STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525558	A. Building B. Wing	01/29/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure 3 of 4 residents (R) reviewed were free from chemical restraints. (R1, R4, R14)The facility is not monitoring resident-specific targeted behaviors for R14's, R1's, and R4's psychotropic medication use. There is no evidence the facility is tracking targeted behaviors to assess the therapeutic effects of the psychotropic medications and ensure R14 is receiving the desired benefits and lowest possible dose. Findings include: The facility policy, titled Depression-Clinical Protocol dated 2001, states in part: 1. The physician and staff will review available information and inquired further to identify and document individuals who have a history of depression or another mood disorder, other psychiatric disorders (s), psychiatric treatment or hospitalizations, or suicide attempts. Mentoring and Follow-up The staff and physical will monitor the resident's response to treatment for a mood disorder and will document approaches. Examples of monitoring criteria include improvement or resolution of symptoms, improved quality of life and enjoyment of usual activities and improved sleep. The facility policy, titled Antipsychotic Medication Use, dated 2001, states in part: Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological and emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. 2. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. 16. The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications. Example 1 R14 was admitted to the facility 12/18/25, with the diagnoses that included traumatic brain dysfunction, Alzheimer's with late onset, non-Alzheimer's dementia, and anxiety disorder. (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R14's Minimum Data Set (MDS) assessment, dated 12/22/25, indicated that R14's Brief Interview for Mental Status (BIMS) scored a 00, meaning severely cognitively disable and unable to complete the screening. R14 is independent for movement and mobility, needs partial to substantial assistance for activities of daily living such as bathing and dressing. R14's physician orders include, in part: quetiapine fumarate oral tablet 25 mg Give 0.5 tablet by mouth at bedtime for sleep. sertraline HCl oral tablet 100mg Give 0.5 tablet by mouth in the morning for anxiety. started 1/30/26. sertraline HCL oral tablet 100mg Give 1 tablet by mouth in the morning for anxiety. started 12/18/25; discontinued 1/29/26. donepezil HCL 10mg oral tablet Give 1 tablet by mouth at bedtime for dementia. R14's care plan, dated 12/18/25, printed 1/30/26, states in part: Focus: Behavior Management. Initiated 12/20/25 Undesirable Behavior(s) Will Be Monitored / Managed. Initiated 12/20/25 Establish boundaries and limits with Resident. Initiated 12/20/25 Notify provider of new onset finding. Initiated 12/20/25 R14's Treatment Administration Record for January printed 1/30/26, includes in part: Observe closely for side effects of Antipsychotic medication . every shift. Observe closely for significant side effects of Anti-Depressant medication . every shift. Surveyor reviewed R14's medical record for behavior monitoring and noted no documentation of agitation, depression, or sleep concerns in the Treatment Administration Record (TAR), Medication Administration Record (MAR), or orders. R14's Certified Nursing Assistance (CNA) Care/ Point Click Care Tasks tab reviewed on 1/28/26 did not include targeted behavior monitoring related to R14's depression or anxiety or nonpharmacological interventions when R14 displays target behaviors. On 1/26/28 at 10:02 AM, Surveyor interviewed Certified Nursing Assistant (CNA) J who stated that R14 has depression and if she is having a bad day or acting different than normal, we would let the nurse know. We do not have to track her behavior, just communicate with the nurse. On 1/28/26 at 10:36 AM, Surveyor interviewed Licensed Practical Nurse (LPN) H who stated we are monitoring R14 for side effects of her medications. Surveyor asked LPN H about behaviors that R14 exhibits that warrant citalopram, olanzapine, and trazadone. LPN H stated that R14 has her days. If she acts out of the norm, I will let others know but we do not monitor and document if behaviors occurred, unless they do. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/29/26 at 11:03 AM, Interim Director of Nursing (DON) B stated to Surveyor that she changed the monitoring to Y/N and no longer just a check box. Interim DON B identified she was referring to the observations for side effects. Surveyor clarified with Interim DON B who stated no, behaviors have not been monitored routinely. Example 2 R4 was re-admitted to the facility on [DATE] with pertinent diagnoses of displaced intertrochanteric fracture of left femur, type 2 diabetes mellitus, depression, anxiety, Post Traumatic Stress Disorder (PTSD), and mood disorder. R4's care plan, dated 04/21/25, with a target date of 04/23/26, states: [R4] uses psychotropic medications related to insomnia and depression and a goal to remain free of psychotropic drug related complications, including movement disorder, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. Interventions such as discuss with MD, ongoing need for use of medications. Review behaviors/interventions and alternate therapies attempted and their effectiveness per facility policy. Surveyor did not find any specific behaviors to be monitoring R4 for in R4's care plan. R4's care plan, dated 03/07/25, with a target date of 04/23/26, states: [R4] will have improved mood state happier and calmer appearance, no signs and symptoms of depression, anxiety, and or sadness. Review behaviors/interventions for risk of self-harm or others, and monitor/record/report any acute episodes of sadness, loss of pleasure in activities, feelings of guilt/worthlessness, change in appetite, sleep patterns, and diminished concentration. R4's physician orders include: -Quetiapine Fumarate Tab 200 MG, Give 1 tablet orally one time a day for MMD. -Trazadone HCL Tab 150 MG, Give 1 tablet orally one time a day for sleep. -Bupropion HCL Tab ER 24 HR, 300 MG, Give 1 tablet orally one time a day for depression. -Duloxetine HCL Enteric Coated Pellets Cap 60 MG, give 1 capsule orally one time a day related to PTSD. Surveyor reviewed R4's medical record for behavior monitoring and noted no documentation of agitation, depression, or sleep concerns. On 01/29/2026 at 10:58 AM, Surveyor interviewed DON B and Social Services E and asked to clarify R4's diagnosis as Surveyor could not see the reason R4 is on Duloxetine, Quetiapine, and Bupropion altogether with no behavior monitoring indicating depression, anxiety, or behavior monitoring for sleep issues. Social Services E reported to Surveyor that R4's diagnosis in the medical record was depression, anxiety, post traumatic stress disorder, and mood disorder with depressive features. DON B reported to Surveyor that DON B would look for behavior monitoring for sleep and depression behaviors but doubt there is monitoring since other Surveyor brought this to our attention. On 01/29/2026 at 11:56 AM, Surveyor interviewed DON (in training) C and asked if correct diagnosis (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was in the medical record for R4. DON C reported that the diagnosis of Mood Disorder is a generic term and not the correct diagnosis. DON C reported that behaviors have not been monitored for R4's sleep disturbances since R4 is on Trazadone and no monitoring for depression or anxiety in R4's medical record. Example 3 R1 was admitted to the facility on [DATE] with pertinent diagnoses of vascular dementia moderate, with anxiety and depression unspecified. R1's most recent quarterly Minimum Data Set (MDS) assessment, dated 01/04/26, noted a Brief Interview for Mental Status (BIMS) score could not be completed as resident is rarely/never understood. R1's PHQ9 score is 00, indicating no depression symptoms present. R1 had delusions present, but no physical or verbal behaviors, no rejection of cares, and no wandering. R1 had no physical restraints or alarms used. R1's care plan, dated 02/17/25, with a target date of 04/04/26, states: R1 uses psychotropic medications and a goal to remain free of psychotropic drug related complications or cognitive/behavioral impairment with interventions to review behaviors/interventions and alternate therapies attempted and their effectiveness or not as per facility policy and monitor/record occurrence of target behavior symptoms including. violence/aggression towards staff/others, and document per facility protocol. R1's physician orders include Quetiapine Fumarate Tab 25 MG Give 1 tablet orally one time a day for agitation AND Give 1 tablet orally at bedtime for agitation. Surveyor reviewed R1's monthly medication regimen (MMR) review and noted on 01/15/26, the pharmacist recommended reduction of quetiapine 25 mg if behaviors had resolved. On 01/18/26, the provider responded, .hard to redirect, positive signs of disease progression, see EMR records. Surveyor reviewed R1's medical record for behavior monitoring and noted no documentation of agitation. On 01/29/26 at 8:42 AM, Surveyor interviewed DON C regarding R1's psychotropic medications. Surveyor asked DON C if agitation was an appropriate indication for use of quetiapine. DON C stated no, not typically. Surveyor asked DON C for documentation of R1's behaviors to indicate need for quetiapine. DON C stated she would talk with DON B to find this. On 01/29/26 at 10:57 AM, Surveyor interviewed Interim DON B regarding behavior monitoring. DON B stated no behavior monitoring could be found for R14, R4, and R1.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not formulate an advance directive for 2 of 16 residents (R)(R32, R33) reviewed.R32 did not have a physician order or code status of DNR documented.R33 did not have R33's code status documented in the medical record or in the binder at the nurse's station, which is for full code status residents.This is evidenced by: Facility policy titled, Emergency Procedure – Cardiopulmonary Resuscitation and Basic Life Support, with a revised date of 04/2025, states in part: General Gudielines.2. If the resident's DNR status is unclear, CPR will be initiated and continued until it is determined there is a DNR or a physician's order not to administer CPR.Preparation for Cardiopulmonary Resuscitation.f. Provide information on advance directives to each resident/representative upon admission. g. Document advance directives in the resident medical records and educate staff on how to access this information. Example 1 R32 was admitted to the facility on [DATE] with pertinent diagnoses of metabolic encephalopathy, hepatic encephalopathy, unspecified cirrhosis of liver, ascites, encounter for palliative care, and CKD stage 3a. Surveyor reviewed R32's care plan and noted no care area indicating code status or advance directive. Surveyor reviewed R32's electronic medical record (EMR) and noted no physician orders or advanced directive indicating R32's code status. On [DATE] at 12:40 PM, Surveyor interviewed Licensed Practical Nurse (LPN) H regarding R32's code status. LPN H stated that R32 had a Do Not Resuscitate (DNR) code status. Surveyor asked LPN H to show where this was documented. LPN H went into R32's EMR and looked for the physician order or advanced directive to demonstrate this. LPN H stated she was unable to find it. Surveyor asked LPN H how staff knew R32 was a DNR status. LPN H stated that was what they were told on admission. Surveyor asked LPN H where staff should be able to see a resident's code status. LPN H stated there should be an order and a clear indication across the top banner of a resident's EMR. On [DATE] at 12:54 PM, Surveyor interviewed Director of Nursing (DON) in-training C regarding code status. DON C stated a physician order for code status should be on every resident's EMR for easy access. DON C stated this is a recognized area of improvement and the facility is in the process of implementing a new check-off for admissions to review this is in place. DON C stated that there had been some uncertainty of R32's code status and this is why it hadn't been ordered yet. Example 2 On [DATE] at 11:01 AM, Surveyor reviewed R33's code status in Electronic Health Record (EHR). Surveyor could not find a code status. Surveyor reviewed scanned in documents from discharge orders from another facility, which only showed that R33 is a full code status. Surveyor did not find physician orders or acknowledgement showing that the facility addressed R33's code status in the (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's system upon or after admission of [DATE]. On [DATE] at 1:10 PM, Surveyor interviewed LPN F and asked how LPN F knows what code status a resident is in case a resident has an emergency or codes. LPN F reported to Surveyor that LPN F would look in the EHR and at the top left-hand corner on the dashboard underneath resident name is the resident's code status. LPN F reported that LPN F will memorize residents' code statuses to know if they are full code or Do Not Resuscitate (DNR). LPN F reported that if you click the blue link that states Advance Directive in the EHR underneath the code status on dashboard, the EHR will take the nurse to the scanned documents where LPN F would see the code status. Surveyor asked LPN F to check R33's code status in EHR. LPN F pulled R33's EHR up to LPN F's computer. LPN F stated, Oh no, it's not there. LPN F then started searching through scanned documents to try to find R33's code status. LPN F stated, It is not there either. Surveyor asked how LPN F would know R33 is a full code. LPN F reported to Surveyor that on admission all residents who are a full code are placed on a list, which is in a binder at the nurse's station. Surveyor asked LPN F to show Surveyor the code status binder. LPN F grabbed the code status binder and LPN F did not see R33 on the list as full code. Surveyor did not observe R33 to be on the most recent code status sheet in binder. Surveyor asked LPN F how often the code status binder is updated. LPN F reported it should be updated every time there is a new admission who is full code status. On [DATE] at 3:25 PM, Surveyor interviewed DON C and asked what the process is for addressing code status with new admission in the facility. DON C reported staff should be addressing code status with admission and making sure the documentation is in the EHR on dashboard, advance directives in the scanned in documents, and if DNR then a physician order as well. DON C reported that R33 should have had code status addressed but this was missing on admission placing the information into the computer so all staff can see code status.

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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 staff interview and record review, the facility did not ensure 2 residents (R) (R4 and R31) of 2 residents reviewed for hospitalization received the proper notice of transfer, reason for transfer, location of transfer, appeal rights, name and address with telephone number of the Office of the State Long-Term Care Ombudsman. In addition, the facility did not ensure R4 and R31 received written information on reserve bed payment policy. R4 was transferred to the Emergency Department (ED) on 10/15/25 and 10/23/25. R4 was not provided with a complete written transfer or bed hold notice. R31 was discharged to home and facility did not have any documentation that Ombudsman was notified.Findings include: Facility's policy titled Transfer or Discharge Notices with reviewed date of March 2025 read in part, .Notice of Transfer or discharge: 3. The resident and representative are notified in writing of the following information: a. The specific reason for the transfer or discharge. d. An explanation of the residents' rights to appeal the transfer or discharge to the state, including: 1. The name, address, email, and telephone number of the entity which receives such appeal hearing requests, 2. Information about how to obtain and appeal form, 3. How to get assistance in completing and submitting the appeal hearing request. Example 1 Surveyor reviewed R4's bed hold notice for 10/15/25 and found no daily bed hold rate, appealed rights information for R4, and no specific reason for transfer to the hospital. Surveyor reviewed R4's bed hold notice for 10/23/25 and found no daily bed hold rate, appealed rights information for R4, and no specific reason for transfer to the hospital. On 01/29/2026 at 12:26 PM, Surveyor interviewed Nursing Home Administrator (NHA) A and Director of Nursing (DON) B and asked about bed hold notice, ombudsman notification, and the daily rate on bed hold notices. NHA A reported to Surveyor that NHA A and staff have recently found the bed holds were not being completed correctly. NHA A reported there should be more information on the bed hold policy. NHA A showed Surveyor a new form that NHA A had typed for correction of bed hold notices to show the exact dollar amount for the daily rate of the bed hold. NHA A added the appeals process and resident rights for the bed hold and will make sure staff are educated on the bed hold policy going forward. Example 2 R31 was admitted to the facility on [DATE] for a short-term rehab stay. On 11/26/25, R31 was discharged to home without services. Discharge summary and medication reconciliation completed. No notification of Ombudsman notification was documented. On 01/29/26, Surveyor requested Ombudsman notification from Social Services (SS) E. No documentation was provided.

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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 interview and record review, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (R14) reviewed for falls. R14 fell on 1/2/26 and 1/25/26. 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 at time of fall or after IDT meeting.Findings include:Facility policy, titled Assessing Falls and Their Causes, dated 2001, states: [The purposes of these procedures are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of all the fall.]Steps in the ProcedureIdentifying Causes of a Fall or Falls Risk:1. Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. Refer to resident-specific evidence including medical history, known function impairments, etc.DocumentationWhen a resident falls, the following information should be recorded int eh resident's medical record:6. Appropriate interventions taken to prevent future falls. Per the facility procedural checklist, titled Post Fall Procedure & Checklist (SNF), undated, states:Purpose: to provide nursing staff with a clear, step by step procedure and checklist to follow immediately after a resident fall, aligned with the facility's Falls and Fall Risk policy.Interventions & PreventionUpdate care planTherapy referral if indicated.Signature Nurse:_____ Date/Time:_____.R14 was admitted to the facility 12/18/25, with diagnoses that included traumatic brain dysfunction, Alzheimer's with late onset, non-Alzheimer's dementia, and anxiety disorder.R14's Minimum Data Set (MDS) assessment, dated 12/22/25, indicated that R14's Brief Interview for Mental Status (BIMS) scored a 00, meaning severely cognitively disabled and unable to complete the screening. R14 is independent for movement and mobility, needs partial to substantial assistance for activities of daily living such as bathing and dressing. R14's care plan, dated 12/18/25, printed 1/30/26, states in part:Focus:R14 is a moderate to high risk for falls r/t Confusion, Gait/balance problems, Incontinence, Poor communication/comprehension, Unaware of safety needs, Vision/hearing problemsFocus: The resident will be free of falls through the review dateInterventions:Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Initiated 12/31/25Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Initiated 12/31/25Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c (wheelchair). Initiated 12/31/25Follow fall protocol. Initiated 12/31/25The resident needs a safe environment with floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, personal items within reach. Initiated 12/31/25Focus: The resident has limited physical mobility r/t Alzheimer's. Initiated 12/19/25Intervention: Ambulation: supervision or touching assistance of 1, front wheeled walker in room and to/from meals and activities.TIPs: please encourage use of front wheeled walker, with assist of 1 and gait belt. Locomotion: n/a Date initiated 12/19/25 Revision 1/28/26Fall incident report from 1/2/26 at 10:30 AM, states: Found resident laying on the floor by her second recliner. There was blood noted on the wall socket, and to the back of her head. She was incontinent with urine at the time. When asked where she was going? She stated I don't know. Immediate action taken included assessment, vital signs and monitoring, resident was not taken to the hospital. No injuries observed at time of incident. The fall incident report did not include root cause or immediate care plan interventions to prevent falls. Surveyor requested the interdisciplinary team (IDT) investigation notes for R14's fall, root cause and interventions to prevent future falls. On 1/29/26 at 10:00 AM, Surveyor reviewed the Interdisciplinary Team (IDT) At-Risk Resident Meeting notes from 1/9/26. Meetings document that R14 had a fall; care plan was updated. No root cause identified, or specific care plan update or intervention implemented. Fall incident report from 1/25/26 at 1:50 PM, states: I was sitting at the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse's stations charting when another resident approached the nurse's station and said that there was a resident who had fallen in the dining room. When I entered the dining room, I observed resident on the floor sitting on her butt in front of her dining chair. There was spilled milk on the resident's table as well as on the floor in front of the resident's chair. Resident was sitting on her butt but slightly leaning back so her head was underneath the dining room table. Resident was confused per baseline but denied any pain or injury. Resident has active ROM in both upper and lower extremities. A&0 (alert and orientated) is at baseline and resident can answer questions appropriately. DON notified via text message and POA notified. Immediate action taken included resident assisted back to dining room chair via Hoyer lift with a sling. VS and neuros obtained. Patient educated on the importance of waiting for assistance before trying to transfer herself. Resident was not taken to the hospital. The fall incident report did not include root cause or immediate care plan interventions to prevent falls. Reported reminders and educations not added to the care plan as interventions.Surveyor requested the interdisciplinary team (IDT) investigation notes for R14's fall that occurred on Sunday, 1/25/26, and IDT team did not meet until Wednesday, 1/28/26. Fall incident report from 1/27/25 at 4:38 PM, states: Resident has a witnessed fall in the dining room this evening around 1638. Resident was sitting at a table in the dining room and then was walking without her walker and fell near another table. No injuries, did not hit her head. Resident is an [AGE] year-old female with a history of Alzheimer's disease, dementia, GAD, and HTN. Also has a history of falls. When this nurse came into the dining room resident observed sitting on her butt, with activity director holding her hand. Residents denies any pain. Reminded resident to use her walker when walking. Immediate interventions taken included her vitals were taken, (vital signs recorded) . Resident was assisted to her chair using Ez-lift. She was not taken to the hospital. The fall incident report did not include root cause or immediate care plan interventions or update to prevent falls. Surveyor requested the IDT investigation notes for R14's fall, root cause and interventions to prevent future falls. On 1/29/26 at 10:00 AM, Surveyor reviewed IDT At-Risk Resident Meeting notes from 1/28/26 meeting. R14's falls were reviewed. R14 has had five falls in the last month. Rehab will screen her again. Reviewed Care plan. Rehab will update the ambulation section. Discussed options to reduce falls including consideration of moving her room closer and increasing safety checks. Suggestion for gait best to be accessible on front wheeled walker training DON will review with the team. No root cause identified. Of suggested interventions above, only addition or update is the ambulation assessment by therapy.Surveyor's review of R14's care plan did not identify an update for fall interventions in active care plan or history between 12/31/25 and 1/28/26. On 1/2/9/26 at 11:32 AM, Surveyor interviewed Interim Director of Nursing (DON) B who stated the expectation of staff after a resident fall is to update care plan interventions. Interim DON B states something needs to be put in place right away. If more investigation is needed, then within 24 hours interventions should be updated.On 1/29/26 at 11:52 AM, Interim DON B came to Surveyor and handed her a post-it note that stated no care plan revisions from R14's falls 1/2/26. Surveyor asked clarifying question about note. Interim DON B stated no, there were no care plan interventions for January 2nd and January 25th, but you have that there was for January 27th.Note: On 1/29/26 at 8:40 AM, Surveyor asked Nursing Home Administrator (NHA) A for all falls for R14 that occurred during this survey period; 10/23/24 to date. Fall documentation is in a risk management system Surveyor does not have access to. Surveyor received 3 falls to review, all were in the month of January 2026, from NHA A. Surveyor did not realize there were 5 falls in the month of January as documented in the IDT notes until after leaving the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525558	A. Building B. Wing	01/29/2026

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

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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, interview and policy review, the facility did not ensure all drugs and biologicals were stored and labeled in accordance with currently accepted professional principles and did not ensure only authorized personnel had access to medication carts and controlled substances. This occurred for 2 of the 3 medication carts/storage rooms observed. During the three-day survey, 1 of 4 observations were made of medication cart left unlocked when unattended and out of view of staff. One observation was made of a lorazepam liquid bottle that was opened and not stored in a double locked compartment while being stored in the medication storage room. Findings include: Example 1 On 01/29/2026 at 7:34 AM, Surveyor observed medication cart left unlocked in hallway down south wing. Surveyor observed 2 Certified Nursing Assistants (CNA) walking by medication cart down hallway. Surveyor did not observe a nurse around the unlocked medication cart. On 01/29/2026 at 7:38 AM, Surveyor observed Licensed Practical Nurse (LPN) G walk out of a room. Surveyor interviewed LPN G and asked what LPN G's normal process is for leaving medication cart unlocked. LPN G reported to Surveyor that LPN G just quickly walked away from medication cart to administer medications. LPN G reported that LPN G should have locked it when walking away from the medication cart. On 01/29/2026 at 7:55 AM, Surveyor interviewed Director of Nursing (DON) B and asked DON B the process for LPN G leaving medication cart unlocked while administering medications. DON B reported that LPN G should always lock medication cart when it is unsupervised. Surveyor requested policy on handling and storage of medications. Example 2 On 01/29/2026 at 7:45 AM, Surveyor toured medication storage room with Registered Nurse (RN) I. Surveyor observed liquid Lorazepam in the medication storage room fridge unlocked. Surveyor interviewed RN I and asked what the expectation for Lorazepam is to be stored. RN I reported that Lorazepam is supposed to be double locked as it's a controlled substance and the medication storage room fridge usually is always locked, but it is not right now. RN I confirmed the fridge was not locked, and RN I immediately locked the fridge with a key located on RN I's key set. On 01/29/2026 at 7:55 AM, Surveyor interviewed DON B and asked what the correct process is for storing Lorazepam or controlled substances in the medication storage room. DON B reported that DON B was just looking into the correct process for controlled substance storage such as Lorazepam but was unsure if the medication storage room being locked and only nurse on the floor had access, was that meeting the requirement. Surveyor informed DON B that Lorazepam is supposed to be double locked to decrease diversion and DON B agreed.

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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, 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.Certified Nursing Assistant (CNA) D did not use Enhanced Barrier Precautions (EBP) when providing direct care for R7.Licensed Practical Nurse (LPN) F did not perform hand hygiene while changing R4's Libre Sensor (glucose monitoring device).This is evidenced by: Example 1 Facility policy titled, Transmission Based Precautions, with a revised date of 06/04/25, states in part: Procedure: .When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door so that personnel and visitors are aware of the need for and the type of precaution. Enhanced Barrier Precautions expand the use of PPE and refer to the use of gowns and gloves for high-contact resident care activities is indicated for residents with an infection or colonization of a multidrug resistant organism (MDRO).or for any resident with wounds.Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: .transferring, providing hygiene.changing briefs or assisting with toileting. R7 was admitted to the facility on [DATE] with pertinent diagnoses of type 2 diabetes mellitus without complications, unspecified urinary incontinence, and weakness. On 01/27/26 at 1:29 PM, Surveyor observed a sign on R7's door indicating EBP precautions were indicated for direct care activities for R7 that included gown and gloves. Surveyor observed PPE cart outside of R7's room that contained hand sanitizer, disposable gloves, gowns, and face masks. Surveyor observed Certified Nursing Assistant (CNA) D enter R7's room and did not don a gown or gloves prior to entering. R7 asked CNA D to assist with using the bathroom. CNA D completed hand hygiene and donned gloves. No gown was used. Surveyor observed CNA D assist R7 to the bathroom using EZ stand lift. Surveyor observed a dressing in place on R7's coccyx. Surveyor observed CNA D assist R7 with peri-care, changing of disposable brief and re-dressing. CNA D assisted R7 into recliner in room and placing of personal items within reach. CNA D discarded gloves, completed hand hygiene, and exited room. On 01/27/26 at 1:52 PM, Surveyor interviewed CNA D regarding observation. Surveyor asked CNA D about the EBP sign on R7's door. CNA D stated that R7 had wounds which meant staff needed to use EBP when doing direct cares. Surveyor asked CNA D if she was wearing the appropriate PPE during R7's cares. CNA D stated no that she should have worn a gown while doing cares. On 01/28/26 at 3:23 PM, Surveyor interviewed Director of Nursing (DON) in-training C regarding EBP. DON C stated that residents with chronic wounds require EBP for direct cares. Surveyor informed DON C about observation of CNA D providing cares for R7 without EBP. DON C stated that a gown should have been used and this is an ongoing concern and re-education would be completed with staff. Example 2 On 01/28/26 at 12:27 PM, Surveyor observed LPN F entering R4's room with short acting insulin and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Libre sensor box. LPN F reported to Surveyor that R4 is due to have sensor change in two hours so LPN F is going to go ahead and complete this task. Surveyor observed LPN F enter R4's room without sanitizing hands. LPN F donned gloves, removed R4's contaminated Libre sensor needle, and disposed of the needle. Surveyor observed LPN F then grab new clean Libre sensor and prep R4's skin then applied the new clean Libre Sensor kit with contaminated gloves. Surveyor did not observe LPN F doff gloves, sanitize, and then apply new clean gloves. On 01/28/26 at 12:35 PM, Surveyor interviewed LPN F and asked expectation of hand hygiene during changing the Libre sensor for R4. LPN F reported LPN F should have doffed gloves after removing the contaminated Libre Sensor and then sanitized hands, donned gloves, and then applied the new Libre sensor. On 01/28/26 at 3:20 PM, Surveyor interviewed DON C and asked expectation for LPN F utilizing hand hygiene when applying the Libre sensor to R4. DON C reported to Surveyor that LPN F should sanitize hands entering room, apply gloves, remove contaminated libre sensor, doff gloves, sanitize hands, and don gloves before applying the new sterile Libre sensor.