STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525489	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newcare	903 Main Ave Crivitz, WI 54114

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not develop and/or implement an individualized, comprehensive care plan for 4 residents (R) (R11, R16, R6, and R13) of 14 sampled residents. R11 smoked and received oxygen therapy. R11 also received diuretic medication and was on contact and droplet precautions. The facility did not develop a comprehensive care plan that included interventions related to smoking, the use of diuretic medication, or infection prevention precautions. R16 smoked and received oxygen therapy. The facility did not develop a comprehensive care plan that included interventions related to smoking. R6's activities of daily living (ADL) and nutritional care plans did not include recommended approaches for staff to use when R6 refused to eat meals in a Broda chair or the dining room.R13 had an order for a WanderGuard for safety. R13's plan of care did not indicate R13 had a WanderGuard or contain intervetions for safety.Findings include: The facility's Care Plans, Comprehensive Person Centered policy, revised March 2022, indicates: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident .3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .7. The comprehensive, person-centered care plan: a. Includes measurable objectives and timeframes; b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .e. Reflects currently recognized standards of practice for problems areas and conditions .11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents conditions change . The facility's smoking policy for residents, revised October 2023, indicates: .6. Resident smoking status is evaluated upon admission .8. A resident's ability to smoke safely is re-evaluated quarterly and when determined by staff .9. Smoking related privileges, restrictions, and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues . 1.From 8/18/25 to 8/20/25, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and type 2 diabetes. R11's Minimum Data Set (MDS) assessment, dated 6/18/25, contained a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R11 had intact cognition. R11 received continuous oxygen. A smoking assessment was completed on 6/12/25. Surveyor noted R11's most recent plan of care did not indicate R11 smoked and did not include interventions or safety (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	measures for smoking; however, staff were aware of and implemented safety measures for R11. On 8/19/25 at 3:20 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated a resident who smokes should have a care plan related to smoking. DON-B indicated residents should be assessed for smoking upon admission, quarterly, and with changes in the resident's status. When asked how staff know the smoking protocol for R11, DON-B indicated there used to be a list of residents who smoke near the nurses' station; however, the list did not contain smoking interventions for R11. On 8/19/25 at 3:32 PM, Surveyor interviewed MDS Coordinator (MDSC)-C who indicated residents who smoke should have a smoking care plan. MDSC-C indicated MDSC-C should have included smoking on R11's care plan. 2. Surveyor also noted R11 received diuretic medication and had the following order: ~ Torsemide 10 milligrams (mg) 1 tablet by mouth daily. R11's medical record did not contain orders to monitor for side effects (i.e., dizziness, dehydration, hypotension, vertigo, headache, restlessness, abdominal pain, nausea, vomiting, rash, muscle spasms, increased urination, increased thirst, severe diuresis, or electrolyte depletion) of diuretic use; however. staff monitored R11 for diuretic use. Surveyor also noted R11's plan of care did not mention diuretic use or contain interventions to monitor for side effects of diuretic use. On 8/19/25 at 3:20 PM, Surveyor interviewed DON-B who indicated residents who receive diuretic medication should have a care plan for diuretic use. DON-B confirmed staff should be aware of side effects so they can monitor R11 for safety and effectiveness. On 8/19/25 at 3:32 PM, Surveyor interviewed MDSC-C who indicated residents on high-risk medications including diuretics should have a care plan for the medication. MDSC-C indicated MDSC-C usually developed resident care plans, including care plans for medications with a black box warning with side effect monitoring. 3. R11's medical record indicated R11 had signs and symptoms of a fever, increased fatigue, increased cough, and increased oxygen needs on 8/17/25. R11 was placed on contact and droplet precautions on 8/19/25. R11's care plan did not indicate R11 was on contact or droplet precautions. On 8/19/25 at 3:34 PM, Surveyor interviewed DON-B who indicated precautions and infection should be added to a resident's care plan the day the resident is symptomatic. DON-B verified infection interventions, including precautions, should have been added to R11's care plan on 8/17/25. On 8/19/25 at 4:32 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-L who indicated CNA-L uses a resident's comprehensive care plan to provide care and for updates on providing care. CNA-L also indicated CNA-L relies on a resident's care plan and signage on the resident's door for guidance on the appropriate personal protective equipment to use when providing care. 4. From 8/18/25 to 8/20/25, Surveyor reviewed R16's medical record. R16 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure, chronic respiratory failure (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with hypoxia, COPD, and chronic kidney disease. R16's MDS assessment, dated 8/6/25, contained a BIMS score of 12 out of 15 which indicated R16 had moderate cognitive impairment. R16 received continuous oxygen. A smoking assessment was completed on 5/5/25. Surveyor noted R16's most recent plan of care did not indicate R16 smoked or contain interventions related to safe smoking On 8/19/25 at 3:20 PM, Surveyor interviewed DON-B who indicated a resident who smokes should have a care plan for smoking. DON-B indicated a resident should also be assessed for smoking on admission, quarterly, and with changes in the resident's status. DON-B indicated MDSC-C completes smoking assessments for residents. When asked how staff know the smoking protocol for R16, DON indicated there used to be a list of residents who smoke near the nurses' station; however, the list did not contain smoking interventions for R16. On 8/19/25 at 3:32 PM, Surveyor interviewed MDSC-C who indicated residents who smoke should have a smoking care plan. MDSC-C indicated MDSC-C should have included smoking on R16's care plans. When asked if R16 was overdue for a quarterly smoking assessment, MDSC-C indicated DON-B completed smoking assessments for residents. MDSC-C reviewed the most recent assessments for all residents who smoked and noted the assessments were all completed by DON-B. On 8/19/25 at 3:38 PM, Surveyor interviewed DON-B who indicated DON-B completes smoking assessments for residents upon admission and quarterly. DON-B indicated DON-B cannot remember all of the things DON-B does but verified DON-B completed resident smoking assessments and was aware that R16's smoking assessment was overdue for completion. 5. From 8/18/25 to 8/20/25, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including alcohol dependence with alcohol induced dementia, mood disorder, major depression, anxiety, and weakness. R6's Minimum Data Set (MDS) assessment, dated 8/6/25, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R6 had moderate cognitive impairment. R6 had an activated Power of Attorney for Healthcare (POAHC) for medical decisions. A care plan, dated 1/30/25, indicated R6 had potential for limited abilities to complete ADLs without substantial assistance from staff. The care plan indicated R6 was alert and oriented x 2 and able to make R6's wants and needs known and contained an intervention to encourage R6 to get into Broda chair or go to the dining room for meals as R6 preferred to eat meals in bed. A nutritional care plan indicated R6 was on a therapeutic mechanical soft diet with thin liquids, received a house supplement of 120 milliliters (ml) three times daily, and enjoyed meals in R6's place of choice. The care plan contained interventions to encourage R6 to consume 100%, encourage R6 to consume 50-70% of meals and adequate fluids at and between meals, offer a clothing protector, and help wash and sanitize hands prior to meals and when necessary. R6's medical record did not contain physician or therapy orders for R6 to get out of bed for meals. A nursing progress note, dated 7/1/25 at 13:41 PM and written by Licensed Practical Nurse (LPN)-H, indicated R6 was uncooperative before lunch and refused to stand in the sit-to-stand lift or bend at the knees and put R6's feet on the stand. R6 stated R6 didn't need to bend R6's knees and didn't want to get up. A Hoyer lift was used to transfer R6 to a Broda chair for safety. R6's mood improved when R6 was in the Broda chair. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/18/25 at 12:57 PM, Surveyor interviewed R6 who indicated R6 was required to get up for lunch and staff made R6 get up when R6 didn't want to. On 8/20/25 at 9:43 AM, Surveyor again interviewed R6 who indicated staff state R6 must get up and sit in the chair at lunch time. R6 indicated when R6 tells staff that R6 does not have to get up, staff haul R6 out of bed which makes R6 angry and not want to eat. R6 also stated staff tell R6 what R6 is going to do and R6 has no say which makes R6 feel like a piece of meat. R6 indicated liked to eat meals in bed. On 8/20/25 at 10:14 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-I who indicated sometimes it takes persuading to get R6 up for meals. CNA-I indicated R6 usually allows staff to get R6 up once per day. CNA-I indicated CNA-I does not force R6 to get up because it's not worth the swearing. CNA-I indicated CNA-I had not witnessed staff get R6 up without R6's consent unless it was to obtain R6's weight. CNA-I indicated CNA-I was involved in the incident on 7/1/25 and staff put R6 back into bed and later got R6 up in the Broda chair. On 8/20/25 at 10:23 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-H who indicated R6 used to get up in the Broda chair, however, R6's care plan was changed because R6 was discovered choking on thin liquids during breakfast. LPN-H indicated R6 needs to be in the Broda chair for meals or staff have to stay with R6. LPN-H indicated R6 yelled and was uncooperative on 7/1/25 and LPN-H had to assist another staff member. LPN-H verified R6 had the right to refuse care but indicated R6 had alcoholic dementia and did not understand. On 8/20/25 at 1:50 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R6's care plan should indicate to get R6 out of bed for meals for safety measures and include interventions for staff to use to encourage compliance. DON-B indicated the way LPN-H documented the incident was not accurate because R6 was transferred back to bed and then transferred into the Broda chair later. DON-B indicated the facility did not complete risk versus benefit education with R6. 6. On 8/18/25, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease and dementia with anxiety. R13's MDS assessment, dated 5/13/25, had a BIMS score of 0 out of 15 which indicated R13 had severe cognitive impairment. R13 had an activated POAHC for medical decisions. R13 had a physician order, dated 5/28/25, to use a WanderGuard daily and test function every Friday. R13 also had a physician order, dated 7/18/25, to check placement of the WanderGuard on the right ankle every shift. A care plan, dated 8/15/22, indicated R13 was at risk for falling related to generalized weakness. The care plan indicated R6 will self-transfer/ambulate at times, especially if R13 needs to use the bathroom and contained an intervention to make sure R6's chair and bed alarm are in place when in wheelchair, bed, or recliner per POAHC's request. A care plan indicated R13 had potential for behavioral symptoms-sundowning and increased anxiety and indicated R13 lacked safety awareness and was impulsive. The care plans did not indicate R13 had a Wanderguard or contain interventions to check placement and function of the WanderGuard. On 8/18/25 at 1:10 PM, Surveyor interviewed POAHC-K who indicated R13 had a history of getting up independently and fell a couple of months ago. Following R13's fall, the family requested that R13 have chair alarms and a Wanderguard.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection. This practice had the potential to affect more than 4 of the 17 residents (R) residing in the facility. R11 was not initially placed on precautions when R11 developed signs and symptoms of a respiratory infection, including a fever, increased cough, and increased wheezing, and was not included on the facility's respiratory surveillance line list. In addition, staff did not follow transmission-based precautions while caring for R11.R13 tested positive for influenza A on 8/6/25. R13's symptoms resolved date was not included on the facility's respiratory surveillance line list.R29 tested positive for influenza A on 8/4/25. R29's symptoms resolved date was not included on the facility's respiratory surveillance line list.Staff did not follow influenza outbreak precautions by wearing a mask at all times.Findings include:The facility's Infection Prevention and Control Manual: Transmission Based Precautions policy, dated 6/11/25, indicates: Contact precautions .require the use of appropriate personal protective equipment (PPE), including a gown and gloves upon entering the room or contacting the resident or resident environment. When leaving the room, PPE will be removed and hand hygiene performed. Droplet precautions .require the use of a face mask upon entry into a resident's room with respiratory droplet precautions .It is essential both to communicate transmission-based precautions to all healthcare personnel and for personnel to comply with the requirements. Pertinent signage and verbal reporting between staff can enhance compliance with transmission- based precautions to help minimize the transmission of infections within the facility .The facility will identify the type of transmission-based precautions required and anticipate duration dependent upon the infectious agent or organism involved .The facility should document in the medical record the rationale for the selected transmission-based precautions .Healthcare personnel caring for residents on contact precautions should wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. Donning PPE before room entry and discarding PPE before exiting the resident's room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination .Documentation in the medical record should include: type of precautions in place, location of infection/colonization, and infectious agent; Resident's cognitive status in the ability to follow hygiene instructions; Any contained drainage, secretions, or secretions; Resident transport - limit transport and movement of resident outside of the room to medically necessary purposes.The facility's Influenza, Prevention and Control of Seasonal policy, revised 8/14/25, indicates: .1. Contact and droplet precautions are implemented for residents with suspected or confirmed influenza for seven days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer. Precautions may be applied for longer periods based on clinical judgment. If the resident needs to leave their room, they will wear a mask.The facility's Influenza-Like Policy and Procedure, revised 8/12/25, indicates: Acute respiratory illness is defined as illness characterized by any two of the following: Fever, cough, rhinorrhea or congestion, sore throat, malaise .Respiratory disease outbreak in a long term care facility is defined by the Centers for Disease Control and Prevention (CDC) and Department of Health as three or more residents and/or staff from the same unit with illness onsets within 72 hours of each other and who have pneumonia, acute respiratory infection, or laboratory confirmed viral or bacterial infection .Caregivers and visitors should adhere to the appropriate precautions when in the presence of a resident with a suspected or confirmed respiratory illness. Until the cause of an acute respiratory illness (ARI) outbreak is determined, both droplet and contact precautions should be initiated. Droplet precautions - Healthcare workers will wear a mask, gloves, and gown for close contact with all ill residents. PPE is donned upon entry in the room and removed before exiting the room .Residents on droplet precautions who (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	must be transported outside of their room shall wear a mask if tolerated and practice respiratory hygiene/cough etiquette. Contact Precautions - Healthcare staff will wear gowns and gloves for all interactions that may involve contact with the resident or potential contaminated areas in the environment .Don PPE upon room entry and discard before exit to contain pathogens implicated in the transmission through environmental contamination .Duration of Contact/Droplet Precautions - When a resident is confirmed or suspected to have influenza, the resident should remain on droplet precautions for seven days or until 24 hours after the resolution of fever (without fever reducing medications) and respiratory symptoms, whichever is longer after the onset of illness. For other respiratory illnesses, the resident should remain on appropriate precautions for the duration of illness, defined as 24 hours after the resolution of fever (without fever reducing medications) and respiratory symptoms.1. From 8/18/25 to 8/20/25, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive, pulmonary disease (COPD), chronic respiratory failure with hypoxia, chronic combined systolic and diastolic heart failure, and type 2 diabetes. R11's Minimum Data Set (MDS) assessment, dated 6/18/25, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R11 had intact cognition. R11 was responsible for R11's medical decisions.R11's medical record contained the following temperatures:~ On 8/19/25 at 4:18 AM: 98.2 Fahrenheit (F) ~ On 8/18/25 at 7:00 PM: 101.6 F ~ On 8/18/25 at 4:47 PM: 100.9 F~ On 8/18/25 at 10:02 AM: 98.9 F~ On 8/18/25 at 4:00 AM: 97.7 F~ On 8/17/25 at 7:40 PM: 99.6 F~ On 8/17/25 at 6:39 PM: 101.6 F~ On 8/17/25 at 12:14 PM: 97.7 FA physician visit note, dated 8/18/25, indicated R11 was seen by the physician due to increased cough, increased fatigue, and increased oxygen demands. The physician noted R11 had experienced increased fatigue for two days, had increased wheezing, and had wheezes in the right lower lung base. The physician ordered labs, influenza A and COVID-19 tests, a chest X-ray, and DuoNebs for 5 days.On 8/18/25 at 10:33 AM, Surveyor observed R11 smoking outside and observed staff push R11 in a wheelchair into the building. R11 was not wearing a mask. Staff put an oxygen canister on R11's wheelchair, assisted R11 with applying the nasal canula, and wheeled R11 to R11's room. On 8/18/25 at 4:40 PM, Surveyor observed R11 outside smoking and then observed staff push R11 in a wheelchair into the building. R11 was not wearing a mask. Staff put an oxygen canister on R11's wheelchair, assisted R11 with applying the nasal canula, and then wheeled R11 to R11's room. On 8/19/25 at 8:30 AM, Surveyor did not observe a precautions sign on R11's door or a PPE cart next to R11's room.On 8/19/25 at 10:05 AM, Surveyor observed contact and droplet precaution signs on R11's door.The droplet precautions sign stated: Stop. Droplet Precautions. Everyone Must: Clean their hands, including before entering and when leaving the room. Make sure their eyes, nose, and mouth are fully covered before room entry (the sign contained two pictures, one of a person in a full face shield and one of a person in a disposable mask over the nose and mouth and goggles over the eyes). Remove face protection before room exit.The contact precautions sign stated: Stop. Contact Precautions. Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reuseable equipment before use on another person. On 8/19/25 at 11:29 AM, Surveyor observed a therapist sitting on R11's bed with a mask on but no gown or gloves. Surveyor observed the therapist stand up and work with R11 to lift a bar up and down. On 8/19/25 at 11:34 AM, Surveyor interviewed Registered Nurse (RN)-M who indicated R11 was tested for influenza A on 8/18/25 due to a fever that started on 8/17/25. RN-M indicated all staff providing care to R11 should wear a mask, gown, and gloves prior to entering R11's room.On 8/19/25 at 3:34 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated Influenza outbreak precautions started in the facility on 8/4/25 and were currently in place. DON-B indicated R11 had a fever on 8/17/25 and should have been placed on precautions that day. DON-B indicated R11 was seen by the physician on 8/18/25 due to a fever and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	respiratory symptoms, was tested for influenza A and COVID-19 on 8/18/25, and was started on contact and droplet precautions on 8/19/25. DON-B verified R11 was not included on the facility's respiratory surveillance line list. DON-B was aware therapy staff worked with R11 without wearing a gown and gloves and indicated the therapist received PPE education. On 8/19/25 at 4:32 PM, Surveyor observed Certified Nursing Assistant (CNA)-L answer R11's call light and walk into R11's room with a mask on but no gown, gloves, or eye protection. CNA-L did not complete hand hygiene prior to entering the room. R11 handed a water cup to CNA-L who exited the room with the cup in hand. CNA-L took the cup to the dining room, filled the cup with water and ice, and walked back to R11's room.On 8/19/25 at 4:34 PM, Surveyor interviewed CNA-L who indicated CNA-L should have completed hand hygiene when entering and exiting R11's room and should have gotten R11 a new water cup since R11 was on contact precautions. CNA-L also indicated CNA-L should have donned the proper PPE prior to entering R11's room.On 8/20/25 at 12:15 PM, Surveyor observed Certified Nursing Assistant (CNA)-E enter R11's room with a food tray. CNA-E wore a disposable face mask and gloves but did not wear eye protection or a gown. Surveyor observed CNA-E dispose of the mask and gloves before exiting the room. CNA-E did not complete hand hygiene before donning another mask.On 8/20/25 at 12:16 PM, Surveyor interviewed CNA-E regarding contact and droplet precautions for R11. CNA-E indicated CNA-E was told by Registered Nurse (RN)-G that CNA-E only needed to wear gloves to bring the meal tray into R11's room. On 8/20/25 at 12:20 PM, Surveyor interviewed RN-G who confirmed RN-G stated CNA-E only needed to wear gloves to set the tray down in R11's room. When Surveyor asked if R11 was on contact and droplet precautions, RN-G indicated RN-G was told by Nursing Home Administrator (NHA)-A that staff only need to wear gloves to deliver trays to residents. When Surveyor asked if the information from NHA-A was for residents on contact and droplet precautions, RN-G was unsure and stated RN-G thought it was for residents on isolation.On 8/20/25 at 12:22 PM, Surveyor interviewed NHA-A who indicated staff should wear a gown, gloves, a mask, and goggles when entering the room of a resident on contact and droplet precautions even if only to deliver a food tray. NHA-A indicated no one should enter the room without the appropriate PPE. NHA-A indicated NHA-A did not tell staff to deliver trays with just gloves. NHA-A indicated staff were provided education on transmission-based precautions but needed more education.2. From 8/18/25 to 8/20/25, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had diagnoses including influenza A, Alzheimer's disease, dementia, and muscle weakness. R13's MDS assessment, dated 8/13/25, did not include a BIMS score. R13 had an activated Power of Attorney for Healthcare (POAHC).R13's medical record indicated was symptomatic for influenza A and tested positive on 8/6/25. R13 was included on the facility's respiratory surveillance line list on 8/6/25.On 8/19/25 at 3:34 PM, Surveyor interviewed DON-B who indicated an Influenza outbreak was identified in the facility on 8/4/25 and DON-B had not yet finished completing the resident respiratory surveillance line list. DON-B indicated R13's symptoms resolved date was blank on the line list. DON-B indicated DON-B usually documents the date a resident can come off precautions in the resident's chart but was unsure if DON-B documented the date in R13's chart. 3. From 8/18/25 to 8/20/25, Surveyor reviewed R29?s medical record. R29 was admitted to the facility on [DATE] and had diagnoses including influenza A, acute cough, weakness, and acute chronic combined systolic and diastolic heart failure. R29's MDS assessment, dated 8/6/25, had a BIMS score of 12 out of 15 which indicated R29 had moderately impaired cognition. R29 was responsible for R29?s healthcare decisions.R29's medical record indicated R29 was symptomatic for influenza A and tested positive on 8/4/25. R29 was included on the facility's respiratory surveillance line list on 8/4/25.On 8/19/25 at 3:34 PM, Surveyor interviewed DON-B who indicated the facility identified an Influenza outbreak on 8/4/25 and DON-B had not yet finished filling out the resident respiratory surveillance line list. DON-B verified R29's symptoms resolved date was blank on the line list. DON-B indicated DON-B usually documents the date a resident can come off precautions in the resident's chart but verified DON-B did not document the date in R29's chart. 4. On 8/18/25 at 9:17 AM, Surveyor observed US (Unit (continued on next page)

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Newcare	903 Main Ave Crivitz, WI 54114

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Secretary)-N at the nurses' station with a mask around US-N's neck and off US-N's face. Surveyor noted the facility was in an influenza outbreak that began on 8/4/25.On 8/18/25 at 9:20 AM, Surveyor interviewed US-N who indicated US-N did not need to wear a mask behind the nursing desk. On 8/19/25 at 3:34 PM, Surveyor interviewed DON-B who indicated the facility was currently in an influenza outbreak and all staff were required to wear a mask in the building at all times.