STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525558	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burnett Medical Center	257 W St George Ave Grantsburg, WI 54840

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure the provider was notified of significant change in condition for one resident (Resident (Resident (R) 1) of three sampled residents reviewed for change in condition in a total sample of six. This failure placed residents at risk of increased medical complications.Findings include. Review of the admission Record provided by the Interim Director of Nursing (IDON) revealed that R1 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (irregular heart rhythm), aortic valve insufficiency, and congestive heart failure. Review of the admission Minimum Data Set (MDS) located in the MDS tab of the electronic medical record (EMR) with an assessment reference date (ARD) of 10/07/25 revealed R1 had a Brief Interview of Mental Status (BIMS) score of 10 out of 15, which indicated R1 was moderately impaired in cognition. Review of a 10/11/25 Plan of Care Note, located in the Progress Notes tab of the EMR revealed, . Res [resident] had an episode of weakness and confusion around 0300 [3:00 AM] this am. Writer assessed after CNA [certified nurse aide] walked by and noted that R1 was having difficulty walking. A w/c [wheelchair] was used to finish x-[NAME] [transferring] her to the BR [bathroom] and back to bed . Res breathing was of a labored puffing out exhales. Res admitted to being scared but denied pain. Her L [left] arm was hanging flaccid, her hand grasps were not equal (very weak on the Left noted to be quite swollen), she was able to swallow a drink of water without difficulty, but she did not answer her orientation questions correctly, except for her name. No facial droop and eyes have equal PERRLA [pupils equal, round, reactive to light and accommodation]. A call was placed to [Family Member (FM) 1] and she was ok with having [R1] sleep here, lay down in her own bed, and get rest, as opposed to waiting in the ER [emergency room] with possibly no help for her anyways . The 10/11/25 Plan of Care Note did not contain documentation that the provider was notified of the significant change in condition. During an interview on 01/07/25 at 12:50 PM, the IDON confirmed the provider should have been notified ASAP (as soon as possible). During an interview on 01/08/25 at 3:19 AM, Registered Nurse (RN) 1 stated, I would have called the physician at the time, period. I was the DON at the time, anytime we have a change in condition, you call the physician. I do not remember having received a call from the staff regarding this change in condition and this is the first time I have heard about it. Staff should not have called the family and got directions from them first. Review of the facility policy titled Change in a Resident's Condition or Status, revised December 2025 revealed, . The facility promptly notifies the resident, resident's attending physician or provider, and the resident representative of changes in the resident's condition and/or status .The nurse will notify the resident's attending physician, provider, or physician on call when there has been .Significant change in the resident's physical, emotional, or cognitive condition . Need to alter the resident's medical treatment significantly .

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525558	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Burnett Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 257 W St George Ave Grantsburg, WI 54840	

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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 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 interviews, record review and review of facility policy, the facility failed to provide a transfer form to the hospital at the time of the transfer for one resident (Resident (R) 2) in a total sample of six. This failure placed residents at risk of lack of information being shared with the hospital.Findings include. Review of the admission Record provided by the Interim Director of Nursing (IDON) revealed R2 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, chronic kidney disease, and a history of urinary tract infections. Review of the admission Minimum Data Set (MDS) located in the MDS tab of the Electronic Medical Record (EMR) revealed R2 had a BIMS score of 10 out of 15, which indicated R2 was moderately impaired in cognition. Review of an 09/16/25 Plan of Care Note located in the Progress Notes tab of the EMR revealed, . Upon inquiry of Res [resident] sitting in her chair with the light on, Res found to be not WNL [within normal limits] for her talking and walking ability. She soiled herself in her chair . Call placed to [Family Member (FM) 2] and she requested that she be taken to the ER for eval [evaluation] . During an interview on 01/08/26 at 3:45 AM, Registered Nurse (RN) 1 stated, I was the Director of Nursing (DON) at that time. The night nurse alerted me that [R2] wasn't doing well, so we sent her to the ER. She was admitted with sepsis [a life-threatening emergency where the body has an overactive response to infection] and she was admitted to the hospital. During an interview on 01/08/26 at 11:30 AM, the IDON stated, I cannot find a transfer notice was done however, a transfer notice should have been done prior to going to the ER. The transfer notice would have included nursing assessment, vital signs, and other pertinent information. Review of the facility policy titled, Charting and Documentation, revised July 2017 revealed, . All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record . The following information is to be documented in the resident medical record . Objective observations .Medications administered . Treatments or services performed . Changes in the resident's condition .Events, incidents, or accidents involving the resident . Documentation in the medical record will be objective (not opinionated or speculative, complete, and accurate .

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility policy review, the facility failed to ensure a complete and accurate medical record for two residents (Residents (R) 1, R2) in a total sample of six. The facility failed to completely describe an accurate description of a fall and document the neurological checks at the time of the fall for R1. This failure placed the residents at risk of unmet care and a diminished quality of life.Findings include: Review of the admission Record provided by the Interim Director of Nursing (IDON) revealed R1 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (irregular heart rhythm), aortic valve insufficiency, and congestive heart failure. Review of the admission Minimum Data Set (MDS) located in the MDS tab of the electronic medical record (EMR) with an assessment reference date (ARD) of 10/07/25 revealed R1 had a Brief Interview of Mental Status (BIMS) score of 10 out of 15, which indicated R1 was moderately impaired in cognition. Review of a 12/09/25 at 9:17 PM Incident Note located in the Progress Notes tab of the EMR revealed, [R1] fell out of bed. Blankets fell onto the floor, and [R1] tripped on them. Blankets were picked up, and [R1] was placed back in bed. There are no cuts or bruises at this time. Dr. notified and son notified. The Incident Note did not show a complete and accurate description of the fall including vital signs or neurological checks at the time of the fall. During an interview on 01/07/26 at 12:50 PM, the IDON confirmed R1's medical record was not complete and accurate, and the neurological checks should have been documented at the time of the fall, and not two days later. During an interview on 01/08/25 at 3:19 AM, Registered Nurse (RN) 1 stated, I was on duty the night she fell. She had not had any falls prior to this fall, but she would transfer herself back and forth to the bathroom. [R1] had a lot of anxiety during the night. At the moment of the fall, [Certified Nurse Aide (CNA) 1] alerted me in the hallway. [R1] was lying on [R1's] stomach near the side of the bed, more towards the foot of the bed and [R1] was wrapped up like a cocoon as [R1] would always have at least two comforters on [R1] at night. [R1] did not hit [R1's] head, [RN 1] did the initial neurological checks and the subsequent neurological checks however, they were not documented at the time, it was a busy night and that was a mistake on my [RN 1's] part. Review of the Assessments tab in the EMR revealed R1's neurological check were not documented until 12/11/25 by RN 1.