STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525553	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shell Lake Health Care Center	802 E Cty Hwy B Shell Lake, WI 54871

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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 maintain a safe and sanitary environment in which food is prepared and distributed. This had the potential to affect all 35 of the 37 residents who consume food or beverages from the facility's kitchen. Facility staff did not wear a hair net in the kitchen.Dietary staff did not check food temperatures on cold beverages before serving to residents.The facility's policy and procedures titled, Standards for Dress and Cleanliness, reads in part, .Hair nets, covering all hair, will be worn by all Food Service employees at all times.The facility's policy titled, Food Temperature Maintenance, dated 1/2007, states in part, .Cold Food Items. Cold liquids should be served at 41 degrees or cooler The Food and Drug Code requires cold food at 41 degrees or below . A calibrated food thermometer must be used to measure the internal temperature of the food. Documentation may involve reviewing logs to see how often and at what temperatures staff monitor food, as it is the only way to properly check internal food temperature is with a calibrated thermometer.This is evidenced by:Example 1On 9/09/25 at 12:23 PM, during follow up kitchen inspection, Environmental Services (EVS) I came into kitchen without wearing a hairnet, walked through the kitchen preparation and clean dishes areas to a door on opposite side, and then came back through. Surveyor interviewed EVS I who stated she is aware that hair nets are required in the kitchen area. EVS I stated she should be wearing a hair net when in the kitchen.Shortly after this, Surveyor interviewed [NAME] J, as Dietary Manager was unavailable. [NAME] J stated everyone who enters the kitchen is required to wear a hair net and that most staff usually knock at the door. Surveyor noted sign on kitchen door reads, This kitchen is a restricted area for dietary personnel - Only authorized personnel allowed.Example 2On 9/09/25 at 12:27 PM, Surveyor noted staff loading trays on to cart for residents eating in dining room upstairs. These trays were filled with cups of milk and juice which had been sitting on a cart outside of the cooler.On 9/09/25 at approximately 12:45 PM, during distribution of food and drinks to residents on the 2nd floor, Surveyor interviewed Dietary Aide (DA) K, who reported she was responsible for checking the temperatures of the beverages before being served and she had taken the temperatures of the cold liquids before bringing them up to floor. DA K reported she remembers all liquids were 38 degrees and will document this later. DA K stated she just forgot to write them down on the temperature log.On 9/09/25 at approximately 1:00 PM, Surveyor requested food/beverage temperature logs for the past week and noted no documentation of milk/supplement temperatures recorded for lunch on 9/5/25 and 9/7/25 and there was no record of beverage temperatures for supper on any of the logs requested.Surveyor interviewed [NAME] J, as Dietary Manager was unavailable. [NAME] J stated the expectation is that beverages like milk and juice, which are pre-poured into cups and covered the morning before lunch is served, would be checked with thermometer at every meal and be recorded by the DA on duty in the food log. [NAME] J stated after review of the logs, beverage temperatures were not recorded on the dates noted by Surveyor for lunch or any for supper.On 9/10/2025 at approximately 3:00 PM, Surveyor interviewed Nursing Home Administrator (NHA) A, who stated everyone that goes into the kitchen is required to wear a hair net. NHA A agreed that food temperatures need to be recorded.

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 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 record review and staff interview, the facility did not ensure the accuracy of the Minimum Data Set (MDS) assessment for 1 of 12 residents (R) (R11) reviewed.R11's nutrition assessments required for quarterly Minimum Data Set (MDS) assessment were not completed.Findings include:The facility policy, titled Minimum Data Set/CAA's, last revised 6/2018, states: Purpose: To ensure that each resident receives the necessary medical, psychosocial and nutritional service to attain and maintain the highest possible mental and physical functionals status.Procedure.Sections will be completed by the staff with relevant professional backgrounds. The Policy and Procedure titled CDM and RD Role in Maintaining or Improving the Nutritional status of Residents, dated 9/10/25, emailed to Nursing Home Administrator (NHA) and Director of Nursing (DON) and shared with Surveyor, states: RD [Registered Dietician] completes comprehensive nutrition risk assessments for residents on admission, for significant changes and annually.The CDM [Certified Dietary Manager] .completes a quarterly nutrition summary documentation which include weigh, weight history within past 30/90/180 days, diet, meal intakes, nutritional supplements, nutritional supplement acceptance, chewing/swallowing abilities, skin impairments, hydration acceptance and eating ability.The Centers for Medicare and Medicaid Services Manual, titled Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2023, states: The Minimum Data Set (MDS) Assessment is a core set of screening, clinical and function status data elements which form the foundation of a comprehensive assessment for all residents. While its (MDS) primary purpose. is to identify resident care problems to address in an individual care plan.Section K related to Nutrition is required on the quarterly MDS assessment. R11 was admitted to the facility on [DATE] and has diagnoses that include type 2 diabetes mellitus with hyperglycemia (low blood sugars), gastro-esophageal reflux disease without esophagitis, chronic kidney disease, Alzheimer's disease, dementia, and hypothyroidism. R11's MDS assessment, dated 6/27/25, indicated that R11 is severely cognitively impaired. R11 has clear speech and can make self-understood and understands what is said to R11. R11's depression screening was scored 00, meaning R11 or Resident Representative (RR) G reported no or minimal symptoms of depression over the last two weeks prior to assessment. R11 does not exhibit signs of aggressing, isolation, or reject cares. R11 requires partial assistance to complete hygiene activities and dress. R11 needs supervision for eating, mobility and position changes, but R11 is ambulatory and likes to walk around the facility. R11's care plan, dated 7/11/25, with a target date of 10/15/2025, states: I am at risk for alteration in body mass and nutrition d/t therapeutic diet, . Alzheimer's, dementia, diabetes, .Goal: I will maintain adequate nutritional status as evidence by maintaining weight within 3-5 lb. range, no s/sx (signs or symptoms) of dehydration, no unacceptable nutrition labs and no skin break down through review date. Initiated 7/15/25, target date 10/15/25. Interventions include but are not limited to:CDM to monitor weekly weights and update RD and MD [Medical Doctor] with weight change of greater than 5# or significant wt (weight) gain or loss. - initiated 6/12/23CDM to notify RD with nutritional concerns regarding skin integrity or nutritional concern- initiated 6/12/23RD to assess diet, medications and nutrition on admit, readmit, significant change and prn (as needed) w/ (with) nutrition concerns. - initiated 6/12/23R11's quarterly nutrition assessments required for quarterly completion of the MDS were not consistently completed. Surveyor reviewed in computer and asked DM G and medical records for printed copies of dietary notes and assessments. R11 was readmitted in the 2nd quarter of 2024. Reviewing for this survey period, dietary failed to complete the quarterly assessment for the 3rd and 4th quarter of 2024, 2nd quarter of 2025 and 3rd quarter is pending. The last nutrition assessment dated [DATE] scored an 8 which indicated that R11 was at risk for malnutrition.Record review of dietary progress notes identified inconsistent completion of dietary assessment notes. Starting with June of 2024, the CDM completed nutrition risk assessment 6/29/24 only, missing the note for the 3rd and 4th quarters. The RD completed the annual assessment (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and note on 7/27/24. In 2025 there is no RD completed annual assessment. On 08/07/2025 at 11:33 AM, Surveyor interviewed R11's representative, RR G, who stated R11 has been losing weight over the last year. RR G stated RR G thinks it was the diabetic medicine R11 was on. RR G stated RR G got a call the other day that R11 has gained weight. RR G stated again, it might be because of the medication R11 is on, or possibly R11's Alzheimer's. RR G stated RR G is not worried about R11's weight loss.On 9/9/25 at 11:39 AM, Surveyor interviewed CDM E who stated, We missed the assessment in June. I don't know how. There are notes that we followed her but no assessment. CDM E stated we should be doing nutrition assessments quarterly. The RD is supposed to do an assessment annually. CDM E again stated DM does not know how they missed June. On 9/10/25 at 3:25 PM, MDS Coordinator H stated nutrition assessments are part of the quarterly MDS assessment.

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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 - Minimal harm or potential for 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 free of accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents for 2 of 3 residents (R), R7 and R11, reviewed.R7 had multiple falls; the facility did not initiate immediate intervention to prevent future falls, investigate the root cause of the fall and review and revise care plan fall interventions. R11 fell on 5/25/25. New intervention to encourage resident to sleep in R11's own bed was documented to be implemented. New intervention not in care plan or on Certified Nursing Assistant (CNA) plan of care/kardex. This is evidenced by: Example 1 Facility policy titled, Falls-Incident Reports-Fall Prevention, with a revised date of 12/2018, states in part: POLICY: .When an accident or incident involving a resident occurs, any witnessing staff will offer immediate assistance. Any occurrence that, without immediate staff intervention would have proceeded in a fall, will be documented and treated as such. An Incident Report and the appropriate documentation will be completed in [name of electronic record system]. PURPOSE: To assure appropriate follow through on all accidents and incidents. To study the cause of accidents and incidents and to give guidance for corrective/preventative action. PROCEDURE: 11. Chart an objective account of the incident in the Nurses' Notes in the resident's electronic medical record, include: g. Complete the Post Fall Evaluation including: preventative interventions implemented, document preventative measures, and put on the care plan. H. Communication preventative measures and interventions per verbal and written report to direct care staff. i. Update Care Plan. j. Update the CNA Cardex. 14. The IDT [Interdisciplinary Team] will review the Incident Report. The IDT will review documentation, evaluate the possible cause and create or change interventions as needed on the resident Care Plan. The team will communicate with nursing staff. INCIDENT/ACCIDENT REPORT: Completion of the Form: 4. With all resident incidents the nurse will state what happened and how to prevent a recurrence. The care plan will be updated. The CNA plan of care will also be corrected in the same manner by adding interventions. R7 was admitted to the facility on [DATE], with pertinent diagnoses of vascular dementia with unspecified severity, localization-related (focal)(partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, and anxiety disorder. R7's most recent quarterly Minimum Data Set (MDS) assessment, dated 07/07/25, noted a Brief Interview for Mental Status (BIMS) score of 06/15, indicating severe cognitive impairment. R7 required partial/moderate assist with chair to bed transfers. R7 required substantial/maximum assist with upper/lower dressing, personal hygiene, rolling left to right, sit to lying, sit to standing, and toilet transfer. R7 had one fall without injury since admission or prior assessment. R7's care plan, dated 06/06/23, with a target date of 10/22/25, states: [R7] is a moderate risk for falls and will be free of falls through review date with interventions of anti-rollbacks on wheelchair, anticipate and meet my needs, be sure call light is within reach and encourage me to use it for assistance as needed, prompt response to all requests for assistance, ensure that I am wearing appropriate footwear when ambulating or mobilizing in w/c, leave w/c outside of room when resident in bed (02/28/24), offer to assist resident to bed after lunch (04/12/24), wear gripper socks with shoes and sign placed to mark resident's room (05/29/24), Dycem in wheelchair (06/11/24), bed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alarm (06/05/23), gripper socks while in bed (06/08/24), mat on floor next to bed (06/08/23), follow facility fall protocol, sensor chair alarm on wheelchair to alert staff of the need to transfer, I need activities that minimize the potential for falls while providing diversion and distraction, wheelchair cushion that straps around back (06/10/23), no crocs or slippers, PT evaluate and treat as ordered or PRN, review information on past falls and attempt to determine causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. R7's Falls Data Collection Assessments: 01/06/25 score 21; high-risk 04/08/25 score 21; high-risk 07/07/25 score 21; high-risk On 01/09/25 at 10:28 AM, facility's fall incident documented, [R7] had an unwitnessed fall in room next to bed and wheelchair. [R7] was found sitting up on the floor at 0948 after heard yelling for help. [R7] was attempting to self-transfer and lost her balance. Root cause of fall is believed to be d/t dementia affecting judgement. Surveyor noted the fall incident documentation did not include immediate interventions to prevent falls. On 03/03/25 at 8:39 PM, facility's fall incident documented, [R7] observed walking from dining room table without assist or wheelchair. [R7] lost her balance before anyone could help and fell hitting back of head on serving table. Ice pack applied to hematoma on back of head for first aid. Surveyor noted the fall incident documentation did not include the root cause of the fall or immediate interventions to prevent falls. On 07/21/25 at 1:43 PM, facility's fall incident documented, [R7] witnessed controlled lowering to the floor. [R7] in the shower room, resident attempted to sit down while CNA standing her up to pull up pants. Was lowered to the floor to prevent injuries. Surveyor noted fall incident documentation did not include root cause of the fall or immediate interventions to prevent falls. On 09/10/25 at 2:00 PM, Surveyor requested from Director of Nursing (DON) B the IDT investigation notes for R7's fall, including the root cause and interventions to prevent future falls. Surveyor's review of the care plans did not identify an update for fall interventions. On 09/10/25 at 4:02 PM, DON B stated being unable to provide any additional IDT investigation fall notes or updated care plans for R7's falls. Example 2 R11 was admitted to the facility on [DATE], with diagnoses including type 2 diabetes mellitus with hyperglycemia (low blood sugars), gastro-esophageal reflux disease without esophagitis, chronic kidney disease, Alzheimer's disease, dementia, and hypothyroidism. R11's Minimal Data Set (MDS) assessment, dated 6/27/25, indicated that R11 is severely cognitively impaired. R11 has clear speech and can make self-understood and understands what is said to R11. R11's depression screening was scored 00, meaning R11 or Resident Representative (RR) G reported no or minimal symptoms of depression over the last two weeks prior to assessment. R11 does not (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exhibit signs of aggressing, isolation, or rejecting cares. R11 requires partial assistance to complete hygiene activities and dress. R11 needs supervision for eating, mobility, and position changes, but R11 is ambulatory and likes to walk around the facility. R11's care plan, dated 7/11/25, with a target date of 10/15/2025, states: FALLS: I am at risk for fall r/t confusion, gait/balance problems, incontinence, Hx. (history) of 2 falls at home during the past year, cognitive deficit I will be free of falls through the review date Anticipate and meet my needs. Be sure my call light is within reach and encourage me to use it for assistance as needed. I need prompt response to all requests for assistance. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Encourage me to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Ensure that I am wearing appropriate footwear when ambulating or mobilizing in w/c. Follow facility fall protocol. I need a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; handrails on walls, personal items within reach) I need activities that minimize the potential for falls while providing diversion and distraction Review of R11's kardex identified no direction for Certified Nursing Assistant (CNA)s to encourage R11 to sleep in R11's own bed. On 5/26/25 at 2:38 AM, facility documented R11 had an unwitnessed fall on the floor sitting directly next to spouse's bed with blood coming out of mouth. Spouse and R11 both state R11 was not fully awake when attempting self-transfer out of spouse's bed and was positioned too close to the edge of the bed, when R11 rolled out onto the floor. R11's spouse and R11 state R11 did hit head but at no time did R11 lose consciousness. No immediate intervention to prevent falls included in documentation. On 9/10/25 at 4:02 PM, Surveyor received from DON B one single piece of paper with the header #2080 Un-witnessed Fall Date 5/25/25 at 2:30 AM. Under the header was R11's name, the incident location: R11's room on west 209-2 and the name of the person preparing the report. This is followed by a second header – Notes: Underneath that is documentation 5/25/2025 Encourage resident [R11] to sleep in her own bed. On 9/10/25 at 4:03 PM, Surveyor interviewed DON B and told DON B that Surveyor did not see the interventions in the care plan or kardex for R11. DON B stated we missed that too.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management 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 failed to adequately assess and provide necessary care and services to attain or maintain the highest practicable physical wellbeing for 1 of 4 residents (R)(R27) reviewed for pain management.R27's care plan did not include resident's desired/tolerable pain level and pain assessments did not include characteristics, location, and duration to determine effectiveness of intervention or worsening of pain.This is evidenced by:Facility policy titled, Pain Management and Assessment, with a revised date of 06/2018, states in part: PURPOSE: To promote and prioritize the recognition, assessment, treatment and monitoring of pain. POLICY: To promote a systematic interdisciplinary and individualized approach to pain management. Pain will be reviewed by Nursing with the following: weekly summary charting review of PRN [As Needed] pain meds used, assess for pain every shift and documented on the electronic TAR [Treatment Administration Record], before and after administration of an as needed analgesic medication.R27 was admitted to the facility on [DATE], with pertinent diagnoses of encephalopathy, rhabdomyolysis, chronic pain, depression, and anxiety disorder.R27's admission Minimum Data Set (MDS) assessment, dated 06/23/25, noted a Brief Interview for Mental Status (BIMS) score of 08/14, indicating moderate cognitive impairment. R27 received scheduled and PRN pain medications. No non-medication interventions for pain noted. R27 has pain present frequently, occasionally affects sleep, and frequently interferes with therapy activities and day-to-day activities. R27's worst pain is noted 7/10.R27's care plan, dated 06/17/25, with a target date of 10/08/25, states: I have chronic pain and will state minimal to no pain when asked through review date with interventions of administer pain medication as ordered/requested, document effectiveness, assess location, frequency, duration and intensity of pain. Document assessment. Report increased pain trend to physician. Attempt non-pharmacological pain relief measures such as repositioning, back rubs, heat or cold, etc and document effectiveness. Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Monitor/record pain characteristics every shift and PRN. Quality (e.g., sharp, burning); Severity (1 to 10 scale); Anatomical location; Onset; Duration (e.g., continuous, intermittent); Aggravating factors; Relieving factors.R27's physician orders:6/17/25 Pain Scale every shift6/17/25 Acetaminophen Oral Tablet 500 MG (Acetaminophen)6/19/25 fentaNYL Transdermal Patch 72 Hour 25 MCG/HR (Fentanyl)7/4/25 HYDROmorphone HCl Oral Tablet 2 MG (Hydromorphone HCl) 7/24/25 Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)8/1/25 Lidocaine External Patch 4 % (Lidocaine) R27's pain assessments noted pain present everyday since admission with a severity score of 1 or higher out of 10. No documentation to include quality, duration, location, or onset was noted. Non-pharmacological interventions were not noted.R27's medication administration record noted pain medications were administered per order with a follow-up evaluation of ?effective.' Pain assessments attached with medication administration note a severity score of 1-10. No documentation of quality, duration, location, or onset was noted.On 09/08/25 at 10:30 AM, Surveyor observed R27 lying in bed in room. Surveyor asked R27 about satisfaction of cares received at facility. R27 began to cry and stated it was ok. Surveyor asked if R27 was having pain. R27 stated all the time. Surveyor asked if the facility was addressing her pain concerns. R27 began to cry more and stated not really. Surveyor asked R27 what the facility was doing to help with pain. R27 stated she did not want to talk about it anymore.On 09/10/25 at 9:57 AM, Surveyor interviewed Licensed Practical Nurse (LPN) C regarding pain assessments. LPN C stated that residents are assessed for pain every shift and assessment should include a severity score of 1-10, if resident is verbal, and document the location, characteristics, quality, etc. Surveyor asked how efficacy is assessed and documented. LPN C stated by asking the resident. Surveyor asked if this is documented. LPN C stated this is usually only documented if a PRN med is administered, but not typically with scheduled (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain meds. Surveyor asked if non-pharmacological interventions are used and documented. LPN C stated that it should be.On 09/10/25 at 1:49 PM, Surveyor interviewed Director of Nursing (DON) B regarding pain assessments. DON B stated that pain assessments should include severity score, characteristics, duration, quality, etc. and should be documented. Residents with chronic pain are more difficult to assess since pain is always there, so frequency, location, quality, duration is not typically documented with every pain assessment. Surveyor asked DON B how changes in pain would be assessed in chronic pain. DON B stated that the nursing staff know the residents well and would know if there was a change. Surveyor asked DON B if residents are included in care planning of chronic pain management to indicate a tolerable level of pain or interventions to help alleviate pain. DON B stated they do include the resident and/or family, but don't ask about a tolerable level to determine baseline. DON B stated that a weekly assessment of patient satisfaction with pain management is completed, but that it is not documented.

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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 provide pharmaceutical services, including procedures that ensured the accurate acquiring, dispensing, administering, storage, and disposal of all drugs and biologicals. Licensed Practical Nurse (LPN) C administered an insulin dose without prior priming of the insulin pen for 1 out of 2 residents (R34) observed for insulin administration.Findings include:Facility's administration procedures states in part, Giving the injection. Prime the pen. The pen must be primed before the resident dose is set and insulin is injected. This will be done by giving an air shot. This removes the air bubbles and ensures the pen and the needle are working properly.R34 was admitted to the facility on [DATE], with diagnoses including epilepsy, hemiplegia following cerebral infarction, and type 2 diabetes mellitus.R34's physicians orders include, Lantus Solution (Insulin Glargine) inject 50 units subcutaneously in the morning related to type 2 diabetes.On 9/10/2025 at 7:18 AM, Surveyor observed LPN C place a new, disposable insulin needle on R34's Lantus pen and dial the pen to 50 units. LPN C then administered the insulin into R34's abdomen and returned to medication cart. Upon returning to medication cart, Surveyor interviewed LPN C about priming the insulin pen. LPN C stated she has never been instructed to prime the insulin pen, and she has never primed insulin pens in the past.On 9/10/2025 at 7:32 AM, Surveyor interviewed Director of Nursing (DON) B, who stated the expectation would be the insulin pens are primed with 2 units prior to dosing with prescribed dose. During the interview with DON B, LPN C asked DON B how to prime the insulin pen and DON B instructed her how to prime an insulin pen.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure each resident's drug regimen was free from unnecessary medications for 1 of 6 residents (R) (R4) reviewed.R4 was prescribed an antidepressant without adequate indication for use. This is evidenced by:Facility policy titled, Psychotropic Medications, with an effective date of 08/2021, states in part: POLICY: To review psychotropic medications for correlating diagnosis, appropriateness and reduction. To ensure that each residents medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial wellbeing. 5. The resident Plan of Care shall address specific behaviors and interventions. 6. The attending physician will document their review, the continued need for, and the effectiveness of the antipsychotic medication in their progress note at the time of their visit.R4 was admitted to the facility on [DATE], with pertinent diagnoses of cerebral infarction, developmental disorder of speech and language, and mild cognitive impairment.R4's admission Minimum Data Set (MDS) assessment, dated 08/18/25, noted a Brief Interview for Mental Status (BIMS) was not completed as resident is rarely/never understood. R4's PHQ9 OV score was 02, indicating minimal depression symptoms.R4's care plan, initiated on 09/10/25, with a target date of 12/03/25, states: I exhibit mood symptoms r/t adjustment disorder with depressed mood and will have improved mood state happier with interventions of administer medications as ordered. Monitor/document for side effects and effectiveness. Monitor/record mood to determine if problems seem to be related to external causes, i.e. medications, treatments, concern over diagnosis. Monitor/record/report to MD prn mood patterns s/sx of depression, anxiety, sad mood as per facility behaviour monitoring protocols. Monitor for flat affect, turning face away from people with interactions as mood symptoms.-Of note: mood/behavior monitoring for depressive symptoms was initiated 10 days after the start of the antidepressant medication.R4's physician orders:8/31/25 Celexa oral tablet 10 mg (Citalopram Hydrobromide) Give 1 tablet by mouth in the morning related to adjustment disorder with depressed mood-Of note: this diagnosis was added to R4's electronic medical record on 08/30/25.Surveyor reviewed R4's behavior monitoring and did not note any behavior or mood symptoms related to depression documented. Surveyor reviewed communication to provider, dated 08/28/25, that stated: Caregiver/guardian feels that [R4] is depressed - they note [R4] was usually very happy - smiling but since being in hospital and nursing home she is flat and rarely smiles. They report that prior to CVA [Cerebrovascular Accident], she would turn her head away from them when she is upset and they are noting she does this frequently with their visits. They would like her to have an antidepressant. Can you order an antidepressant for situational depression?Provider responded on 08/29/25: Celexa 10 mg PO [by mouth] every day-Of note: no provider assessment documented noted reviewing behavior/mood monitoring prior to ordering antidepressant.On 09/10/25 at 2:19 PM, Surveyor interviewed Director of Nursing (DON) B regarding initiating of R4's antidepressant. DON B stated the facility frequently uses input from family and caregivers regarding mood and behaviors to determine use of antidepressants since they know the resident best. Surveyor asked if R4 was assessed for depressive mood or behaviors prior to the use of antidepressant. DON B stated no, because they were not familiar with what behaviors R4 demonstrates when depressed as this was later learned from R4's caregivers. Surveyor asked DON B if R4 was assessed for alternative causes of behavior or mood changes such as pain. DON B stated no.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525553	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shell Lake Health Care Center	802 E Cty Hwy B Shell Lake, WI 54871

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This affected 2 of 2 residents (R) reviewed for infection control (R2, R9) Certified Nursing Assistant (CNA) F did not practice proper hand hygiene during cares for R2. Environmental Manager (EM) D was in a R9's room and did not cover nose or mouth while sneezing and did not wipe down the surface prior to leaving the room.Findings include:The facility policy, titled [Name of Facility] Subject: Handwashing, dated 1/2017, states: 5. Except for a true emergency, personal should always wash their hands:a. Before and after their tour of duty.c. Before and after physical contact with each residentd. After handling a source that is likely to be contaminated, such as equipment, dressings, and secretions and excretions form residents.g. After using the bathroom, blowing your nose or covering a sneeze or cough. Attached to the policy is a document that says CDC [Center for Disease Control] . Recommendations. to clean your hands, Immediately before touching a patient Before moving from work on a soiled body site to a clan body site on the same patient. After touching a patient or patient's surrounds After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal.When to use alcohol-based hand sanitizer.When to wash with soap and water.Example 1:R2 was admitted to the facility on [DATE], with diagnoses that include dementia, major depressive disorder, cardiomegaly, chronic obstructive pulmonary disease, osteoarthritis, and retention of urine.R2's Minimum Data Set (MDS) assessment dated [DATE], indicates that R2 is severely cognitively disable but does not exhibit any delirium or behaviors. R2 needs substantial assistance with hygiene, dressing, and position changes. On 9/9/25 at 6:52 AM, Surveyor observed morning cares on R2. CNA F and CNA L transferred R2 to the bathroom via EZ stand lift. CNA F performed hand hygiene and put on glove and then removed R2's soiled brief. CNA F continued to perform R2's personal cares with contaminated gloves. CNA F then took off gloves, washed hands and put on new gloves, helped R2 to stand, performed pericare, and then placed R2 in a sitting position. CNA F, who was still wearing the contaminated gloves after performing pericare, proceeded to change the pad and top sheet on R2's bed. CNA F then took off gloves, sanitized hands and put on new gloves. LPN M came into R2's room to change a dressing. At this time, CNA F applied barrier cream to R2, took off gloved, did not perform hand hygiene, and applied new gloves.On 9/10/25 at 9:02 AM, Surveyor interviewed CNA F regarding hand hygiene and when this should be done. CNA F stated when hand hygiene should be completed. Surveyor asked when it would be appropriate to use soap and water versus hand sanitizer. CNA F stated at the very beginning and very end, and in between if you are doing peri care. Surveyor shared observations with CNA F of pulling a brief and getting new clothes, making a bed with same gloves, and taking gloves off, touching radio. CNA F stated I should have washed my hands. It's considered going dirty to clean.On 9/10/25 at 12:44 PM, Surveyor interviewed DON B, who stated DON B expects all staff to wash their hands before they enter a room, after they have been in a room, if they touch a surface in a resident's room, if they are doing cares, before they put on the gloves, and when they take them off. Example 2On 09/09/2025 at 11:11 AM, Surveyor observed EM D in room [ROOM NUMBER] helping with R9's TV and holding R9's TV remote. EM D was facing TV when EM D sneezed. EM D did not cover his sneeze. EM D did bend over at the waist when EM D sneezed, stood up, and continued with the task. EM D left the room. EM D did not wipe any surfaces, wash ED M's hands, or use hand sanitizer before leaving R9's room. EM D did not use the hand sanitizer on the hall wall. EM D left the floor, touching the doorknob to the vestibule leading to the elevator.On 09/09/2025 at 3:00 PM, Surveyor interviewed DON B, who stated that all staff, including environmental/maintenance, are provided annual training on infection control and hand washing.