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	12/11/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, interviews and record reviews, the facility did not ensure staff maintained 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. The facility did not transport soiled laundry in a sanitary manner. This has the potential to affect the 17 residents that live between R90's room and the dirty linen storage area.The facility did not transport clean linen from laundry through the facility to patient's rooms on a hanging rack. This has the potential to affect all 35 residents whose linen at minimum is laundered and transported by the facility. Registered Nurse (RN) F did not practice hand hygiene or wear gloves when giving a subcutaneous injection to a resident (R) (R32).Certified Nursing Assistant (CNA) H delivered fresh water cups into R10's and R73's room and then into R7's and R24's room without practicing any hand hygiene between rooms and after handling dirty water cups. CNA G did not perform hand hygiene after handling contaminated cups and delivering clean cups of water to R13, R1, R63, and R29. This is evidenced by: Facility policy titled, Departmental (Environmental Services)-Laundry and Linen dated January 2014, states in part: Bagging and Handling Soiled Linen 1. All soiled linen must be placed directly into a covered laundry hamper which can container moisture. 3. Place any linen saturated with blood or body fluids into a leak- resistant bag before placing it into the hamper. Washing Linen and Other Soiled Items. 7. Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts. Note: Policy provided did not directly address how staff on unit should handle soiled linen and clothing. According to the CDC Appendix D titled, Linen and Laundry Management, dated March 19, 2024, states in part: Never carry soiled linen against the body. Always place it in the designated container. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Bag laundry where it originates. Example 1 On 12/20/25 at 7:33 AM, Surveyor was by the elevator on first floor when Surveyor observed Laundry Aide (LA) I exiting the elevator pulling a large cart of uncovered clean resident clothing. Some clothing was hanging, and some was folded on the base of the rack; nothing was covered. On 12/10/25 at 7:46 AM, Surveyor interviewed LA I who stated, That is the boo boo I did. I didn't cover this (the hanging rack) when I went out. I hoped you hadn't noticed. LA I stated the rolling rack should have been covered. LA I stated she's been here since 1:00 AM because she wants to get home before the weather. On 12/10/25 at 8:12 AM, Surveyor interviewed Environmental Services Manager (ESM) D during tour of laundry. Surveyor asked her expectations. ESM D stated she expects linen is covered when it is being transported. ESM D was informed of Surveyor's observation. Surveyor asked ESM D for a policy for transporting linen. On 12/10/25 at 10:47 AM, ESM D told Surveyor, I do not think we have any policy related to transporting linen clean or dirty. I am working on policies now, trying to get them organized and updated. Example 2 On 12/10/25 at 9:52 AM, Surveyor observed CNA J leave R90's room with a bag of dirty linen. CNA J dragged the linen down the hall and around the corner to where the dirty linen and clothes are stored before they go to laundry. On 12/20/25 at 10:58 AM, CNA J showed Surveyor where the linen chutes were. CNA J stated linen is bagged in the room and brought to the dirty area to be stored. CNA J stated eventually covered carts are taken to the chute and bags are sent down to laundry. Surveyor asked what if the bag is too big. CNA J stated that we usually try to do multiple small but otherwise it has to be taken down in a covered cart. Surveyor asked how the linen gets from the resident's room to the holding spot. CNA J stated it is bagged and carried. Surveyor asked if it is carried off the floor or dragged on the floor. CNA J stated no, the dirty linen is never dragged. Surveyor asked CNA J how the linen was carried when Surveyor saw CNA J with the linen from R90's room. CNA J stated, Oh, I dragged it. I shouldn't have. On 12/11/25 at 11:18 AM, Surveyor interviewed Assistant Director of Nursing (ADON) C, the facility's Infection Preventionist, who stated dirty laundry should not be dragged down the hall. ADON C stated we do not want cross contamination; dirty clothes and linen should be bagged and tied closed. ADON C stated dirty linen should not be dragged or carried unbagged. Example 3 The facility's procedure document titled, Subcutaneous Injections, revised April 2007, states in part, .Steps in the Procedure. 1. Perform hand antisepsis. 2. Put on gloves. 3. Place the equipment on the bedside stand or overbed table. Arrange the supplies so they can be easily reached, 4. Select injection site. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/10/25 at 9:10 AM, Surveyor observed RN F draw up 3 units of Aspart Insulin and prime R32's glargine insulin pen and set the pen to 12 units. RN F entered R32's room with insulin, cleared off spot to set insulin on R32's bedside table, explained procedure to R32, then injected both syringe and injector pen insulin into R32's L abdomen without putting on gloves or practicing hand hygiene prior to giving injections. On 12/10/25 at 9:13 AM, Surveyor interviewed RN F about hand sanitization and using gloves when administering insulin. RN F stated she had forgotten. On 12/11/25 at 8:21 AM, Surveyor interviewed ADON C, who reported the expectation would be hand hygiene be performed and gloves be worn during an injection. Example 4 The facility's policy statement titled, Handwashing/Hand Hygiene, revised August 2015, states in part, .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . l. after contact with objects (e.g. medical equipment) in the immediate vicinity of the residents. On 12/09/25 at 11:27 AM, Surveyor observed CNA H pass fresh water to residents. CNA H entered the room of R55 and R59 carrying fresh water for both residents, then took their used water cups out of room and set them on the cart. CNA H then took fresh water cups into R10 and R73 without practicing any hand hygiene between rooms and after handling dirty water cups. Surveyor observed CNA H do this for 2 more rooms, R7 and R24, and did not observe CNA H practice any hand hygiene. On 12/09/25 at 11:32 AM, Surveyor interviewed CNA H, who stated, I'll be honest with you, I am bad at that. CNA H was not sure when to perform hand hygiene but reported the facility did provide education on it. On 12/10/25 at 9:51 AM, Surveyor observed CNA G deliver fresh water to residents and remove the used water cups without practicing hand hygiene after handling contaminated cups and delivering clean cups of water for R13, R1, R63, and R29. On 12/10/25 at 9:58 AM, Surveyor interviewed CNA G. CNA G stated she was unaware she needed to use hand hygiene after contact with used water cups and performs hand hygiene before passing water to all the residents on the hall and not in between each resident or rooms. On 12/11/25 at 8:23 AM, Surveyor interviewed ADON C, who reported the expectation would be hand hygiene be performed after handling resident's used dishes and before handling clean cups and entering another resident's room.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility did not ensure that a resident who is fed by enteral means received the appropriate treatment and services to prevent complications of enteral feedings for 1 out of 1 resident (R) reviewed. (R90)Nurse did not measure enteral feeding appropriately and if not questioned, she would have had too much enteral feeding in the tube feeding set up.Nurse did not prime the tubing before connecting the feeding tubing to the J-G tubing, resulting in the air in tubing to be pushed into R90's stomach.Findings include:Surveyor asked for all policies that pertain to tube feeding. Surveyor received two polices Maintaining Patency of a Feeding Tube (Flushing), revised 2012, and Administering Medications through an Enteral Tube, revised May 2014. Neither policy addresses setting up and administering a tube feeding.The American Society for Parenteral and Enteral Nutrition, Enteral Nutrition Practice Recommendations indicate that priming the tubing is a standard procedure. The purpose is to remove air from the line to prevent air from entering the patient's stomach or intestines which can cause discomfort or other complications.R90 was admitted to the facility on [DATE] with history of pneumonia and the goal of getting stronger and recovering. R90 has only been at the facility one week and does not have a fully completed Minimum Data Set (MDS). Surveyor interviewed R90; he is alert and oriented times 3 and appeared cognitively intact. R90's physician order for his enteral feeding via a J/G peg tube, dated 12/9/25, states: Mix 60ml sterile water with 350 mL Jevity 1.5 via bolus feeding, four (4) times per day. Feeding times: 0600, 1000, 1400 and 1800. Give 60 mL sterile water before and after each feeding. Additional free water with medications. Four Times A Day AM, Noon, PM, HS.On 12/10/25 at 9:48 AM, Surveyor began the observation for the set up and administration of R90's tube feeding to receive medication via his tube feeding. Nurse Manager (NM) K was with during the treatment. At 10:02 AM, Registered Nurse (RN) F completed hand hygiene and put on a gown and gloves. RN F checked for correct tube placement and administered medications appropriately. When completed RN F started to set up enteral feeding. RN F stated the bag is changed on night shift, and Surveyor observed it labeled appropriately. RN F poured 60 ml of water directly into the feeding bag. RN F then opened one bottle of Jevity (237ml) and added it. RN F then looked at NM K and said, It's 350 ml of feeding so I don't need this whole thing. Wait how much for 350cc, how should I do this? During this conversation of determining how much Jevity was still needed, R90 stated, 120ml, you need 120ml. RN F turned and looked at the bag. Yeah, where is that on the bag? I can fill it to (pause to look), well it isn't totally marked but . RN F trailed off speaking and looked at NM K. NM K stated you should use a graduate. RN F poured 120 cc of Jevity into the graduate and turned to pour it into the feeding bag. After questions RN F realized that she was going to have 357ml of feeding and it is ordered for 350ml. RN F sat the graduate back on the table, took the syringe and pulled off 7ml and then poured remaining Jevity into the bag. RN F proceeded to connect the tubing and open the flow. RN F did not prime the tubing that was full of air. The last feeding ran dry and emptied tubing completely.On 12/10/25 at 10:42 AM, Surveyor interviewed RN F about measuring the Jevity. RN F stated she should have used the graduate the whole time, but it works to just pour it in the bag. Surveyor asked if there is anything else that needs to be done when setting up a tube feeding with the bag or tubing. RN F stated the bag and tube are all connected so not really. RN F stated I just connect it, there is nothing special. Surveyor asked what about the air in the tubing, where does it go. RN F stated, Oh, I should have primed it, I see.On 12/10/25 at 10:44 AM, Surveyor interviewed NM K who stated tubing should be primed.