STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525502	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baldwin Care Center	650 Birch St Baldwin, WI 54002

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and record review, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to affect all 30 residents residing in the facility. Dietary [NAME] G did not monitor that dishes were being washed with the minimum requirement of 120 degrees Fahrenheit for proper sanitization of dishes. Findings include:Surveyor reviewed facility policy titled, Dish Machine Temperature, dated revised on 04/2024, stated in part: .-9. If the temperature gauge on the machine malfunctions, staff will need to clean the dishes twice, once via 120 temperature water and dawn dish soap and then run the dishes through the dish machine. A recorded document will be provided next to the dishwasher, and the Dietary Manager will oversee making [NAME] it is completed and communicated to all staff until further notice.Surveyor reviewed facility policy titled, Dish Machine Operation, dated revised on 04/2024, stated in part: .-3. Wash temperature should reach between 120-140 degrees F. and rinse temperature should reach between 140-160 degrees F when washing dishes.Surveyor reviewed Dish Machine Temperature log dated for the month of November 2025, November 26th being repaired at 2:00 PM, Unable to temperature check dish machine.Surveyor observed November 27th and 28th log was blank for temperature checks.On 12/09/25 at 9:44 AM, Surveyor observed dishwasher located in the back of kitchen. On the dishwasher the machine had a label that stated, Temperature wash should at minimum 120 degrees F. Rinse cycle should be at minimum 140 degrees F. On 12/09/25 at 9:52 AM, Surveyor observed [NAME] G wash dishes in kitchen area. [NAME] G began loading dishes into the dishwasher. Surveyor observed temperature of dishwasher on wash cycle with temperature of 111 degrees Fahrenheit, and then the rinse cycle was temperature of 119 degrees Fahrenheit. Surveyor never observed temperature gauge exceed 119 degrees Fahrenheit.On 12/09/25 at 10:01 AM, Surveyor interviewed Dietary Manager (DM) F and asked if the dishwasher is a high temp dishwasher or chemical sanitization dishwasher. DM F reported to Surveyor that the dishwasher is a chemical sanitization dishwasher, and the facility switched over in the last year and half. On 12/09/25 at 3:35 PM, Surveyor interviewed DM F and asked if DM F was aware the thermometer on the dishwasher was not functioning properly, and that staff are not checking the temperature during dishwashing cycle. Surveyor reported to DM F the temperature only rose to 111 degrees Fahrenheit on the wash cycle and 119 degrees Fahrenheit on the rinse cycle when observing [NAME] G during washing of the dishes. DM F reported to Surveyor that the dishwasher had an issue with the booster heater malfunctioning causing the thermometer to not work about a week or so ago and they had someone come out to try and fix it. DM F reported the person instructed DM F that the thermometer will need to be recalibrated. DM F then verbally reported the calibration request to Maintenance H to call the [name of] company who provides maintenance for the dishwasher in the kitchen. Surveyor requested documentation that Maintenance H contacted name of company of the need for the recalibration of thermometer. DM F reported that DM F would gather from Maintenance H. On 12/10/25 at 6:45 AM, Surveyor interviewed DM F who stated, [Nursing Home Administrator (NHA) A] tried calling [name of] company for records that the company was called about the recalibration and there was no (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	recollection that the company was notified. DM F reported to Surveyor that Maintenance H must have not notified the company of the needed recalibration of the thermometer. On 12/10/25 at 7:10 AM, Surveyor interviewed NHA A and asked for confirmation that [name of] company was notified of the need for recalibration of the dishwashing machine in the kitchen. NHA A reported that NHA A made a call yesterday and the company was not aware that the dishwasher needed recalibration. NHA A reported to Surveyor that NHA A placed a work ticket in yesterday on 12/09/25 since it was not completed by Maintenance H. NHA A provided Surveyor with an invoice from the original company that came to repair the booster heater on 12/01/25 that stated, Checked water going in at 200 degrees and coming out at 152 degrees, but that the customers gauge said 120 degrees out, so facility was going to get a new thermometer changed out.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation and interview, the facility failed to maintain an effective pest control program so the facility is free of rodents with the potential to affect all 30 residents.Surveyor observed mouse droppings in the dry storage room located in the kitchen area.This is evidenced by:Surveyor reviewed facility policy titled, Pest Control, dated revised on 09/30/2024, which stated in part: .-Purpose: To reduce the potential of specific pest problems within the facility.Policy: Maintenance staff will monitor all parts of the building for prevention and elimination of any insects and/or rodents in a safe, efficient manner.Procedure: A specific pest control service plan will always be in place at facility. Services provided will include prevention and elimination of any insects and/or rodents in a safe, efficient manner. The Maintenance Department is responsible for maintaining a current contract with a pest control company.On 12/08/2025 at 8:47 AM, Surveyor entered kitchen and began tour. Dietary Manager F was in kitchen to walk Surveyor around. Surveyor walked into dry storage room and observed sticky stuff on the floor and debris with trash around on floor under dry storage shelves. Surveyor asked Dietary Manager F if the dry storage room has pest control throughout the kitchen. Dietary Manager F reported to Surveyor that Dietary Manager F does not think there is any pest control units in the kitchen or in the dry storage room. Dietary Manager F Manager reported to Surveyor that underneath the dry storage shelves it appeared dirty. Surveyor requested Dietary Manager F to retrieve pest control policy. On 12/08/25 at 8:48 AM, Surveyor interviewed Maintenance H and asked if the kitchen and dry storage area had pest control. Maintenance H reported to Surveyor that the kitchen does not have any pest control units. Maintenance H took Surveyor outside to show Surveyor there was a pest control unit outside the door for coverage of pests. Surveyor did not observe a pest control outside the back kitchen door. Surveyor asked Maintenance H where the pest control unit was, and Maintenance H reported the unit must be covered with snow. Surveyor asked how often pest control comes to the facility to check units. Maintenance H reported to Surveyor that pest control comes monthly. On 12/08/25 at 9:08 AM, Surveyor re-entered the dry storage room and observed the floor to have been swept. Surveyor observed a mouse dropping on a cardboard box located on the first shelf close to the floor. Surveyor continued to observe mouse droppings in the corner of the dry storage room next to the door. While Surveyor was in the dry storage room Maintenance H walked in with a pest control unit in hand. Surveyor had asked Maintenance H if Maintenance H could please observe the corner near the door and the cardboard box which looked like mouse droppings and explain what it might be. Maintenance H looked and stated, I cannot see down that low as my glasses are in the office. Maintenance H asked if Surveyor could pick up the mouse droppings and show him closer. Surveyor picked up the mouse droppings and showed Maintenance H in Surveyor's hand. Maintenance H stated, Oh yup that is mouse droppings, and we had an issue a few weeks ago and set live traps. We thought we fixed the issue.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure residents/representatives received notice before transfer or discharge, notice of bed-hold policy, and did not send a copy of the discharge notice to the Office of the State Long Term Care Ombudsman Notification for 2 of 2 residents (R7 and R39). R7 and/or representative were not provided/received notice of transfer to hospital, notice of bed-hold policy and facility did not notify Ombudsman of transfer.Facility did not notify Ombudsman of R39's discharge. The facility policy titled Notice of Bedhold Policies undated, states in part: If a Resident of [name of facility] is temporarily transferred to a hospital or another health care facility for emergency care .[Facility] will hold the resident's bed until the resident or residents representative waives the right to have the bed held for the resident.The facility policy titled Notice of Transfer/Discharge undated, states in part, This information is provided to a resident and/or resident representative at the time of the resident's transfer to a hospital of more appropriate health care facility or a discharge to home or a therapeutic leave, so as to inform the resident and/or resident representative of the resident's transfer/discharge and the facility's bedhold policies and the resident's rights to appeal the transfer/discharge.The facility policy titled Notification of Ombudsman states purpose: To provide the Ombudsman with the list of residents who have unplanned transfers or discharges from the [name of facility] monthly R7 was transferred to hospital on [DATE] following a fall with head injury and facility did not provide a copy of the bed hold, notice of transfers or inform the State Long Term Care Ombudsman.R39 discharged Against Medical Advice (AMA) on 10/07/25 and facility did not inform the State Long Term Care Ombudsman.On 12/10/25 at 10:18 AM, Surveyor interviewed Social Worker E and requested documentation of notice of transfer, bed hold and notification to Ombudsman for R7 and notification to Ombudsman for R39. Social Worker E stated she was unable to provide documentation due to being unaware of the need to provide notice of transfer, and notification to Ombudsman for R7, nor to provide notification to Ombudsman for R39's discharge.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not follow best standards of practice when administering medication for 1 resident (R26) of 25 residents reviewed for medication administrationR26's Gabapentin medication was removed from its original packaging from pharmacy, placed into a medication cup, stored in a locked cupboard to be administered 2 hours later to a resident, which has potential for a medication related adverse event to occur.Findings include:Wisconsin State Legislature, 132.65 Section 7(b) states in part: Additional requirements for unit dose systems.the individual medication shall remain in the identifiable unit dose package until directly administered to the resident.R26 was admitted to the facility on [DATE] and has a Brief Interview for Mental Status (BIMS) score of 3/15, meaning severe cognitive impairment. On 12/09/25 at 7:38 AM, during Surveyor observation of medication administration, Registered Nurse (RN) J prepared R26's morning medications to be given before breakfast. One of R26's medications, Gabapentin (an anticonvulsant which is often used for chronic neuropathic pain control), was scheduled to be given at 10:00 AM daily. RN J removed Gabapentin 100mg tablet from its original identifiable unit dose packaging as received from the pharmacy, placed the medication into a medication cup, labeled medication with R26's name, medication, dose, date and time, and RN J's initials. RN J then placed the medication cup in the locked medication storage cupboard outside of R26's room with intent to administer it at 10:00 AM. It is to be noted that every resident has an individual locked medication cupboard outside of their rooms. Prior to this, RN J verified correct medication and dosage against the physician orders on R26's Medication Administration Record (MAR).On 12/09/25 at 7:40 AM, Surveyor asked RN J the reasoning behind preparing medication ahead of time and storing in R26's medication cupboard. R26 stated it was easier to do this because the medication carts with computers are separate from where medications are stored for residents. RN J indicated when medications are to be given later, this allows the RN to administer the medication without having to bring medication cart back to the room. R26 stated she would be the nurse administering the medication at 10:00 AM.On 12/09/25 at 9:00 AM, record review of R26's MAR shows Gabapentin 100mg tablet to be given at 10:00 AM. This was compared against physician order, which stated same medication, dosage, and time for administration.On 12/09/25 at 11:55 AM, record review of R26's MAR showed RN J's initials for administration of Gabapentin 100mg at 10:00 AM.On 12/11/25 at 7:48 AM, Surveyor interviewed RN D and asked what the facility's practice was for administering medications scheduled for times other than morning, noon, or at bedtime. RN D stated medications are sometimes prepared ahead of time by removing them from the original identifiable packaging from pharmacy, placed in medication cups which are labeled with resident's name, drug name and dosage, and time to be given, and then placed into a locked drawer in the portable medication cart. RN D also stated this was done when residents had requests for medications to be given at different times than their regular medications, for example, after a meal.On 12/10/25 at 12:31 PM, Surveyor interviewed Director of Nursing (DON) B on the facility's standard of practice for administering medications. DON B stated all medications should be administered at time scheduled. DON B stated Centers for Medicare/Medicaid Services states it is allowable to prepare medications ahead of time, if they are labeled with resident's name, drug, dose and time to be given, and placed in a locked area. Surveyor asked DON B if in the event the nurse who prepared the medication had to leave the facility unexpectedly, was it expected for another nurse to administer a medication they did not prepare themselves, and when it was not in its original, identifiable packaging. DON B stated the bubble packaging with more of the medication is in the cupboard, and the nurse administering can either compare the appearance of the medication against the packaging of look-alike medication or throw the medication away and start over. They would contact pharmacy later to replace the wasted medication.

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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. Based on observation, record review and interview, the facility did not ensure procedures were in place to ensure medication with expired dates were removed/destroyed from 1 of 2 medication storage rooms.Four bottles of Aspirin were expired in 1 of 2 medication storage rooms.On 12/09/2025 at 1:40 PM, Surveyor observed the medication storage room on one unit with assist of Registered Nurse (RN) D and observed 4 bottles of Aspirin 325 mg that were expired: 2 unopened bottles that expired June 2025; 1 bottle open with approximately 1/2 of remaining tablets that expired June 2025; and 1 unopened bottle expired August of 2025. RN D stated there was a resident who was in the facility during June 2025, who the bottles of Aspirin were used for. This resident was no longer in the facility and no other resident since then required Aspirin 325mg. RN D stated RN D will destroy immediately. On 12/09/2025 at 1:46 PM, Surveyor interviewed Director of Nursing (DON) B regarding observation of 4 bottles of expired medication in storage room. DON B indicated was not aware of expired medications in medication storage.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not maintain infection prevention to provide a safe, sanitary environment to help prevent the development and transmission of communicable diseases and infection for 2 residents (R32, R17) of 5 residents reviewed for infection prevention in a sample of 12.Facility did not:Perform hand hygiene between feeding multiple residents at same time which could result in possible infection transmission. Perform hand hygiene after touching contaminated surfaces and prior to feeding residents which could result in possible infection transmission by cross contamination.Offer hand hygiene to residents prior to meal being served.Perform hand hygiene during peri-area cares which could result in possible infection transmission.Findings include: Example 1 Facility policy titled Hand Hygiene Policy for dining room/feeding, revised 03/2023, states in part: Nursing Staff of [NAME] Care Center will perform adequate hand hygiene at all appropriate times to reduce the spread of infection to other residents.before, during and after feeding. Step 1. Make sure all residents are offered the opportunity to clean their hands with hand sanitizer. They do have the right to refuse. Step 3. Staff are to sanitize their hands between each resident when feeding more than one resident. R32 was admitted to facility on 05/31/2012, and has a BIMS score of 0, meaning severe cognitive impairment. R32's Minimum Data Set (MDS), dated [DATE], indicated that R32 requires substantial/maximum assist with feeding. R17 was admitted to the facility on [DATE], and has a BIMS score of 3, meaning severe cognitive impairment. R17's MDS, dated [DATE], indicated that R17 requires substantial/maximum assist with feeding. On 12/08/25 at 12:20 PM, Surveyor observed R32 and R17 sitting alongside each other at dining table with Certified Nursing Assistant (CNA) I between them. CNA I alternated spooning food into the mouths of R32 and R17 with bare hands, using feeding utensils. CNA I touched body surfaces of both residents and did not perform hand hygiene in between alternating feedings for both. CNA I was then observed pouring water from a pitcher into a glass at kitchenette counter, touching counter surface, pitcher, water glass, and another resident's wheelchair with bare hands. No hand hygiene was done before CNA I resumed assisting with feeding for R17 and R32, or in between feedings of both residents. On 12/08/25 at 12:25 PM, Surveyor observed CNA I wipe R17's mouth with a napkin using bare hands, set napkin down onto table, not perform hand hygiene, then assist R32 with feeding. CNA I then wiped R32's mouth with a napkin using bare hands and returned to feeding R17. No hand hygiene done in between. On 12/10/25 at 11:58 AM, Surveyor observed CNA I assist R17 to drink from a glass, holding the straw with bare hands and directing it into R17's mouth. CNA I then proceeded to assist R32 with feeding without performing hand hygiene first. On 12/10/25 at 12:15 AM, Surveyor interviewed CNA I on expectations of staff to perform hand hygiene during feeding assistance of multiple residents at one time. CNA I stated if only the feeding (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	utensils were touched while feeding multiple residents, no hand hygiene in between was needed. CNA I stated there are no instances of cross contamination that happens any other time, including after touching surfaces. CNA I was asked what resources are available for staff to perform hand hygiene during feeding, and CNA I pointed to a sink nearby. On 12/09/25 at 7:43 AM, Surveyor observed two residents be rolled up to a table by a staff person for breakfast. Food was immediately served to both residents without staff first offering hand hygiene to them. Both residents were independent with feeding. No hand hygiene product was available at table for residents to assist themselves to. On 12/10/25 at 11:58 AM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectations of staff were during dining times in regard to hand hygiene for residents and staff. DON B stated all residents are to be offered hand hygiene prior to meals being served. Staff is to wash hands or use alcohol-based product themselves before assisting residents with feeding, after touching contaminated surfaces such as wheelchairs and tables and before feeding residents and in between feeding multiple residents at one time. Example 2 Facility policy titled Perineal (Peri) Care Policy for Elderly Residents revised 03/2024, states: Purpose: To ensure safe, hygienic, and dignified perineal care for elderly residents while preventing cross-contamination through proper glove use and hand hygiene. Under the section identified Procedure B(2) states in part, 2. Specific steps during peri care – you must change gloves and perform hand hygiene at the following points: A. After removing soiled incontinence productsB. After cleaning the genital area (front)C. After cleansing the anal area (back) On 12/09/2025 at 7:18 AM, Surveyor observed CNA C conduct morning cares that included incontinence care on R17. CNA C conducted hand hygiene and donned clean gloves. After completing upper body cleansing, CNA C removed urine soiled incontinent product and did not remove gloves and conduct hand hygiene until the following tasks were completed: CNA C obtained a premoistened wipe from a package, cleansed R17's anal area, touched and positioned a clean incontinent product under R17's bottom, picked up a bottle of powder and sprinkled on R17's bottom, reached and obtained a premoistened wipe from package, cleansed R17's front genital area, fastened clean incontinent product. On 12/09/2025 at 7:43 AM, Surveyor interviewed CNA C regarding facility's expectations on when to remove gloves and conduct hand hygiene. CNA C stated, Before and after all cares and when there is BM on gloves. Surveyor asked what the facility's expectation of glove removal and hand hygiene is when going from contaminated area to clean area. CNA C stated expectation would be to change gloves and conduct hand hygiene. Surveyor shared observation of conducting rectal area cleansing then proceeding to frontal peri care and no observation of removing gloves and conducting during incontinence care. CNA C confirmed, I did not, and stated, Should not go from icky part to frontal part. On 12/09/2025 at 2:02 PM, Surveyor interviewed DON B regarding observation of incontinence care conducted by CNA C, wherein cleansing of rectal area prior to vaginal area and no observation of glove change or hand hygiene in-between. DON B stated was made aware of same and expectation would be for staff to conduct frontal peri care prior to posterior care and to remove gloves and conduct hand hygiene in-between clean/dirty areas.