STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525589	A. Building B. Wing	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rennes Health and Rehab Center-Rhinelander	1970 Navajo St Rhinelander, WI 54501

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. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not immediately report to the resident's representative when a resident was found unresponsive in spa tub and was transferred via Emergency Medical Services (EMS) to the Emergency Department (ED). This occurred for 1 of 1 resident (R) reviewed, (R1).Findings include: R1 was admitted to the facility on [DATE] with diagnoses including, in part, chronic obstructive pulmonary disease, left bundle branch block, bipolar disorder with moderate depression, COVID-19 respiratory disease, urinary tract infection, hypertensive chronic kidney disease stage 1-4, epigastric pain chronic, flaccid neuropathic bladder, anxiety, hyperlipidemia, insomnia, peptic ulcer, benign prostatic hyperplasia, right artificial hip and knee joint. R1's Minimum Data Set (MDS) assessment, dated 09/05/25, identified on admission that R1 had a Brief Interview for Mental Status (BIMS) score of 14. This indicated R1 had intact cognition. The MDS assessment also identified R1 required partial/moderate assist with bathing/showering self. R1 was partial/moderate assist with bathing/shower transfers.R1's progress notes reviewed and stated, -On 09/29/2025 at 9:47 PM, Resident in spa room, resident not verbally responding to RN, Resident did not respond to sternal rub. Resident was breathing, had a strong pulse. EMS was called and proceeded to provide care. Resident sent to the ED. Report given to ED nurse. Resident provided with bed hold and transfer appeal rights.-On 09/30/2025 at 3:09 AM, resident is being transferred to [NAME]. On 10/02/25 at 7:04 PM, Surveyor interviewed Family Member (FM) T and asked if FM T had any updates pertaining to R1's disposition in the hospital and if FM T could provide any updates about R1's condition. FM T stated to Surveyor, I do not know what you are talking about. What happened to my brother? Why am I now just hearing my brother is in the hospital. What hospital? When? How long will he be there? Surveyor asked FM T if facility had contacted FM T about the incident with R1 on 09/29/25. FM T reported to Surveyor that FM T does not know what is going on and is very overwhelmed at this moment. Surveyor suggested that FM T call the facility for an update and to clarify what had occurred. FM T thanked Surveyor for Surveyor's time and hung up the phone to call facility. On 10/03/25 at 8:36 AM, Surveyor spoke with R1's emergency contact FM T again and asked if FM T received information about R1's condition and disposition. FM T reported that FM T has not heard from the facility yet. FM T reported that FM T was very upset as FM T called the facility last night on 10/02/25 and staff told FM T that he would have to wait until administration is in the building and would not divulge any information. FM T reported to Surveyor that on 10/03/25 at around 8:00 AM, FM T called facility and again was told FM T would have to wait until administration was in the building. FM T reported that Nursing Home Administrator (NHA) A was rude and only stated to FM T that an incident happened where R1 was left unsupervised and became unresponsive and sent via EMS to the hospital. FM T reported to Surveyor that NHA A gave FM T the hospital name and asked FM T to call for more details. FM T stated to Surveyor, I am very upset that this has happened. What was my brother doing alone in the tub for that long? Why was I not given more information about this incident? Surveyor suggested to FM T that FM T should contact hospital to check on R1. On 10/06/25 at 9:03 AM, Surveyor interviewed Registered Nurse (RN) J who was the RN who found R1 in R1's condition in the spa room. Surveyor asked if RN J notified physician on call or R1's emergency contact. RN J reported that RN J did not because in a situation like this R1 is his own person and that we usually just ask the resident, but since R1 was unresponsive that RN J usually just makes that nurse judgement on her own. RN J reported that RN J contacted Emergency Department (ED) Physician S in the ED to report the incident but did not call R1's emergency contact, FM T. On 10/07/25 at 9:45 AM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked why R1's emergency contact, FM T, was not contacted about the incident on 09/29/25. NHA A reported that NHA A spoke with R1's emergency contact, FM T. Surveyor asked NHA A when NHA A spoke with R1's emergency contact FM T. NHA A reported that NHA A spoke with FM T on 10/03/25 and answered all of FM T's questions. Surveyor asked if NHA A notified FM T that R1 had an incident on 09/29/25 and was transferred to hospital after the incident. NHA A reported that NHA A contacted R1's POA on 10/02/25 which was activated on 10/02/25 in hospital. Surveyor asked NHA A if R1's emergency representative, FM T, was contacted the same day of R1's incident on 09/29/25 at that time. NHA A reported to Surveyor that NHA A does not know if anyone else contacted FM T.

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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 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 the interview and record review, the facility did not report 1 of 1 (R1) potential misconduct incidents to the State's Office of Caregiver Quality (OCQ) via the State's Misconduct Incident Reporting (MIR) system immediately upon learning of the incident.Findings include: Facility policy titled, Abuse Prevention, dated reviewed on November 23, 2016, states in part: .Neglect Definition-Means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.*Facility will immediately report all alleged violations involving mistreatment, neglect, of abuse, including injuries of unknown source to the facility administration and to the Division of Quality Assurance. CMS defines immediately to be as soon as possible but not to exceed 24 hours after discovery of the incident. R1 was admitted to the facility on [DATE] with diagnoses including, in part, chronic obstructive pulmonary disease, left bundle branch block, bipolar disorder with moderate depression, COVID-19 respiratory disease, urinary tract infection, hypertensive chronic kidney disease stage 1-4, epigastric pain chronic, flaccid neuropathic bladder, anxiety, hyperlipidemia, insomnia, peptic ulcer, benign prostatic hyperplasia, right artificial hip and knee joint. R1's Minimum Data Set (MDS) assessment, dated 09/05/25, identified on admission that R1 had a Brief Interview for Mental Status (BIMS) score of 14. This indicated R1 had intact cognition. The MDS assessment also identified R1 required partial/moderate assist with bathing/showering self. R1 was partial/moderate assist with bathing/shower transfers. On 10/02/25 at 2:25 PM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked for any type of incidents that require an investigation that may have been reported or were in the process of being reported. NHA A stated to Surveyor, If it is reportable then it would be obviously reportable. Surveyor asked NHA A again if there were any incidents that NHA A is working on that have not been reported. NHA A reported that any of those incidents would be considered in our Quality Assurance QI department for PIPs and that it is confidential. On 10/02/25 at 3:14 PM, Surveyor interviewed Director of Nursing (DON) B and asked if DON B had any other incidents or investigations that DON B is working on. DON B explained DON B's process for managing incidents like falls, med errors, etc. is that they are kept in a binder, reviewed at daily meetings, and then new interventions are implemented. DON B reported to Surveyor that NHA A and Assistant Director of Nursing (ADON) C have been working on an incident with R1 and the spa room from 09/29/25 where R1 was left unsupervised and found unresponsive. DON B and Surveyor then went to NHA A's office for investigation documents. On 10/02/25 at 3:17 PM, Surveyor entered NHA A's office. In attendance were NHA A, DON B, and regional resource staff. Surveyor asked NHA A why R1's incident was not reported to OCQ. NHA A reported to Surveyor that through investigation NHA A found there was no willful intent and did not report the incident pertaining to R1 being left in the spa room unsupervised and becoming unresponsive requiring EMS transport to a higher level of care. NHA A stated to Surveyor, I did not feel it was necessary to report the incident, therefore I did not.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure the residents' environment remains as free of accident hazards as possible. The facility did not ensure staff followed supervision of residents when needed to prevent accidents, which affected resident (R) R1 and had potential to effect 5 other residents. Facility staff did not stay with R1 during the time R1 was in a spa bath. Staff intermittently checked on R1 during the spa bath, and after approximately 2 hours, staff found R1 in the spa tub unresponsive, which required facility to call 911 for Emergency Medical Service (EMS). EMS found R1 with body temperature of 106 degrees Fahrenheit (F), Blood Pressure (B/P) 116/96, Respirations (R) 10 breaths per minute requiring intubation for breathing, and Pulse (P) 59 and increasing to 124 beats per minute (bpm). R1 had first degree burns (reddened skin) noted to be greatest on his right upper extremity, over his abdomen, and a second degree burn to his left calf, skin was blistered and did break on transport to the ER, second degree burn to left upper thigh, and right buttocks blister. R1 was transported to hospital ER and later transferred to an Intensive Care Unit (ICU) at a higher-level of care hospital.The facility's failure to monitor water temperature checks in the spa tub and supervise R1 during R1's spa bath created a finding of immediate jeopardy that began on [DATE]. Surveyors notified Nursing Home Administrator (NHA) A, Director of Nursing (DON) B, and Regional Nurse of the immediate jeopardy on [DATE] at 11:08 AM. The immediate jeopardy was removed on [DATE] however, the deficient practice continues at a severity/scope of E (Potential for Harm/Pattern) for residents R2, R3, R4, R5, R6, who use the spa bath and as the facility continues to implement its action plan. Findings include:According to Nature Reviews Disease Primers ([NAME], M.G., van [NAME], M.E., [NAME], M.A. et al. Burn injury. Nat Rev Dis Primers 6, 11 (2020). https://doi.org/10.1038/s41572-020-0145-5), Burns that affect the uppermost layer of the skin (epidermis only) are classed as superficial (first-degree) burns; the skin becomes red, and the pain experienced is limited in duration. Superficial partial-thickness (second-degree) burns (formerly known as 2A burns) are painful, weep, require dressing and wound care, and may scar, but do not require surgery. Deep partial-thickness (second-degree) burns (formerly known as 2B burns) are less painful owing to partial destruction of the pain receptors, drier, require surgery and will scar. A full-thickness (third-degree) burn extends through the full dermis and is not typically painful owing to damage to the nerve endings, and requires protection from becoming infected and, unless very small, surgical management. Finally, a fourth-degree burn involves injury to deeper tissues, such as muscle or bone, is often blackened and frequently leads to loss of the burned part. Although superficial and superficial partial thickness burns usually heal without surgical intervention, more severe burns need careful management, which includes topical antimicrobial dressings and/or surgery. Importantly, burns are classified as either minor or major. A minor burn is usually a burn that encompasses <10% of the total body surface area (TBSA), with superficial burns predominating. By contrast, the burn size that constitutes a major burn is not commonly well-defined; some guidance to classify severe burn injuries are: >10%TBSA in elderly patients. The uniqueness of a severe or major burn injury is anchored in the body responses to it. After the injury, an immediate systemic and local stress response is triggered that, unlike sepsis or trauma, does not recover quickly. Severe burns cause a complex pattern of responses that can last up to several years after the initial insult. In general, immediately after the insult, an inflammatory response is triggered to promote the healing process. However, in severe burns, this inflammatory process can be extensive and become uncontrolled, leading to an augmented inflammation that does not induce healing but rather causes a generalized catabolic state and delayed healing. This response is almost unique to burns and is referred to as the hypermetabolic response; it is associated with catabolism, increased incidence of organ failure, infections and even death. According to The Effect of Age and Mitigation Strategies During Hot Water Immersion On Orthostatic Intolerance And Thermal Stress ([NAME] J. Steward, [NAME], [NAME] D. [NAME], [NAME] E. [NAME], [NAME] Hill, [NAME] J. A. [NAME], C. [NAME] Thake, [NAME]. First published: 27 February 2023 https://doi.org/10.1113/EP090993), It is well established that thermal intolerance ([NAME] & [NAME], 1987) and orthostatic intolerance ([NAME] et al., 2017) are altered by age. In response to an orthostatic challenge following passive heating, older adults have been shown to have a greater reduction in cerebral blood flow and slower corrections in blood pressure when compared with younger adults (Lucas et al., 2008). Accordingly, characterization of the safety and tolerability of hot water immersion protocols should be done separately for different age groups. Surveyor reviewed manufacturing instructions for facility's spa

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview the facility did not provide adequate equipment to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member, or to a centralized staff work area, for 1 resident (R1) out of 6 sampled residents. This had the potential to affect all 6 residents. * R1 did not have access to a call light while R1 was left in spa room unsupervised. Findings include: On 10/02/25 at 10:29 AM, Surveyor observed spa room down 400-wing. Surveyor did not observe a call light in the spa tub room. Surveyor did not observe a call light cord long enough to reach to the spa tub room from the shower room. On 10/02/25 at 10:36 AM, Surveyor observed spa room down 100-wing. Surveyor did not observe a call light in the spa tub room. Surveyor did not observe a call light cord long enough to reach to the spa tub room from the shower room. On 10/02/25 at 3:14 PM, Surveyor interviewed Director of Nursing (DON) B and asked DON B's expectation for call lights in the spa room and staff utilizing the call light. DON B reported that if staff leave a resident in the spa room, DON B would expect that a call light is in reach. Surveyor asked DON B if there was a reachable call light in the spa room. DON B reported that DON B knows there is one near the shower area. On 10/02/25 at 5:15 PM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked NHA A if it was facility practice to leave R1 alone in the spa tub. NHA A stated R1 is his own person and can have privacy in the tub. Surveyor asked if NHA A knew there was no call light in the spa tub room. NHA A reported that NHA A was unaware there was no call light in spa room and there are call lights at the vanity and shower in each spa room. NHA A reported to Surveyor that R1's preferences are to be left alone while taking a spa bath. Surveyor asked if R1 was assessed to safely bathe on own in spa room. NHA A reported that R1's preference had not been care planned, but everyone knew that he liked his privacy in spa room. Surveyor asked what the expectation is for staff leaving R1 without a call light in reach. NHA A reported that NHA A didn't realize there was not a call light in reach. On 10/07/25 at 1:23 PM, Surveyor interviewed DON B and NHA A and asked if DON B and NHA A could walk with Surveyor to the 100-wing spa room. Surveyor asked NHA A to show Surveyor where call lights were in the spa room. NHA A grabbed a call light to show Surveyor in the entrance of the spa room. There were 3 call lights located near the vanity, again another about 5 feet and then another near the shower. Surveyor asked if the string to the call lights could reach into the other room where the spa tub is located. NHA A and DON B reported that call light does not reach to the spa tub. Surveyor asked if there was a call light in the spa room. NHA A reported to Surveyor there was not a call light in the spa room. Surveyor asked why there was not a call light accessible to R1 at the time of the event on 09/29/25. NHA A stated, I don't know. I didn't build the building.