed.R32 has not had routine dental services since admission in 2023.This is evidenced by:Facility policy titled, Dental Services, with a reviewed date of 11/12/24, states: Policy: It is the policy of this facility to assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care. Definitions: ?Routine dental services' means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease.taking impressions for dentures and fitting dentures.8. For residents or resident representatives who do not wish to be referred for dental services: a. The physician shall be notified. b. The dietician shall be consulted to assess for any necessary change in diet. c. The resident's plan of care will be revised to reflect preferences. 9. All actions and information regarding dental services, including any delays related to obtaining dental services, will be documented in the resident's medical record.R32 was admitted to the facility on [DATE].R32's admission Minimum Data Set (MDS) assessment, dated 03/18/23, noted R32 had no natural teeth or tooth fragments. R32's most recent MDS, dated [DATE], noted no dental concerns. R32's Brief Interview for Mental Status (BIMS) score was 15/15, indicating cognition is intact.Surveyor reviewed R32's medical record and noted no documented routine dental visits since admission.Surveyor reviewed R32's care plan and noted no refusal of dentist services or documentation of notifying provider of refusal of dental services.On 04/13/26 at 1:52 PM, Surveyor interviewed R32. Surveyor asked R32 if the facility assists with arranging routine dental services. R32 stated he came to the facility in 2023 with no teeth or dentures so why would he need to see a dentist. Surveyor asked R32 why he did not have dentures. R32 stated he couldn't afford them. Surveyor asked if R32 would want dentures if he could afford them. R32 stated, sure.On 04/14/26 at 11:42 AM, Surveyor interviewed Unit Manager (UM) C regarding R32's dental appointments. UM C reviewed the upcoming appointment binder and stated R32 had no upcoming dental appointments scheduled. UM C reviewed R32's chart and stated she could not find any past dental appointments/visits since admission.On 04/14/26 at 2:05 PM, Surveyor interviewed Director of Nursing (DON) B regarding R32's dental appointments. DON B stated that R32 had no teeth and did not express any interest in getting dentures. Surveyor asked DON B if she had asked R32 if he would want to get dentures. DON B stated that this had never been explicitly asked, but that she would.