STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525567	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Lights Hcc	706 Bratley Dr Washburn, WI 54891

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse to the appropriate agencies for 1 (R3) of 4 sampled residents reviewed for falls/accidents out of a total sample of 6 residents. R3 was diagnosed with a right hip fracture, identified as an injury of unknown origin and the facility did not report the injury to the state agency (SA). CMS's definition of abuse to be reported within 2 hours, as identified, in part, by 483.12(c)(1) as: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 2 hours if the events that cause the allegation do involve abuse and do not result in serious bodily injury, to the administrator of the facility and other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.Findings include:R3 was admitted to the facility on [DATE] and had diagnosis that included dementia, osteopenia, falls and weakness. R3 had a brief interview of mental status (BIMS) score of 0 which means severe cognitive impairment. R3 had a legal representative for healthcare. Record review of R3's medical chart: R3 was transferred to the emergency department (ED) on 04/04/2026 after R3 complained of right leg pain during cares. Radiology testing done in the ED found a moderately displaced, mildly comminuted (broken in more than one place) proximal right femur (leg/hip) fracture. Radiology testing also confirmed severe osteopenia (loss of bone density which could lead to high risk for fracture). During R3's hospital course, it was determined through professional medical opinion that R3 was not a surgical candidate due to advanced age and multiple medical comorbidities. R3 was discharged from hospital back to the facility on [DATE] on comfort care measures. On 04/07/2026, Director of Nursing (DON) B initiated an investigation on R3's injury of unknown origin, right hip fracture. According to the investigative report and nursing documentation in R3's medical chart, R3 started to complain of right leg pain the morning of 04/03/2026. DON B interviewed several nurses and certified nursing assistants (CNAs) who worked 24 hours prior to the AM shift of 04/03/2026. All staff interviews done by DON B indicated R3 had no complaints of pain prior to 04/03/2026, and no traumas or injuries to R3 were witnessed by staff. Report stated R3's legal representative was aware of injury and R3's prognosis. As part of review of R3's fall investigation report, Surveyor did not find indication the facility reported the incident of R3's injury of unknown origin, fracture to right hip to the SA (State Agency).On 05/04/2026 at 10:36 AM, Surveyor interviewed R3's legal representative/Power of Attorney (POA) F regarding R3's injury of unknown origin, right hip fracture diagnosed on [DATE]. R3's POA was aware of the right hip fracture and that no trauma or fall was witnessed by staff. POA F stated because R3 was known to have poor bone health, it was very possible that R3's hip fractured spontaneously while R3 propelled herself with her legs in a wheelchair. POA F stated R3 has a new wheelchair and sat (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	higher than what R3 was used to. POA F did not have any concerns of staff abuse or neglect resulting in R3's right hip fracture. On 05/04/2026 at 12:52 PM, Surveyor interviewed DON B. Surveyor asked DON B if the facility submitted a facility reported incident for R3's injury of unknown origin, right hip fracture on 04/04/2026 to the SA. DON B stated the facility did not submit a self-report on the injury of unknown origin, and DON B was not aware that one needed to be done. DON B confirmed R3's right hip fracture was considered an injury of unknown origin.

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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 - 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 as free of accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents for 1 of 3 residents (R) reviewed (R1.) R1 was a 2 person assist for transfers with the EZ stand lift. Certified Nursing Assistant (CNA) H independently transferred R1 with the EZ stand and R1 fell resulting in a 3.5 cm x 4 cm laceration of the left temporal scalp requiring transfer to the local hospital for treatment consisting of 7 staples to the temporal scalp.This is evidenced by:Facility policy titled Mechanical Lifts (Total Body and Sit-to-Stand) with a reviewed date of 04/2026 states: All mechanical lifts will be operated per the manufacturer's instructions.Sit to Stand: Assistance with the sit-to-stand lift is determined by therapy and the assistance level is documented in the Care Plan and Kardex.EZ Way Smart Stand Operator's Instructions state: The EZ Way Smart Stand was designed to be operated by one caregiver. However, depending on the situation, facility policy, and the patient's condition, two caregivers may be necessary.R1 was admitted to the facility on [DATE] with hemiplegia and hemiparesis following cerebral infarction affecting left dominant side.R1's quarterly Minimum Data Set (MDS) assessment, dated 04/01/26, noted a Brief Interview for Mental Status (BIMS) score of 08, indicating moderate cognitive impairment.R1's care plan, dated 01/21/25 with a target date of 06/24/26, states: Actual deficit with ADLs with a goal to have needs met. Interventions include: chair/bed transfer - 2 assist with use of EZ stand.R1's most recent PT (Physical Therapy) discharge note, dated 03/06/26, noted transfer assist of 2 using an EZ stand lift.On 04/19/26 at 12:45 PM, CNA H independently transferred R1 from the bathroom to the recliner using the EZ stand lift. R1's wife was present in the room during the transfer. As CNA H moved R1 into position with the back of R1's legs against the recliner, R1's wife asked CNA H if R1's chair could be moved closer to the TV. CNA H began to move the EZ stand to accommodate R1's wife's request as R1's wife began repositioning the recliner. CNA H then observed R1 suddenly fall straight down, out of the sling in the EZ stand, and land on the floor on R1's left side. R1's head hit the floor and began bleeding. CNA H quickly got Licensed Practical Nurse (LPN) C to assist. LPN C completed first aid and the RN manager entered shortly after to assess R1. Provider was notified and ambulance was called. R1 was transferred to the local hospital for evaluation and returned to the facility the same day.Surveyor reviewed R1's hospital records, dated 04/19/26, and noted R1 had a 3.5 cm (length) x 4 cm (depth) laceration to the left temporal scalp requiring repair with 7 staples. A CT scan and x-rays were completed without findings of fracture or other injuries.On 05/04/26 at 9:39 AM, Surveyor interviewed R1's wife regarding the incident on 04/19/26. She stated she was present in the room at the time of the incident and observed CNA H transferring R1 to the recliner. R1's wife stated she didn't remember anything abnormal happening at the time of the incident but only that R1 fell straight down out of the sling so fast, like he just collapsed. R1's wife couldn't recall any additional details. Surveyor asked if R1 had any other falls or incidents while at the facility and she stated no.On 05/11/26 at 9:33 AM, Surveyor interviewed CNA H regarding the incident. CNA H stated that she transferred R1 independently with the EZ stand lift. Surveyor asked CNA H how she determined R1's transfer status was an assist of 1. CNA H stated that she assumed R1 was an assist of 1 but did not review R1's care plan prior to assisting with the transfer to ensure this. CNA H stated she had gotten into a bad habit of not checking residents' care plans.On 05/04/26 at 11:00 AM, Surveyor observed R1 sitting in recliner in room. R1's care plan was observed in place and up-to-date and affixed to the inside closet door. Surveyor asked R1 if he remembered the incident that occurred on 04/19/26. R1 stated no. Surveyor asked R1 if he was in pain. R1 said no.On 05/04/26 at 11:40 AM, Surveyor interviewed LPN C regarding the incident. LPN C stated being unsure as to why CNA H had transferred R1 with the EZ (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	stand independently as there were sufficient staff on duty. LPN C stated he had worked with CNA H over the past year numerous times and always felt CNA H was very competent and followed the residents' care plans. LPN C stated that CNA H likely forgot that R1 required 2 assist with the EZ stand because some residents have variable assist levels depending on their individual needs but he did not feel CNA H did it deliberately.On 05/04/26 at 1:09 PM, Surveyor interviewed Director of Nursing (DON) B regarding the incident. DON B stated in the approximate year that CNA H has been employed at the facility, there have never been any complaints or concerns regarding resident care and following care plans. DON B stated CNA H was interviewed about the incident immediately after it happened to determine why the care plan wasn't followed and CNA H stated that she didn't know R1 was a 2 assist and that she did not deliberately ignore the care plan. Afterwards, DON B completed additional training and reeducation with CNA H and all other nursing staff on the importance of reviewing resident care plans at the start of each shift.Surveyor reviewed facility's investigation of incident. A Quality Assurance Performance Improvement (QAPI) plan was initiated on 04/19/26. All nursing staff were reeducated on reviewing resident's care plans at start of shift and competency assessments using lift equipment were completed. Ongoing audits were being completed for care plan compliance and safe use of lift equipment. R1's care plan was updated to assist of 2 with Hoyer and currently being reevaluated by Physical Therapy (PT.) All residents' care plans were reviewed. CNA H received first written warning for not following R1's care plan and reeducation and training was completed.Based on Surveyor's investigation, the facility was not in compliance related to Quality of Care when staff did not follow R1's care plan for transfers resulting in a fall with actual harm. The facility recognized the deficient practice, conducted an investigation, put interventions in place, and provided staff education. The facility has no current noncompliance. This is being cited at past noncompliance actual harm/isolated.