STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525419	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chippewa Manor Nursing and Rehabilitation	222 Chapman Rd Chippewa Falls, WI 54729

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 - 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 3 of 4 residents (R) reviewed for pressure injuries (PI) (R48, R47, and R51) received care consistently with professional standards of practice to prevent further deterioration and promote healing of an existing PI. R48 and R47 are being cited at (actual harm/isolated). R51 is being cited at (potential for minimal harm/isolated).R48 and R47 were at risk for PI development. The facility failed to provide adequate interventions to prevent PI development, and did not complete comprehensive weekly assessment with staging of the PI. The facility did not complete weekly comprehensive skin assessments, obtain physician orders for wound treatments, and implement interventions to promote skin integrity and healing for R51. This is evidenced by Facility's policy titled Skin Integrity Policy dated 09/04/15 documented in part, Pressure Ulcer prevention recommendations include a comprehensive assessment of the skin, etiology, nutrition and risk assessment.Skin integrity assessments are done upon admission by a nurse.Risk assessment is completed to identify susceptible patients to target appropriated interventions to prevent pressure ulcers.Appropriate interventions are placed based on the above and include but are not limited to repositioning schedules, support surfaces such as pressure relief or reducing mattresses and chair cushions, heel floating, nutritional supplements/vitamins RD [Registered Dietician] recommendation. Treatment will be determined by accurate diagnosis and classification of pressure ulcers. Changes in treatment is based upon wound healing with MD notification of nonhealing or worsening pressure ulcers. Indicators of healing include weekly wound measurement with wound assessment documentation. Example 1 R48 was admitted to the facility on [DATE]. R48's diagnoses include encounter for palliative care hospice on 02/17/26, Alzheimer's disease, chronic diastolic congestive heart failure, and legal blindness. R48's admission Minimum Data Set (MDS) dated [DATE] documented a brief interview for mental status (BIMS) score of severely impaired cognition. R48 had altered level of consciousness. R48 is dependent on staff for all activities of daily living (ADL). R48 is at risk for PI and has no PI. On 02/17/26, the facility completed a Braden assessment with a score of 9, meaning at very high risk to develop PI. On 03/11/26 another Braden assessment was completed with a score of 9. Care plan: Problem: Resident is at risk for pressure ulcers R/T [related to] limited mobility, terminal diagnosis on hospice. Category - Start Date 02/17/2026 Last Reviewed/Revised 02/17/2026. Approach: Heel protectors or float heels at all times, air mattress Start Date 03/03/2026. Certified (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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F 0686 Level of Harm - Actual harm Residents Affected - Few	Nursing Assistant (CNA) care plan documented start date of 03/03/26 Heel protectors or float heels at all times, air mattress. R48's progress notes read in part,03/01/2026 at 2:20 PM, Skin Note Comments: red area noted to lower spine, measures approx [approximately] 8.8 cm long by 1.6 cm wide, blanchable. Applied 4x4 foam with border for protection. Repositioning resident as frequently as resident will allow, enrolled in Hospice 03/02/2026 at 1:07 PM, (Name) hospice RN, (Name), here for routine visit. Aware of reddened area to spine. Reports DTI (Deep tissue injury) to right heel that is open to air. Float heels. Foam border dressing and air mattress ordered. Note, facility did not comprehensively assess, and document the DTI to the right heel. 03/2/26 at 12:22 PM, documented right heel pressure ulcer measuring 4 cm x 3 cm. Physician orders documented 03/02/26 Float heels with pillows or heel protectors at all times Twice A Day 06:00 - 18:00, 18:00 - 06:00. 03/02/26 Change foam border to pink area on spine, Once A Day on Mon, 06:00 - 18:00. 03/09/2026 at 10:48 AM, Skin Note Skin and Ulcer/Injury Treatments: Wound care Comments: Dressing changed to spine, two pink areas noted, proximal measures 4.5cm by 3cm with superficial open area to center. Distal area measures 2cm by 1cm, skin intact. Pink areas are blanchable, areas cleansed and patted dry and foam with border applied for protection. Note, the facility did not comprehensively assess and stage the superficial open area/PI to the spine. No weekly PI assessment was completed for the right heel. 03/16/2026 at 3:23 PM, Skin Note Skin and Ulcer/Injury Treatments: Wound care, Turning/repositioning program, Pressure-reducing device for bedComments: changed mid-spine dressing, approximated 1.7cm by 1.5 cm, with a small dark scabbed area, surrounded by flaking red skin, cleansed with normal saline, dried with gauze, and applied foam border. Note, the facility did not comprehensively assess and stage the PI to the spine. No weekly PI assessment was completed for the right heel. On 03/24/2026 at 6:21 AM, Surveyor observed R48 in bed. Surveyor interviewed Certified Nursing Assistant (CNA) H asking how often does R48 get repositioned and if there are any open areas on R48's skin. CNA H stated R48 gets repositioned about every 2 hours. R48 does not have any open areas on R48's skin. On 03/24/2026 at 9:56 AM, Surveyor interviewed Hospice Registered Nurse (RN) I about R48 having any open areas. RN I stated R48 has a DTI to the right heel and skin is intact. Facility staff are to float heels and reposition R48. RN I removed R48's sock to observe the right heel. Surveyor noted R48 had a large circler black eschar area. RN I rolled R48 to observe the spine area. Surveyor noted R48's lower spine area was red and blanchable and above the blanchable area R48's skin was red and appeared to have an area that was open, dry and was not blanchable. Hospice RN I stated she does measurements weekly of the area and the facility gets the notes. Surveyor asked Hospice RN I if the PIs were avoidable or unavoidable. Hospice RN I stated the PIs were avoidable. When the PIs were noted an air mattress was ordered and to float R48's heels. On 03/24/26 at 10:17 AM, Surveyor interviewed Assistant Director of Nursing (ADON) E about facility (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	policy and procedure regarding comprehensive weekly assessments including measuring and documenting R48's PIs. ADON E stated she does not have weekly assessment measurements of the heel. The Hospice RN would take over documenting the PIs. Typically, they don't have hospice assessing and would put in orders to document the PIs 3 times a week. This was not done. On 03/24/26 at 10:17 AM, Surveyor reviewed with Director of Nursing (DON) B regarding R48's PIs. DON B stated the facility did not complete weekly comprehensive PI assessments and staging. Interventions of pressure relief were not in place to prevent development of PIs when R48 was assessed on admission to be a very high risk of developing PI. The interventions of floating heels and an air mattress were not added until after the PIs developed. Example 2 R47 was admitted to the facility on [DATE]. R47's diagnoses include encounter for palliative care hospice (03/07/26), secondary malignant neoplasm of bone and lung, tumor lysis syndrome, depression, and chronic kidney disease stage 3a. An admission MDS dated [DATE] documented a BIMS score of 15/15, meaning R47 is cognitively intact. R47 requires moderate staff assistance to complete Activities of Daily Living (ADLs). R4 has one unstageable PI present on admission. A Braden assessment was completed on 02/25/26 and documented a score of 17, meaning at mild risk for development of a PI. On 02/25/26, an admission observation report documented R47 having no pressure injuries. Only having a scab on a toe. Physician orders documented on 02/27/26 Float heels with pillow or apply heel protectors at all times when restingTwice A Day 06:00 - 18:00, 18:00 - 06:00 03/20/26 L(left) plantar posterior heel. Cleanse with wound cleanser, pat dry with gauze. Apply puracol collagen 2x2 with bordered foam. Change weekly and PRN [as needed]. Hospice wound RN to assess and change weekly. Facility staff to change PRNOnce A Day on Fri 06:00 - 18:00 02/27/26 Heels sores - cleansed and apply bordered foam - measure and document on areas Once A Day on Mon, Wed, Fri 06:00 - 18:00 03/20/26 R (right) Heel sores - cleansed and apply bordered foam - measure and document on areas Once A Day on Mon, Wed, Fri 06:00 - 18:00. Care plan: Problem: Impaired skin integrity r/t [related to] unstageable pressure ulcer to left heel. Chemotherapy, end stage cancer. Category -Start Date 02/25/2026Last Reviewed/Revised 03/03/2026 13:00Approach: Air mattress to bed, heel protectors or float heels with pillows at all times except for transfers Start Date 03/02/2026 Progress notes: 02/25/2026 at 11:03 PM, Resident has a pink, blanchable area to her lower back bone and her sacral area, no open areas noted. Lotion was applied, per resident request. No reports of pain or discomfort.A wound management detail report created 03/03/26 by ADON E states an unstageable pressure ulcer was observed on 02/25/26 to the left heel measuring 1.2 cm x 1.2 cm with 100 % (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	slough. Progress note dated 02/27/26 documented, .Left heel wound measures approximately 1.5 cm x 1.25 cm x 0.2 cm with black escar(sic) at lower edge border of wound. Peri wound is pink and no drainage noted. Right heel has an approximately 0.5 cm circumference black escar(sic) wound with no drainage. Note there are now two PIs, and the facility did not stage the PIs. 03/02/26 Left heel noted to have open area measuring 1.8 cm by 2.2 cm, yellow wound bed, pink surrounding skin that blanches, no s/sx [signs or symptoms] of infection noted. Pink area to right heel measuring 1 cm by 1.2 cm, blanches. Of note there is no comprehensive assessment for R47's right heel the week of 3/3/26. 03/03/26 Left heel 1.2 by 1.2 open area, with a dark/scabbed center. Moderate drainage noted on old dressing, miniscule amount of slough at wound bed. 03/09/26 Right heel red, blanchable, no open areas. Left heel open area measuring 1.3 cm by 2.3 cm, wound bed tan/yellowish slough, scant tan drainage. 03/10/26 Left heel wound bed noted to be beefy red, measures approx. 2.5 cm wide by 1.4 cm long.Changed dressing to right heel, no redness noted, heel feels slightly boggy to the touch. 03/13/26 Left heel has 2.2 x 1.6 with slough at wound bed, right heel has two small scabs about 1cm diameter. 03/16/26 Left heel minimal yellow drainage noted area is approximately 2.3cm by 1.3 cm .right heel has two almost pinpoint scabs measuring 0.2 cm diameter for both. Dark scabbed center. 03/20/26 Right heel pink but blanchable, left heel superficial open area measuring 0.7cm by 1.7 cm with beefy red wound bed . 03/23/26 Left heel superficial open area measuring 0.9 cm by 1.9 cm with pink wound bed. On 03/24/26 at 12:27 PM, Surveyor interviewed ADON E and DON B about when R47's PI to the left heel developed. ADON E stated the area was there on admission. Surveyor reviewed the wound management detail report with the created date of 03/03/26 stating it developed on 02/25/26. Surveyor asked if ADON E did the assessment on 02/25/26. ADON E stated she did not see the wound on admission. DON B stated DON B observed the wound. Surveyor asked if DON B took measurements and documented the assessment. DON B stated no. Surveyor reviewed R47's admission observation report with ADON E and DON B of the admission observation report documenting no PIs and the progress note documenting no PIs to the left heel. Interventions to float heels were not added to the care plan until 03/02/26. The progress notes assessments did not stage the PIs. Example 3 R51 was admitted to the facility on [DATE] with diagnoses including dementia, dependence on renal dialysis, heart failure, and obesity. R51 scored 11/15 during Brief Interview for Mental Status (BIMS), indicating moderately impaired (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	cognition. R51's Minimum Data Set (MDS) assessment, completed on 01/09/26, noted R51 was at risk of pressure ulcers and R51 had no pressure, arterial, or venous skin ulcers. R51's care plan included: Start Date 03/10/26, last reviewed/revised 03/10/26: Resident's skin will remain intact.Approach: Report any signs of skin breakdown (sore, tender, red, or broken areas).Approach: Use moisture barrier product to perineal area.Approach: Provide incontinence care after each incontinent episode. Avoid hot water, and use a mild cleansing agent that minimizes irritation and dryness of the skin; avoid friction to skin.Approach: Use absorbent, skin-friendly pads/briefs to maintain personal hygiene and dignity.Approach: Float heels when indicatedApproach: Keep bony prominences from direct contact with one another with (pillows, foam wedges, etc).Approach: Reduce friction injuries by using lubricants, protective films, protective dressings, and/or protective padding.Approach: Avoid shearing resident's skin during positioning, transferring, and turning.Approach: Conduct a systematic skin inspection (weekly, daily, etc). Pay particular attention to the bony prominences.Approach: Keep linens clean, dry, and wrinkle free.Approach: Keep clean and dry as possible. Minimize skin exposure to moisture.Approach: Use lifting device(e.g., trapeze, lift sheet, etc.) to move resident in bed. R51's current physician orders did not include any skin treatments. Previous physician orders included, 11/25/25-01/01/26, Measure and document right buttock wound, cleanse with normal saline, dry with gauze, and apply foam dressing. Note, Surveyor was unable to find any other skin treatment orders in R51's record. A nutritional assessment completed on 03/19/26, noted R51 had no open skin areas. R51 has no orders for supplements for wound healing. Surveyor was unable to find weekly comprehensive skin assessments in R51's record. R51's progress notes included: -12/06/25, Skin Note: Skin temperature location: Warm, Skin and Ulcer/Injury Treatments: Wound careComments: Dressing noted to be soiled to left buttock, dressing removed, skin cleansed and patted dry, superficial open area noted measuring 0.4cm in diameter, no s/s of infection noted, new foam with border applied. Skin and Ulcer/Injury Treatments: Wound careComments: Dressing changed to right buttock, area cleansed and patted dry, two open areas noted, proximal measuring 1cm by 0.5cm, distal measuring 1cm by 0.4cm, scattered scabbed areas noted near open areas, new foam dressing applied. -12/09/25, open area right buttock is 0.5cm x 0.5cm. Area cleansed and patted dry. Foam dressing applied. Res. has excoriated area left buttock and is 2cm x 1cm. Area cleansed and patted dry. Foam border dressing applied. Posterior scrotum is sl. excoriated. Area cleansed and patted dry. Zinc applied. -12/23/25, open area right inner buttock is 0.3cm x 0.3cm and dry. Cleansed and patted dry. New foam border dressing applied. -12/24/25, Skin Notes: Shower given by staff, small open area noted to right buttock, measures approx 0.4 cm wide by 0.2 cm long, applied new 3x3 foam with border (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-12/25/25, Healing right inner buttock cleft dressing change. measures 1.2 cm x .75 cm with clear boarder. No sign of infection noted. Cleansed and dressed with 3x3 foam dressing. Resident had no complaint of pain or discomfort. Encourage positioning on side in bed. Resident prefers sleeping in recliner. Educated on benefit of sleeping in bed. -01/14/26, Dressing changed to left buttock. Noted to have a 0.75cm circular open area to left buttock. Scant amount of bloody drainage noted. Area cleansed and dried and new foam boarder applied. -01/21/26, Foam border dressing applied after shower to Resident's buttocks - three areas: a) left buttock, approximately 0.5 cm x 0. 75 cm x 0.1 cm; b) left upper posterior thigh, approximately 0.3 cm wide x 1. 5 cm long x 0.1 cm deep; c) right buttock approximately 0.3 cm x 0.3 cm x 0.1 cm. Scrotum area appeared greatly improved compared to writer's last observation. Mild redness noted, offloading practiced when able, Nystatin applied to areas where moisture prone fungal skin infection is present: groin. Improving with therapy. -01/27/26, Res. has a 2.5cm x 1.5cm superficial open area left buttock. Area cleansed with NS and patted dry. 3x3 foam border dressing applied. Res. has a 1cm x .1cm open area right buttock. Area cleansed with NS and patted dry. 3x3 foam border dressing applied. Res. has a reddened area left upper inner thigh, not open. Area cleansed with NA and patted dry. Zinc applied. -01/28/26, Skin and Ulcer/Injury Treatments: Wound careComments: right buttock 2.6 x 0.5, superficial with sanguineous drainage, flaking skin surrounding open area. Cleansed, dried, and applied foam border.left buttock open area is 1.2 by 1.0, superficial with sanguineous drainage, flaking skin surrounding open area. Cleansed, dried, and applied foam border. -02/01/26, Skin Notes: Changed dressing to left inner buttock, area measures approx 2.0cm wide by 2.0 cm long, superficial open area, cleaned with saline, applied new 4x4 foam with border. -02/15/26, Skin Notes: Open area noted to left buttock, measures approx 2.7 cm wide and 1.4 cm long, wound bed is white in color, small amount of active bleeding noted, cleaned with saline, applied new 4x4 foam with border. -03/04/26, Writer called to resident's room to place dressings on open areas to buttocks. Right buttock has superficial open area 1.5cm x 1.5cm. Cleansed, dried and foam border applied. Left buttock has 4cm x 4cm round open area noted with granular tissue in the center, margins are clean. Area cleansed and dried and foam border applied. Will have wound RN assess as well. On 03/04/26, R51 was hospitalized for urosepsis; he was re-admitted to the facility on [DATE]. R51's re-admission skin assessment on 03/10/26, noted 2 cm x 2 cm on left back of thigh, 1.5 cm x 2 on right back of thigh appears to be shearing from lift sheet. Surveyor was unable to locate any skin assessments or progress notes related to R51's skin after 03/10/26. On 03/24/26 at 11:00 AM, Surveyor interviewed Certified Nursing Assistant (CNA) C. CNA C confirmed R51 had an open area on his buttocks, but was unable to report left or right side. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 03/24/26 at 11:34 AM, Surveyor observed R51's buttock with CNA C and Registered Nurse (RN) G. Surveyor observed RN G remove a foam border dressing from R51's left inner buttock. Surveyor observed R51 had an open area to left inner buttock. R51's right buttock noted no open area, and skin was discolored, and presented dark purple in color. Surveyor asked RN G if R51's wound was a pressure ulcer. RN G stated R51, sits a lot. Surveyor asked RN G if the dressing removed from R51's left buttock was initialed or dated. RN G stated it was not. Surveyor asked if R51 had an order for treatment to his left buttock and RN G was not sure. RN G stated she was not sure who placed the dressing on R51. On 03/24/26 at 12:28 PM, Surveyor interviewed Director of Nursing (DON) B and Assistant Director of Nursing (ADON) E, DON B and ADON E stated R51's wounds heal and reoccur. ADON E reported R51 should have a roho cushion and this is in R51's care plan. Surveyor reviewed R51's care plan with DON B and ADON E and confirmed a roho cushion is not on the care plan. Surveyor asked DON B and ADON E about other skin interventions and asked if R51's interventions were individualized. DON B and ADON E did not provide a statement. Surveyor asked DON B and ADON E if R51 had previous skin treatments ordered and noted R51 did not have current orders, and Surveyor was only able to find a single order from 11/2025-01/2026. DON B and ADON E were not sure why R51's order would have ended on 01/01/26. DON B and ADON E reported R51's provider should be aware of R51's wounds. Surveyor asked for documentation to support R51's provider was updated on R51's skin condition. The facility did not provide supporting evidence of this. Surveyor asked DON B and ADON E if the facility's Registered Dietician (RD) was aware of R51's wounds. ADON E stated the RD has access to the facility notes and would be able to see if R51 had wounds or skin concerns. ADON E stated if RD saw documentation of a wound she definitely would have ordered a supplement. Surveyor asked DON B and ADON E if there were weekly comprehensive skin assessments for R51. DON B and ADON E indicated R51's skin assessments were in the progress notes. Surveyor noted these assessments were not completed weekly and were not comprehensive. Surveyor noted some dates included both right and left side and other dates included only one side, and documentation did not confirm if and when wound healed or re-opened. DON B and ADON E did not provide a statement. Surveyor requested documentation to support R51's provider was updated, treatment orders, revised skin interventions, and weekly comprehensive skin assessments. DON B and ADON E provided no further information.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was transmitted within 14 days of completion to the Centers for Medicare and Medicaid Services (CMS) for one of five residents (R7) reviewed for MDS.R7 expired in the facility on [DATE] with hospice services. R7's Minimum Data Set (MDS) assessment for a death in the facility was not submitted to the CMS System. On [DATE], Surveyor requested the facility's policy related to MDS assessments; the facility did not provide Surveyor with this policy. Per CMS requirements, within 14 days after a facility completes a resident's assessment, the facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including a resident's death. On [DATE] at 8:34 AM, Surveyor interviewed Registered Nurse (RN) F. RN F also acts as the MDS coordinator. RN F stated she completed R7's MDS, but Director of Nursing (DON) B and Assistant Director of Nursing (ADON) E are responsible for transmitting the assessment. RN F stated the MDS death assessment completed on [DATE], was not submitted. On [DATE] at 9:19 AM, Surveyor interviewed DON B and ADON E. DON B and ADON E stated the process is for MDS coordinator to hit complete button when finished with the MDS assessment, and then it is sent to NHA, DON, and/or ADON to complete and transmit. DON B reported only three staff have access to transmit MDS assessments, and that is NHA, DON, and ADON. DON B stated since MDS coordinator did not hit complete, NHA A, DON B, and ADON E were not aware R7's MDS needed to be transmitted.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that a resident who requires dialysis receives such service, consistent with professional standards of practice for 1 of 1 residents (R51) reviewed for dialysis.The facility failed to provide ongoing assessment of R51's condition and monitoring for complications before and after dialysis treatments.On 03/23/26 at 3:30 PM, Director of Nursing (DON) B reported the facility did not have a policy. On 03/24/26, DON B provided Surveyor with a policy titled Hemodialysis Policy and Procedure. DON B stated the policy was created on 03/24/26. The policy read in part, The facility will ensure that each resident receives care and services consistent with professional standards of practice, including the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility; ongoing assessment and oversight of the resident before, and after dialysis treatments, monitoring for complications, implementing appropriate interventions, and using appropriate infection control practices; ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. R51 was admitted to the facility on [DATE] with diagnoses including dementia and end stage renal disease with dependence on dialysis. R51's Minimum Data Set (MDS) assessment completed on 12/29/25 confirmed R51 scored 11/15 during Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. R51's care plan included: -I have end-stage renal disease and depend on dialysis to remove extra fluid and waste from my body. My nutrition and fluid intake must be carefully managed to help me stay healthy between treatments. Start Date, 03/10/2026. Last Reviewed/Revised, 03/10/2026. -Interventions: I need my nurses to monitor my weight before and after dialysis and as ordered. Check for swelling, shortness of breath, or other signs of fluid overload. Monitor my labs (especially potassium, phosphorus, and albumin) and report changes to my doctor and dietitian. Remind me about my fluid limits if I am drinking too much between treatments. Give my medications and phosphate binders as prescribed. I need my aides to record how much I eat and drink, as directed. Report if I am refusing meals or seem more tired than usual after dialysis. Help me with meal setup and offer fluids within my limits. Watch for and report swelling, confusion, or decreased appetite. I need dietary staff to provide me with a renal diet that is lower in sodium, potassium, and phosphorus, as ordered. Offer high-protein foods to help me maintain my albumin and strength. Prepare foods I like within my diet restrictions to encourage eating. Monitor my intake and weight for any significant changes.Start Date, 03/10/2026. R51's orders included: -03/10/26, DIALYSIS, Mon-Wed-Fri - check in 2:15pm - Dialysis at 2:30pm. Patients Express Van taking at 1:45pm. Will return around 6:30-6:45pm. Kitchen aware to send out supper tray at that time.-03/10/26, Check and document bruit and thrill (left forearm fistula). -03/10/26, Give resident his supper when returning from dialysis-is in family room fridge. -03/10/26, Monitor vitals three times per week M-W-F post dialysis. On 03/23/26, Surveyor reviewed R51's record and noted vital signs, temperature, respirations, and blood pressure pre and post dialysis since 03/10/26. Surveyor reviewed weights and noted weekly weights with no pre and post dialysis weights. Surveyor was unable to locate communication with dialysis center. On 03/23/26 at approximately 2:30 PM, Surveyor interviewed Certified Nursing Assistant (CNA) C. CNA reported the nurses are responsible for checking resident vital signs. CNA C was aware R51 was on a fluid restriction. CNA C stated R51 takes a packet with him to dialysis. CNA C did not know what information the packet contained. On 03/23/26 at 3:00 PM, Surveyor interviewed Registered Nurse (RN) D. RN D confirmed nurses take resident vital signs. RN D reported RNs assess R51's vital signs and bruit post dialysis and R51 has an order for a weekly weight. Surveyor asked RN D where R51's documentation of communication with facility and the dialysis center would be located, and RN D did not know where this would be. Surveyor asked RN D what type of dialysis R51 received, and RN D stated, Regular dialysis, not peritoneal. Surveyor asked RN D what assessments would be completed for a resident receiving (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525419	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chippewa Manor Nursing and Rehabilitation	222 Chapman Rd Chippewa Falls, WI 54729

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis, RN D stated, We check his vital signs and bruit after dialysis. On 03/23/26 at 3:03 PM, Surveyor interviewed DON B. DON B stated R51 switched dialysis providers, A while ago, more than six months. DON B reported she does not have documented communication with new dialysis center, related to R51's dialysis treatments. DON B reported nurses take R51's vital signs and monitor bruit post dialysis. DON B stated she thinks R51 has order for weights three times weekly. DON B stated she would confirm R51's orders and update Surveyor. On 03/24/26 at 7:30 AM, DON B reported she spoke with dialysis center, and the facility will begin a communication form. DON B stated she is unsure how this was missed.