STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525592	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care & Rehab - Ladysmith 1	1001 E 11th St N Ladysmith, WI 54848

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. This had the potential to affect all 40 residents (R).-The facility did not complete surveillance of the onset of symptoms for resident infections. (R28, R1, and R27)-Certified Nurse Assistant (CNA) did not perform hand hygiene during water pass for R1, R6, R17, R20, and R27. -No Enhanced Barrier precautions (EBP) in place for R6 related to open wounds.-Improper PPE utilized with wound care for R6. Findings include: Example 1 Surveyor reviewed infection control line lists from January 2025-present. Surveyor reviewed line lists for months of December 2025-January 2026, which stated in part, .- On 01/06/26, Site of infection: Cold symptoms. [R28] was placed on respiratory precaution monitoring for 3 days. [R28] has cough. No fever at this time. On 01/08/26 [R28] has flu-like symptoms. Nonproductive cough noted. Sneezing noted. Closed. -On 01/09/26, Site of infection: Cold symptoms. [R1] was noted to have wheezing and congestion at 0710. Afebrile, blood pressure and heart rate within resident baseline. Low saturations. Facility tested for COVID with negative results. [R1] was sent to hospital 01/11/26 and returned on antibiotics with possible pneumonia. Closed. -On 01/14/26, Site of infection: Cold symptoms. [R27] noted to have sore throat this shift. Noted to be weak and unsteady on her feet. [R27] has scratchy gravelly voice, occasionally dry cough, loose stools. On 01/18/26 [R27] continues to have nonproductive loose cough. On 01/21/26, cold resolved. Isolation ended. Closed. Surveyor did not find line lists thoroughly completed to show what type of isolation was used, when isolation was placed, what tests were performed for infectious residents, and did not find well dates consistently documented in line lists. Examples: Surveyor did not find documentation for R28 on when or if R28 was placed on isolation precautions. Surveyor did not find any testing completed for R28 to rule out COVID, influenza, or RSV despite the connecting building having an active influenza outbreak in the facility. Surveyor did not find that any other action was taken to protect infection from spreading. Surveyor did not find R28's well date or outcome of infection. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525592	A. Building B. Wing	02/24/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor did not find documentation for R1 on when or if R1 was placed on isolation precautions Surveyor did not find any testing completed for R1 to rule out influenza and/or RSV despite the connecting building having an active Influenza outbreak in the facility. Surveyor did not find that any other action was taken to protect infection from spreading. Surveyor did not find R1's well date. Surveyor did not find documentation for R27 on when or if R37 was placed on isolation precautions Surveyor did not find any testing completed for R27 to rule out COVID, influenza, or RSV despite the connecting building having an active Influenza outbreak in the facility. Surveyor did not find that any other action was taken to protect infection from spreading. On 02/10/26 at 9:04 AM, Surveyor interviewed Infection Preventionist (IP) C regarding the process for tracking infections and documenting on infection control line lists. IP C reported to Surveyor that IP C is newer at this line list and has been IP C for almost a year but is trying to work out process. Surveyor asked if it is IP C's expectation to document what type of isolation precautions certain residents should be placed on and documentation of when isolation ended for the infection. IP C reported that type of infection and when isolation precautions start and end should be placed on resident line lists and has not been consistently documented in that fashion over the last year. IP C stated, I am following the process from previous on how I was trained in by the former DON. Surveyor reviewed infection control line lists from January 2025-present with IP C and pointed out several different examples such as R28's, R1's, and R27's which are just a few records reviewed for possible infections and noted that IP C did not document what tests were performed to rule out certain infections. IP C reported to Surveyor that IP C didn't know the facility needed to test for more than just COVID for respiratory like symptoms in the residents with respiratory infections such as R28 and R27. IP C stated, Not everyone was even tested for COVID if they had symptoms, it is mostly up to the digression of the provider and the resident. Surveyor asked IP C what guidelines IP C follows to ensure that infection is not spread. IP C stated, I really follow the facility policies, but I see here that the Isolation and PPE policy needs to be updated as there are different processes that need to take place when residents have an active infection. IP C reported to Surveyor that IP C needs to follow the CDC guidelines and make sure the process for tracking active infections is handled according to the guidelines from the state, which has not been done consistently across the board. Example 2 The facility policy, titled Hydration Water Pass, revised February 2020, states: .Infection Control and Prevention: Perform hand hygiene using sanitizer or hand washing after removing dirty mug/glass. On 02/09/2026 at 8:54 AM, Surveyor observed Certified Nurse Assistant (CNA) K enter R17's room with clean water pitcher, and CNA K grabbed contaminated water pitcher and set the contaminated water pitcher on the water pitcher cart. CNA K then grabbed another clean water pitcher, entered R1's room and placed the clean water pitcher down on R1's table. Surveyor did not observe CNA K sanitize hands upon exiting R17's room nor did CNA K sanitize hands before entering R1's room. CNA K grabbed contaminated water pitcher, exited R1's room and placed contaminated water pitcher on water cart. Surveyor did not observe CNA K sanitize hands upon exiting R1's room. Surveyor observed CNA K enter R20's room without sanitizing hands with clean water pitcher. CNA K grabbed contaminated water pitcher, exited R20's room and placed contaminated water pitcher on water cart. Surveyor did not observe CNA K sanitize hands upon exiting R20's room. Surveyor observed CNA K enter R27's room with clean water pitcher without sanitizing hands. CNA K grabbed contaminated water pitcher, exited R27's room and placed contaminated water pitcher on water cart. Surveyor then observed CNA K go into R6's room to continue passing water. Surveyor did not observe CNA K (continued on next page)

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	525592	A. Building B. Wing	02/24/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	complete hand hygiene. On 02/09/26 at 9:01 AM, Surveyor interviewed CNA K and asked what CNA K's process is for delivering clean water pitchers during water pass. CNA K reported that CNA K should be sanitizing hands in between each resident room especially if grabbing contaminated water pitchers and going into the next resident room. Surveyor asked if CNA K sanitized hands in between resident rooms. CNA K looked at Surveyor and stated, I did or maybe forgot one room, but I am unsure. On 02/10/26 at 9:24 AM, Surveyor interviewed IP C regarding process for sanitizing hands during water pass. IP C reported that all staff should be using hand hygiene such as sanitizing or washing hands between resident rooms and especially if taking out contaminated water pitchers and going into other resident rooms with clean water pitchers. IP C reported to Surveyor that CNA K should have washed or sanitized hands. Example 3 The facility policy, titled Enhanced Barrier Precautions (EBP), revised July 2025, states: .Implementation of Precautions: Wear gloves and gown when in High Contact Activity with the individual, surfaces, objects within his/her environment. PPE, including gown and gloves before or upon entering the room or cubicle. Prior to leaving the residents room, the PPE removed, and hand hygiene is performed. High Contact Activities Include: -Wound Care: any skin issue requiring a dressing. R6 was admitted to the facility on [DATE]. On 01/08/2026 R6's Brief Interview for Mental Status score was 15/15, indicating cognitively intact. On 02/10/26 at 9:25 AM, Surveyor observed wound care for R6. R6 has open wounds to buttocks stage 3. Registered Nurse (RN) L and Certified Nursing Assistant (CNA) P were present. Both staff donned gloves. R6 has an Enhanced Barrier Precautions (EBP) sign on door frame but no Personal Protective Equipment (PPE) was present. Neither staff member wore gowns. On 02/10/26 at 10:41 AM, Surveyor interviewed RN L. RN L stated Infection Preventionist (IP) C is responsible for who gets placed on precautions. RN L stated it would be appropriate for residents with catheters to be on EBP but did not mention any other reasons. RN L stated they would use droplet precautions for respiratory concerns. Once advised, the nurses will put the signs and PPE up. RN L stated they have signs and instructions at the desk. RN L showed Surveyor the guides at the desk after asking RN D where to find them.On 02/10/26 at 10:47 AM, Surveyor interviewed CNA P. CNA P stated CNA P knows when stuff is on the outside of the door that is when a resident is on precautions. CNA P is unaware of who is responsible for putting signs and PPE on resident doors. CNA P was also unaware of what kind of things require the use of PPE and states CNA P just follows the signs. CNA P stated PPE education might be part of the monthly training.On 02/10/26 at 10:53 AM, Surveyor interviewed IP C. IP C stated she is responsible for putting residents on precautions if she is here. IP C stated if she is not here and someone else catches it, they will initiate it and then follow up when she returns. IP C stated sometimes IP C will also sometimes have the cleaning lady put it up. IP C stated it would be appropriate to initiate EBP for residents with a catheter, history of certain infections, indwelling lines, or something is open. IP C stated the nurses will enter the vitals and a progress note, and IP C will complete the assessment form in the computer and add the resident to the line list. IP C stated it depends on what kind of wounds the resident has and if they felt the wound was taking a certain (continued on next page)

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	525592	A. Building B. Wing	02/24/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	course they would initiate EBP. IP C asked, What do you mean? when Surveyor asked when to utilize EBP versus contact precautions. IP C stated, EBP is a part of contact precautions, isn't it? IP C stated they initiate EBP if wounds have an infection. IP C stated, Maybe I don't know enough. IP C stated IP C is new to this role and started in March of 2025. IP C stated she had some training by Minimum Data Set (MDS) coordinator/Director of Nursing (DON) B. IP C stated it was mostly from her IP training online. IP C stated the staff use an online education platform when they first start and the rest is mostly on paper. IP C stated, It's been kind of wishy-washy in some respects. IP C stated IP C was just following the education/training the staff had been provided with the year prior.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 cabinets on 100 unit and 200 unit. This occurred for 6 of the 26 medication cabinets outside residents' rooms observed. -During the three-day survey, 6 of 26 observations were made of individual resident (R6, R27, R17, R28, R31, and R11) medication cabinets left unlocked when unattended and out of view of staff with prescribed medications in cabinets. Findings include: The facility policy, titled Medication Administration, revised August 2025, states: .#2. Storage of Medications: b. Only licensed nurses, med techs, the consultant pharmacist and those lawfully authorized to administer medications are allowed access to medications. Medication rooms, carts, and medication supplies are locked when unattended, or attended by persons with authorized access only . On 02/10/26 at 12:04 PM, Surveyor observed medication cabinet outside R6's room unlocked. Surveyor observed Trimacolone ointment labeled with R6's identifying information and dispersed on 04/14/24. Surveyor observed R6's calcium alginate dressing also located in unlocked medication cabinet. On 02/10/26 at 12:05 PM, Surveyor observed medication cabinet outside R27's room unlocked. Surveyor observed unknown white powder in a medicine cup located in unlocked medication cabinet. On 02/10/26 at 12:06 PM, Surveyor observed medication cabinet outside R17's room unlocked. Surveyor observed arthritis cream labeled with R17's identifying information located in unlocked medication cabinet. On 02/10/26 at 12:07 PM, Surveyor observed medication cabinet outside R28's room unlocked. Surveyor observed Difloneac cream labeled with R28's identifying information in unlocked medication cabinet. On 02/10/2026 at 12:17 PM, Surveyor observed medication cabinet outside R31's room unlocked. Surveyor observed prescription bottle of Hibiclens and Aspercreme tube in R31's unlocked medication cabinet. On 02/10/2026 at 12:19 PM, Surveyor observed medication cabinet outside R11's room unlocked. Surveyor observed Equate arthritic cream and Trolamine Salicylate medication in R11's unlocked medication cabinet. On 02/10/26 at 12:25 PM, Surveyor interviewed Registered Nurse (RN) L and asked if medication cabinets outside resident rooms were supposed to be locked. RN L reported that if any prescribed medication is stored in the medication cabinets, all medication cabinets should be locked. Surveyor asked if RN L could review R6's medication cabinet. RN L stated to Surveyor, I see [R6] has Trimalicone cream that he doesn't even use anymore in the medication cabinet and that the cabinet should be locked regardless. Surveyor observed RN L trying to lock medication cabinet right away. On 02/10/26 at 1:23 PM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked expectation for medication cabinets locked outside resident rooms. NHA A reported that all medication cabinets located outside resident rooms should be locked if prescribed medications are in the medication cabinet and staff are out of sight.

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	525592	A. Building B. Wing	02/24/2026

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview, observation and record review, the facility did not take action through documenting grievances, conducting a thorough investigation of the issues identified or providing resolution of the concerns brought to the attention of facility staff regarding missing golden necklace. This affected R9.This is evidenced by:The facility policy, titled Grievance Complaint Procedures, revised October 15, 2021, states: .Procedure: #10. Social Worker or designee will begin investigating the complaint in a timely manner to ascertain its validity and will keep a record of the investigation in the complaint file. #11. A plan of action to resolve the grievance/complaint shall be developed within 72 hours of the social worker's knowledge of the compliant. The person filing the complaint or grievance will be informed within reasonable amount of time of the plan of action and the social worker will complete a follow-up to determine if the plan has succeeded. The person filing the complaint or grievance will receive periodic updates throughout the process. If the plan is not successful, another plan of action will be formulated and followed.#12. All parties involved and witnesses, if any, will be interviewed and responses recorded as a part of the investigation. Written statements will be signed and dated by the person.#14. The Grievance Official will work toward a solution to the problem and consult with the staff as needed .Surveyor reviewed Grievance logs dated October 2024-present (4 pages).Surveyor observed an incomplete grievance complaint form attached to grievance log, dated 12/04/25, which states in part, .[R9's] Gold necklace with (Sister) on the necklace missing.Surveyor did not see a proper investigation or process for resolution of the missing item on the incomplete grievance form. On 02/11/26 at 8:51 AM, Surveyor interviewed Social Services J and asked how Social Services J handles complaints and who oversees investigating and finding a resolution. Social Services J reported to Surveyor that typically the staff or a resident will fill out a grievance form. Social Services J then reviews the grievance and starts the investigation and interviews potential witnesses or resources who may know more of the situation. Social Services J will interview the complainant and follow up through the investigation process. Social Services J reported that Social Services J finds a resolution and makes sure to update all parties involved. Surveyor asked how Social Services J keeps record of the steps in investigation and processes. Social Services J reported that every complaint is documented on the grievance log and then a narrative of the steps and outcome are kept in a file folder per grievance. Surveyor asked if Social Services J has the investigation file for R9 and what the disposition was for R9's missing Golden necklace. Social Services J reported to Surveyor that Social Services J was out on maternity leave from 09/17/25-12/15/25, so Social Services J is unsure what came of R9's grievance. Social Services J reported that while Social Services J was on maternity leave, Nursing Home Administrator (NHA) A was to oversee grievances.On 02/11/26 at 9:05 AM, Surveyor interviewed NHA A and asked why R9's grievance of missing Golden Necklace did not have investigation process or resolution in place. NHA A reported that NHA A didn't realize the grievance was not followed up on and that it was a mistake.

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	525592	A. Building B. Wing	02/24/2026

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on record review and interview, the facility did not ensure residents were free of misappropriation and/or exploitation. The facility failed to investigate and report to the State of Wisconsin or local authorities when alleged misappropriation was first reported by resident (R) R9 on 12/04/25. This led to no resolution of R9's missing golden necklace.This is evidenced by:The facility policy, titled Grievance Complaint Procedures, revised October 15, 2021, states:.Procedure:#10. Social Worker or designee will begin investigating the complaint in a timely manner to ascertain its validity and will keep a record of the investigation in the complaint file.#9. Consistent with CMS regulation 483.13 (c) (2), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property to the administrator and any other officials as required by State law (including the state survey and certification agency) .#11. A plan of action to resolve the grievance/complaint shall be developed within 72 hours of the social worker's knowledge of the compliant. The person filing the complaint or grievance will be informed within reasonable amount of time of the plan of action and the social worker will complete a follow-up to determine if the plan has succeeded. The person filing the complaint or grievance will receive periodic updates throughout the process. If the plan is not successful, another plan of action will be formulated and followed.#12. All parties involved and witnesses, if any, will be interviewed and responses recorded as a part of the investigation. Written statements will be signed and dated by the person.#14. The Grievance Official will work toward a solution to the problem and consult with the staff as needed .Surveyor observed an incomplete grievance complaint form attached to grievance log, dated 12/04/25, which states in part, .[R9's] Gold necklace with (Sister) on the necklace missing. Surveyor did not see a proper investigation or process for resolution of the missing item on the incomplete grievance form. On 02/11/26 at 8:51 AM, Surveyor interviewed Social Services J and asked how Social Services J handles complaints and who oversees investigating and finding a resolution. Social Services J reported to Surveyor that typically the staff or a resident will fill out a grievance form. Social Services J then reviews the grievance and starts the investigation and interviews potential witnesses or resources who may know more of the situation. Social Services J will interview the complainant and follow up through the investigation process. Social Services J reported that Social Services J finds a resolution and makes sure to update all parties involved. Surveyor asked how Social Services J keeps record of the steps in investigation and processes. Social Services J reported that every complaint is documented on the grievance log and then a narrative of the steps and outcome are kept in a file folder per grievance. Surveyor asked if Social Services J has the investigation file for R9 and what the disposition was for R9's missing Golden necklace. Social Services J reported to Surveyor that Social Services J was out on maternity leave from 09/17/25-12/15/25, so Social Services J is unsure what came of R9's grievance. Social Services J reported that while Social Services J was on maternity leave, Nursing Home Administrator (NHA) A was to oversee grievances.On 02/11/26 at 9:05 AM, Surveyor interviewed NHA A and asked why R9's grievance of missing Golden Necklace did not have investigation process or resolution in place. NHA A reported that NHA A didn't realize the grievance was not followed up on and that it was a mistake.

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	525592	A. Building B. Wing	02/24/2026

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Care & Rehab - Ladysmith 1	1001 E 11th St N Ladysmith, WI 54848

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility did not ensure each resident is free from unnecessary drugs as evidenced by not completing adequate drug monitoring for 1 of 5 residents (R) R9 reviewed for unnecessary medication reviews.The facility failed to accurately monitor resident-specific targeted behaviors for R9's psychotropic medication use. The facility policy, titled Antipsychotic use in residents with dementia and discus requirements, dated 08/24, states: Procedure: 1. Upon admission of a resident who has a diagnosis of dementia and is ordered an antipsychotic medication, the nursing staff will obtain from the physician an approved diagnosis for the antipsychotic medication and a specific targeted behavior/indication for it use.The facility policy further states under Procedure: 3. The nursing department will monitor specific behavior(s) for which the antipsychotic medication was prescribed for.*Of note, the policy does not address all psychotropic medication use.R9 was admitted to facility on 10/16/25 with diagnoses that include vascular dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety and major depressive disorder.R9's physician orders include the following psychotropic medications:-Buspirone HCl Oral Tablet 15 mg. Give 1 tablet by mouth two times a day for depression (anti-anxiety)-Trazodone HCl Oral Tablet 50 mg. Give 1 tablet by mouth one time a day for Insomnia. (anti-depressant).-12/10/25 Paroxetine HC oral tablet 20 mg. Give 1 tablet my mouth one time a day for major depression and anxiety. Give 1 tablet (20 mg) with 1 (40mg) to equal 60 mg. (anti-depressant).-12/10/25 Paroxetine HC oral tablet 40 mg. Give 1 tablet by mouth one time a day for major depression and anxiety. Give 1 tablet (40 mg) with 1 (20mg) to equal 60 mg. (anti-depressant).R9's care plan initiated on 10/28/25 and last revised on 01/22/26 states: Focus: The resident has impaired cognitive function/Alzheimer's dementia/Vascular dementia r/t Difficulty making decisions, Psychotropic drug use.R9's care plan does not include specific focus/interventions for targeted behaviors or monitoring for all 3 psychotropic medications.R26's monitoring order for targeted behaviors related to antidepressants and anti-anxiety use was not put into place until 02/10/26 when Surveyor requested supporting targeted documentation.On 02/10/2026 at 2:15 PM, Surveyor interviewed MDS/Interim Director of Nursing (DON) B regarding R9's behavior charting and monitoring for specific targeted behaviors for use of anti-anxiety and anti-depressant medication use. MDS/DON B stated was unable to find any supporting documentation. On 02/10/2026 at 4:15 PM, Surveyor made Nursing Home Administrator (NHA) A aware of concerns with no targeted specific behaviors being monitored for R9. NHA A stated was aware of concern and targeted behaviors were to be added for monitoring in R9's record.

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	525592	A. Building B. Wing	02/24/2026

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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. Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported/reported timely for 3 of 3 residents reviewed (R7, R26, R9) to the State Agency (SA) or to law enforcement.The facility did not report R7's injury of unknown origin to the State Agency (SA) or to law enforcement.The facility did not report R26's injury of unknown origin to the SA or to law enforcement.The facility did not report misappropriation of R9's personal property to the SA or to law enforcement. Findings include: Facility policy titled, Abuse -Alleged Incidents of Caregiver Misconduct and Injuries of Unknown Origin, last revised 05/25, reads in part: Immediately upon learning of an incident of resident mistreatment or discovering an injury of unknown source, nursing staff must take the necessary steps to protect all residents from possible subsequent incidents of mistreatment, neglect, exploitation, or injury by removing the individual under suspicion from duty until the investigation is completed, or any suspected causative factors in the environment.In addition to Federal and State reporting requirements, The Elder Justice Act requires notification of local law enforcement authorities.A thorough investigation may include.interviewing staff who worked previous shifts to determine if they were aware of an injury. Example 1 On 02/02/26 at 5:50 AM, Certified Nursing Assistant (CNA) O went to assist CNA Q get R7 out of bed and when pulling back the covers discovered two skin tears to the right forearm near the elbow. CNA O asked CNA Q what happened, and CNA Q stated CNA Q did not know. CNA Q had been taking care of R7 at 4:30 AM that morning and had called for assistance as R7 was reportedly combative with cares. No one went to assist CNA Q at the time. CNA Q stated there were no skin tears when CNA Q left R7's room the first time. CNA O got Licensed Practical Nurse (LPN) N to come assess. LPN N stated upon arrival to R7's room there was dried blood on the blanket and two skin tears to the right forearm. LPN N provided first aid to skin tears. CNA Q was not allowed back in R7's room but was allowed to remain in the building and finish the shift. CNA Q left at 6:45 AM. R7 does not have side rails or the ability to reach the headboard of the bed that R7 could have hit with R7's forearm. The facility initiated an alleged abuse investigation related to CNA Q. The initial incident report was not submitted within 2 hours to the State. The initial report was submitted on 02/04/26. Law enforcement was not contacted regarding allegation of abuse. On 02/11/26 at 10:37 AM, Surveyor interviewed LPN N. LPN N stated LPN N did not report the incident to Director of Nursing (DON) B until after 8:00 AM when DON M arrived at work. LPN N stated DON M then reported the incident to Nursing Home Administrator (NHA) A. On 02/11/26 at 10:45 AM, Surveyor interviewed NHA A. NHA A stated the facility did not call law enforcement because the facility could not prove abuse. NHA A acknowledged the facility should have contacted law enforcement due to the allegation of abuse. NHA A stated the initial report was completed on 02/02/26 at 12:00 PM but had not been completely submitted to the State. NHA A acknowledged the report would still have been beyond the 2-hour reporting time. NHA A reported it is an expectation for CNAs to report any allegations of abuse immediately to a nurse, or if it involves a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525592	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care & Rehab - Ladysmith 1	1001 E 11th St N Ladysmith, WI 54848

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse, to management immediately. NHA A stated it is an expectation for nurses to report an incident within 2 hours. NHA A stated it would be appropriate to report to law enforcement if the incident was aggressive including physical abuse. Example 2 Surveyor reviewed Grievance logs dated October 2024-present (4 pages). On 02/10/26 at 2:31 PM, Surveyor received grievance logs and an attached stack of papers paperclipped together pertaining to R26's ankle fracture. Surveyor reviewed a narrative note dated 08/25/25, which states in part, .[R26's] left ankle fracture resulted from most likely during one of the transferring events per provider. Writer received a text message from night nurse to update findings of bruising and swelling to [R26's] left ankle. Nurse reported that CNA was pivot transferring [R26] to toilet from bed and back to bed. Upon returning back to bed [R26] complained of left ankle pain. Nurse assessed and found scattered bruising 7cmx4.5cm and swelling to the left ankle area and lighter colored bruising above and around the outer area of the ankle bone. On 08/26/25 [R26] was seen for acute visit and had received x-rays that showed acute oblique nondisplaced distal fibular ankle fracture and [R26] is to be non-weight bearing and cast placed. Per nursing charting on 08/25/25, nurse documented R26 complained of left ankle pain for the last week . Surveyor reviewed R26's progress notes that state in part, .-On 08/18/25, [R26] complained of pain to the left ankle top/ or left foot. Increased swelling noted. Lift used due to difficulty transferring. Will continue to monitor . Surveyor reviewed all notes and did not find that facility reported R26's unknown injury to state agency. On 12/11/26 at 9:15 AM, Surveyor interviewed Nursing Home Administrator (NHA) and asked what the expectation is for reporting R26's unknown injury to state officials. NHA A reported that NHA A did not realize that R26's injury should have been reported, therefore did not get reported to the state within the allotted time frame. Example 3 The facility policy, titled Grievance Complaint Procedures, revised October 15, 2021, states: .Procedure: #9. Consistent with CMS regulation 483.13 (c) (2), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property to the administrator and any other officials as required by State law (including the state survey and certification agency) . Surveyor reviewed Grievance logs dated October 2024-present (4 pages): Surveyor observed an incomplete grievance complaint form attached to grievance log, dated (continued on next page)

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	525592	A. Building B. Wing	02/24/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/04/25, which states in part, .[R9's] Gold necklace with (Sister) on the necklace missing. Surveyor did not see a proper investigation, process for resolution, or reporting of the missing item on the incomplete grievance form. On 02/11/26 at 8:51 AM, Surveyor interviewed Social Services J and asked how Social Services J handles complaints. On 02/11/26 at 9:05 AM, Surveyor interviewed NHA A and asked why R9's grievance of missing Golden Necklace wasn't reported to law enforcement or to the state agency. NHA A reported that NHA A didn't realize the grievance was not followed up on and that it was a mistake.

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	525592	A. Building B. Wing	02/24/2026

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility did not have evidence that all injuries of unknown origin and allegations of misappropriation of property are thoroughly investigated for 2 of 2 residents reviewed (R7, R9).R7's injury of known origin was not thoroughly investigated.R9's allegation of misappropriation of property was not thoroughly investigated.Findings include: Facility policy titled, Abuse -Alleged Incidents of Caregiver Misconduct and Injuries of Unknown Origin, last revised 05/25, reads in part: Immediately upon learning of an incident of resident mistreatment or discovering an injury of unknown source, nursing staff must take the necessary steps to protect all residents from possible subsequent incidents of mistreatment, neglect, exploitation, or injury by removing the individual under suspicion from duty until the investigation is completed, or any suspected causative factors in the environment.In addition to Federal and State reporting requirements, The Elder Justice Act requires notification of local law enforcement authorities.A thorough investigation may include.interviewing staff who worked previous shifts to determine if they were aware of an injury.A thorough investigation may include.Interviewing other residents to determine if they have been abused or mistreated, interviewing staff worked the same shift, interviewing staff that worked the previous shift, and involving other regulatory authorities that may assist. Example 1 R7 was admitted to facility on 11/01/23. R7's diagnoses in part include Alzheimer's disease, dementia with psychotic disturbance, and mild neurocognitive disorder. On 12/30/25, R7's Brief Interview for Mental Status (BIMS) score was 7/15 indication moderate cognitive impairment. On 02/02/26 at 5:50 AM, CNA O went to assist CNA Q get R7 out of bed and when pulling back the covers discovered two skin tears to the right forearm near the elbow. Both CNAs denied knowing what caused the skin tears. CNA O got Licensed Practical Nurse (LPN) N to come assess R7. LPN N stated upon arrival to R7's room there was dried blood on the blanket and two skin tears to the right forearm. Skin tears measured 2 centimeters (cm) by 1.9cm and 9.5cm by 6.7cm. LPN N provided first aid to skin tears. CNA Q was not allowed back in R7's room but was allowed to remain on the unit and finish the shift. CNA Q left at 6:45 AM. LPN N questioned CNA O and CNA Q. Both denied having any knowledge of how the skin tears happened. LPN N talked to both CNAs about how to care for resistive residents. The facility determined this could possibly be an abuse situation or an injury of unknown origin. Director of Nursing (DON) M was notified upon arrival to work after 8:00 AM. DON M then informed Nursing Home Administrator (NHA) A. MDS Coordinator/DON B interviewed 2 residents from the same unit with severely impaired cognition and were not good historians. Education was initiated and CNA Q was removed from the schedule. On 02/02/26 at 1:19 PM, night shift Registered Nurse (RN) R stated RN R was assisting another resident to the bathroom when CNA Q called on the walkie talkie for assistance stating R7 was (continued on next page)

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	525592	A. Building B. Wing	02/24/2026

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Care & Rehab - Ladysmith 1	1001 E 11th St N Ladysmith, WI 54848

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	getting physically and verbally aggressive. RN R stated CNA Q reported R7 threatened to bite CNA Q in the arm and take a chunk of skin off. RN R stated there was no report of a skin tear at that time. RN R stated, Multiple residents were awake, confused and causing problems. RN R did not respond to R7's room. LPN N filled out a resident abuse form which indicated R7 does not have side rails and does not have the ability to reach the headboard to cause the injury to R7's arm. On 02/02/26, DON M completed a form titled, Abuse-Alleged Incident of Caregiver Misconduct Checklist. The line stating, If there is a reasonable suspicion of a crime against a resident, law enforcement will be contacted immediately, was marked as not applicable. On 02/03/26, Nursing Home Administrator (NHA) A and MDS/DON B interviewed CNA Q. CNA Q stated CNA Q washed R7 up and saw no skin tears to R7's arms until CNA Q and CNA O went to get R7 out of bed. CNA Q stated R7 was not resistive to cares earlier in the shift, CNA Q did not hold R7's arm, R7 did not yell or hit CNA Q, and CNA Q did not have long fingernails, a watch, or rings that would have caused the skin tears. It was reported that CNA Q was wearing a hoodie with a zipper during the incident. CNA Q stated that no one else took care of R7 that night. On 02/05/26, NHA A terminated CNA Q. The report included in part: Following the investigation, it was determined there was cause for termination of employment. The investigation did not find concrete evidence of abuse but lack of knowledge of the injury was concerning and neglectful. On 02/10/26, Surveyor reviewed provided education. 50% of staff had been educated on abuse and reporting. On 02/11/26 at 10:08 AM, Surveyor interviewed RN D. RN D stated if RN D was made aware or witnessed potential abuse RN D would remove the perpetrator, ensure the resident is safe and notify management immediately. On 02/11/26 at 10:37 AM, Surveyor interviewed LPN N. LPN N stated LPN N sent CNA Q out of R7's room but allowed her to stay and finish CNA Q's shift on the unit. LPN N stated LPN N reported the incident to DON M after 8:00 AM when DON M arrived for work. LPN N stated LPN N did not have an RN complete a follow up assessment of R7 and acknowledged there were RNs in the building at the time of the incident. LPN N stated the expectation would be to remove the accused staff member from the building and report to management immediately. On 02/11/26 at 10:45 AM, Surveyor interviewed NHA A. NHA A acknowledged further interviews should have been conducted with residents with higher cognition possibly on the other unit, as CNA Q had previously worked both units. Example 2 The facility policy, titled Grievance Complaint Procedures, revised October 15, 2021, states: .Procedure: #10. Social Worker or designee will begin investigating the complaint in a timely manner to ascertain its validity and will keep a record of the investigation in the complaint file. (continued on next page)

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	525592	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care & Rehab - Ladysmith 1	1001 E 11th St N Ladysmith, WI 54848

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#11. A plan of action to resolve the grievance/complaint shall be developed within 72 hours of the social worker's knowledge of the compliant. The person filing the complaint or grievance will be informed within reasonable amount of time of the plan of action and the social worker will complete a follow-up to determine if the plan has succeeded. The person filing the complaint or grievance will receive periodic updates throughout the process. If the plan is not successful, another plan of action will be formulated and followed. #12. All parties involved and witnesses, if any, will be interviewed and responses recorded as a part of the investigation. Written statements will be signed and dated by the person. #14. The Grievance Official will work toward a solution to the problem and consult with the staff as needed . Surveyor reviewed Grievance logs dated October 2024-present (4 pages): Surveyor observed an incomplete grievance complaint form attached to grievance log, dated 12/04/25, which states in part, .[R9's] Gold necklace with (Sister) on the necklace missing. Surveyor did not see a proper investigation or process for resolution of the missing item on the incomplete grievance form. On 02/11/26 at 8:51 AM, Surveyor interviewed Social Services J and asked what the process is for how Social Services J handles complaints and who oversees investigating and finding a resolution. Social Services J reported to Surveyor that typically the staff or a resident will fill out a grievance form. Social Services J then reviews the grievance and starts the investigation and interviews potential witnesses or resources who may know more of the situation. Social Services J will interview the complainant and follow up through the investigation process. Social Services J reported that Social Services J finds a resolution and makes sure to update all parties involved. Surveyor asked how Social Services J keeps record of the steps in investigation and processes. Social Services J reported that every complaint is documented on the grievance log and then a narrative of the steps and outcome are kept in a file folder per grievance. Surveyor asked if Social Services J has the investigation file for R9 and what the disposition was for R9's missing Golden necklace. Social Services J reported to Surveyor that Social Services J was out on maternity leave from 09/17/25-12/15/25, so Social Services J is unsure what came of R9's grievance. Social Services J reported that while Social Services J was on maternity leave, Nursing Home Administrator (NHA) A was to oversee grievances. On 02/11/26 at 9:05 AM, Surveyor interviewed NHA A and asked why R9's grievance of missing Golden Necklace did not have investigation process or resolution in place. NHA A reported that NHA A didn't realize the grievance was not followed up on and that it was a mistake.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review, the facility did not implement the care developed in a comprehensive care plan for 1 (R16) resident of 12 residents reviewed for care plans in a sample of 12 residents.R16's comprehensive care plan was not implemented by staff regarding the placement of the torticollis orthosis (a device designed to restore proper head and neck alignment). Findings include:The facility's policy, titled Care Planning with Resident and/or Representative, dated 11/23/2016, states in part: A comprehensive plan of care is a systemic assessment and identification of resident problems accomplished through short- and long-term measurable goals.it includes which disciplines are responsible for the identified approaches. It is updated when changes occur.The facility's policy, titled Standards of Care, revised 2/2026, states in part: Physician orders, standing orders, MAR/TAR, care plans, CNA charting, and policies and procedures provide guidelines to follow to meet the needs of the residents. R16 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's disease with late onset, moyamoya disease (a progressive cerebrovascular disorder that can lead to reduced blood flow to the brain, causing strokes), hemiplegia and hemiparesis following cerebral infarction (stroke) affecting left nondominant side, epilepsy, dysphagia (difficulty swallowing) and aphasia (impaired speaking).R16's Minimum Data Set (MDS) assessment, dated 12/30/2025, indicated R16 has a Brief Interview for Mental Status (BIMS) score of 10/15, which means moderate cognitive impairment. R16 has an activated power of attorney for healthcare. R16's care plan, last revised 12/23/2025, with a target date of 03/31/2026, states in part: Self-care deficit related to dementia, history of strokes, contractures both arms and legs. Interventions include.Torticollis Orthosis: apply during AM shift meals, padded area placed on right side of head. Strap around back with padded strap under arm and along front of chest. Secured at buckle. Encourage me to relax head back in a more upright position. Feed from left side to encourage improved positioning.From 02/09/2026 at 12:28 PM to 02/11/2026 9:13 AM, Surveyor observed R16 being assisted by staff with feeding at breakfast and lunch meals. R16 was seated in Broda chair, parked with dining table to the right. R16 was assisted with feeding by staff seated on R16's right side. R16 did not have torticollis orthosis cushion in place during each meal observed. On 02/10/2026 at 1:45 PM, Surveyor observed signage on R16's closet door instructing proper use and application of torticollis orthosis cushion. Cushion was lying on desk in R16's room. Surveyor asked R16 if cushion was being used during meals to help with positioning of neck and R16 stated it was not. Surveyor asked R16 if assistance with feeding was required and R16 stated he could not feed himself. R16 stated it was hard to swallow foods because of neck flexion to the right. On 02/10/2026 at 1:50 AM, Surveyor interviewed Certified Nursing Assistant (CNA) F on proper timing and use of the torticollis orthosis cushion for R16. CNA F stated R16 is supposed to wear it however refuses to because he does not like it and says it hurts when it is on. Record review includes the following: On 11/01/2026, a physical therapy evaluation on R16 indicated reason for referral was in part. contracture of the cervical spine. He is rotated and side bending severely to the right. On 12/08/2026, physical therapy documentation states in part: Response to treatment - actively participates with skilled interventions.patient would benefit from torticollis orthosis for positioning while eating as well as other times of the day. Education provided to DON [director of nursing] regarding torticollis orthosis for positioning. On 12/10/2026, physical therapy documentation states in part: patient was provided education about orthosis and is in agreement to wear.On 02/11/2026 at 9:05 AM, Surveyor interviewed Occupational Therapist (OT) H about what the expectations of staff were for placement of the torticollis orthosis cushion on R16. OT H stated it is intended for R16 to wear the cushion during mealtime to assist with proper neck alignment while eating. OT H was aware R16's cushion was often not in place during meals. OT H stated R16's compliance with wearing the cushion (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525592	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care & Rehab - Ladysmith 1	1001 E 11th St N Ladysmith, WI 54848

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	depended on which staff person applied the cushion. OT H clarified when OT or physical therapy (PT) staff apply the cushion, R16 does not complain. When certain CNA staff apply the cushion, R16 does not want it in place due to discomfort the cushion causes him. On 02/11/2026 at 10:14 AM, Surveyor interviewed PT I about what the expectations were of staff to apply the torticollis orthosis cushion on R16. PT I stated cushion was to be worn by R16 at meals. PT I stated R16's compliance depended on which staff member was applying the cushion. PT I stated education had been provided to staff as a whole group. PT I stated individual staff training was also provided when requested to promote R16's compliance in wearing the cushion.

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	525592	A. Building B. Wing	02/24/2026

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Care & Rehab - Ladysmith 1	1001 E 11th St N Ladysmith, WI 54848

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not revise the comprehensive care plan based on the preferences and needs of the resident for 1 (R16) resident for 12 residents reviewed for care planning in a sample of 12 residents.R16's comprehensive care plan was not revised by staff regarding the placement of the torticollis orthosis (a device designed to restore proper head and neck alignment) based on changing goals and preferences of R16. Findings include:The facility's policy, titled Care Planning with Resident and/or Representative, dated 11/23/2016, states in part: A comprehensive plan of care is a systemic assessment and identification of resident problems accomplished through short- and long-term measurable goals.it includes which disciplines are responsible for the identified approaches. It is updated when changes occur.The facility's policy, titled Standards of Care, revised 2/2026, states in part: Physician orders, standing orders, MAR/TAR, care plans, CNA charting, and policies and procedures provide guidelines to follow to meet the needs of the residents. R16 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's disease with late onset, moyamoya disease (a progressive cerebrovascular disorder that can lead to reduced blood flow to the brain, causing strokes), hemiplegia and hemiparesis following cerebral infarction (stroke) affecting left nondominant side, epilepsy, dysphagia (difficulty swallowing) and aphasia (impaired speaking).R16's Minimum Data Set (MDS) assessment, dated 12/30/2025, indicated R16 has a Brief Interview for Mental Status (BIMS) score of 10/15, which means moderate cognitive impairment. R16 has an activated power of attorney for healthcare. R16's care plan, last revised 12/23/2025, with a target date of 03/31/2026, states in part: Self-care deficit related to dementia, history of strokes, contractures both arms and legs. Interventions include.Torticollis Orthosis: apply during AM shift meals, padded area placed on right side of head. Strap around back with padded strap under arm and along front of chest. Secured at buckle. Encourage me to relax head back in a more upright position. Feed from left side to encourage improved positioning.From 02/09/2026 at 12:28 PM to 02/11/2026 9:13 AM, Surveyor observed R16 being assisted by staff with feeding at breakfast and lunch meals. R16 did not have torticollis orthosis cushion in place during each meal observed. On 02/10/2026 at 1:45 PM, Surveyor asked R16 if cushion was being used during meals to help with positioning of neck and R16 stated it was not. R16 stated he did not like the cushion because it hurt while in place. Surveyor observed torticollis orthosis on a desk in R16's room. On 02/10/2026 at 1:50 AM, Surveyor interviewed Certified Nursing Assistant (CNA) F on proper timing and use of the torticollis orthosis cushion for R16. CNA F stated R16 is supposed to wear it when eating, however refuses to because R16 does not like it and tells staff it hurts when it is on. On 02/11/2026 at 7:20 AM, Surveyor interviewed Registered Nurse (RN) D what the expectations were for placement of R16's torticollis orthosis cushion. RN D stated, We have tried it. He didn't like it. It hurts him. On 02/11/2026 at 9:05 AM, Surveyor interviewed Occupational Therapist (OT) H about what the expectations of staff were for placement of the torticollis orthosis cushion on R16. OT H stated it is intended for R16 to wear the cushion during mealtime to assist with proper neck alignment while eating. OT H was aware R16's cushion was often not in place during meals. OT H stated R16's compliance with wearing the cushion depended on which staff person applied the cushion. OT H clarified when OT or physical therapy (PT) staff apply the cushion, R16 does not complain. When certain CNA staff apply the cushion, R16 does not want it in place due to discomfort the cushion causes him. On 02/11/2026 at 10:14 AM, Surveyor interviewed PT I about what the expectations were of staff to apply the torticollis orthosis cushion on R16. PT I stated cushion was to be worn by R16 at meals. PT I stated R16's compliance depended on the moment and which staff member was applying the cushion. PT I stated R16 was inconsistent with assessments, sometimes stating he had pain with it, then moments later denying having pain with the cushion in (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525592	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care & Rehab - Ladysmith 1	1001 E 11th St N Ladysmith, WI 54848

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	place. PT I stated another physical therapy evaluation for effectiveness of torticollis orthosis cushion is indicated for R16 and needs to be ordered by nursing staff. Record review of R16's medical record has following documentation: On 01/11/2026, monthly restorative/maintenance summary by nursing states: Torticollis orthosis: apply during AM shift meals. [R16] participated 10/19 AMs. On 02/08/2026, monthly restorative/maintenance summary by nursing states: Torticollis orthosis: apply during AM shift meals. [R16] participated 0/30 Ams. CNA documentation indicated R16 refused placement of torticollis cushion 5 days in January 2026, and 5 days in February 2026. To be noted: CNA documentation on R16's compliance for use of torticollis orthosis was not completed for all days in January and February. R16's care plan, last revised on 12/23/2026, does not indicate R16's resistance to wearing torticollis orthosis. R16's care plan does not have interventions in place to promote R16's compliance when having discomfort from cushion. R16's care plan does not have interventions for alternatives to maintaining neck alignment during meal time. R16's treatment administration record does not have documentation for monitoring placement of cushion. R16 does not have orders in medical record for a PT reevaluation for placement and/or effectiveness of torticollis orthosis cushion. On 02/11/2026 at 8:35 AM, Surveyor interviewed MDS Coordinator/Interim DON B on the facility's process for updating/revising care plans when changes in a resident's care routine were acknowledged. MDS/DON B stated any nurse can make changes to a resident's care plan at any time. Any staff discipline can notify MDS/DON B of changes in a resident's routine and ask for changes to be made in the care plan. All care plans are reviewed and/or updated quarterly, and as needed. MDS/DON B was aware R16 did not always wear the cushion stating, [R16] is tricky sometimes.

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	525592	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care & Rehab - Ladysmith 1	1001 E 11th St N Ladysmith, WI 54848

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 5 residents reviewed (R2).R2 was not repositioned per plan of care.Findings include:Facility policy titled, Care Planning with Resident and/or Representative, effective 11/23/2016, reads in part: To provide a team approach in the planning and care of the resident as a whole and to periodically review this plan to attain and maintain the highest practicable physical, mental, and psychosocial wellbeing.Facility policy titled, Standards of Care, last revised 2/26, reads in part: All employees are to follow the Standards of Care for their specific job position.care plans are to be followed on all residents, at all times. Update nurse if the care plan requires changes.R2 was admitted to the facility on [DATE].On 11/18/25, R2 had a Brief Interview for Mental Status (BIMS) of 99 indicating R2 was unable to complete the interview.R2's care plan includes in part: The resident has potential for pressure ulcer development related to immobility with an intervention of assist to shift weight in wheelchair every 15 minutes and the resident needs (reminding/assistance) to turn/reposition at least every 2 hours (8-12-25).On 02/10/26 at 7:03 AM, R2 was taken to the dining room for breakfast in R2's Broda chair. Surveyor observed R2 until 9:18 AM. R2 was not repositioned or had weight shifted every 15 minutes per plan of care. R2 remained in Broda chair in dining room placed in front of the television.On 02/11/26 at 9:57 AM, Surveyor interviewed Certified Nursing Assistant (CNA) O. CNA O stated if CNAs need to know what care residents need, they have care plans in the computer, and the care plans are updated all the time.On 02/11/26 at 10:08 AM, Surveyor interviewed Registered Nurse (RN) D. RN D stated CNAs are expected to follow the care plans. RN D stated if the CNAs do not agree with something in the care plan, they can talk to the nurses about possible changes needing to be made. RN D stated care plans get updated as changes happen. RN D stated CNAs will get verbal reports, there is a communication board, and therapy will give both nurses and CNAs any changes made by that department.On 02/11/26 at 10:24 AM, Surveyor interviewed CNA F. CNA F stated they have care plans available to know what care the residents need. CNA F stated the care plans are found in the electronic system the facility uses, and they also have daily sheets that give them a little insight.On 02/11/26 at 10:32 AM, Surveyor interviewed Minimum Data Set (MDS) coordinator/Director of Nursing (DON) B. MDS/DON B stated MDS/DON B updates care plans at a minimum quarterly when everything is checked to make sure it is correct and up to date. MDS/DON B stated care plans are also updated as needed when changes happen.On 02/11/26 at 10:45 AM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A stated NHA A would hope CNAs would follow the care plan. NHA A stated the care plans are available to the CNAs on the computer and they should know what their tasks are. NHA A stated CNAs have shift-to-shift reports and the floor nurses should be monitoring the CNAs for compliance. NHA A was informed about Surveyor's observation and what the care plan states.

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	525592	A. Building B. Wing	02/24/2026

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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 observation, interview, and record review, the facility did not ensure 1 of 4 residents (R6) received adequate supervision and assistance devices to prevent accidents.R6 was left unsupervised in the bathroom.Facility staff did not provide supervision or alarm system per care plan.Findings include:Facility policy titled, Care Planning with Resident and/or Representative, effective 11/23/2016, reads in part: To provide a team approach in the planning and care of the resident as a whole and to periodically review this plan to attain and maintain the highest practicable physical, mental, and psychosocial wellbeing.Facility Policy titled, Fall Risk Management Policy, last revised 1/26, reads in part: It is the policy of {Care and Rehab-Ladysmith} to promote resident safety by identifying resident as risk for falling.as well as implement appropriate interventions to prevent continued/repeated falls.High risk fall interventions may include.Do not leave a high risk for falls resident unattended when toileting.Facility policy titled, Standards of Care, last revised 2/26, reads in part: All employees are to follow the Standards of Care for their specific job position.Residents with alarms are not to be left unattended on the toilet.R6 was admitted to the facility on [DATE].On 01/08/26, R6 had a Brief Interview for Mental Status score of 15/15 indicating cognitively intact.Surveyor reviewed most recent falls. On 12/04/25, R6 had a fall from the toilet. On 12/12/25, R6 had a fall while trying to self-transfer from recliner to bathroom. On 01/15/26, R6 had a fall from the recliner. On 02/01/26, R6 had a fall due to sliding out of his wheelchair. Interventions in place on 12/05/25 after the fall on 12/04/25. No new interventions or revisions for most recent 3 falls.R6's care plan includes in part: Focus of self-care deficit with intervention of doorbell motion alarm in bathroom (01/06/26) and do not leave me unsupervised while toileting (12/05/25). Focus of falls/injury with interventions of lessen my risk for falls/injury: Assure alarms are in place in case I attempt to self-transfer. Do not leave unsupervised during toileting (12/05/25).On 02/10/26 at 9:21 AM, Surveyor observed R6 on the toilet unsupervised with no alarms.On 02/10/26 at 9:23 AM, Surveyor observed Certified Nursing Assistant (CNA) O inform Registered Nurse (RN) L that R6 was in the bathroom if RN L wanted to look at R6's buttocks bandage. RN L informed Surveyor R6 was in the bathroom and RN L would be doing wound care shortly.On 02/11/26 at 9:57 AM, Surveyor interviewed CNA O. CNA O stated if a care plan states a resident should not be left alone while toileting or the resident has alarms, they cannot leave that resident unattended in the bathroom.On 02/11/26 at 10:08 AM, Surveyor interviewed RN D. RN D stated CNAs are expected to follow the care plans. RN D stated if the CNAs do not agree with something in the care plan, they can talk to the nurses about possible changes needing to be made.On 02/11/26 at 10:24 AM, Surveyor interviewed CNA F. CNA F stated CNA F would not leave a resident alone in the bathroom if they have alarms or the care plan stated they should not be left unsupervised in the bathroom.On 02/11/26 at 10:45 AM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A stated NHA A would hope CNAs would follow the care plan. NHA A stated the care plans are available to the CNAs on the computer and they should know what their tasks are. NHA A stated CNAs have shift-to-shift reports and the floor nurses should be monitoring the CNAs for compliance.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure pain management consistent with the comprehensive assessment and plan of care for 1 (R5) resident of 2 residents reviewed for pain management in a sample of 12 residents. R5 did not have pain assessment according to the comprehensive plan of care and physician orders documented on treatment administration record (TAR), or in medical record. This possibly resulted in R5 not attaining highest practicable level of well-being.Facility did not recognize R5's agitated and restless behaviors as possible indicators of pain through assessment and/or documentation in R5's medical record, possibly resulting in R5 not attaining highest practicable level of well-being.R5 had history of left femur fracture while residing at facility and currently has an indwelling urinary catheter for chronic urinary retention, both which have potential for causing R5 pain and distress. Findings include:The facility policy, titled Pain Management/Assessment, last revised 04/2025, states in part: All residents have the right to pain management. All residents will be evaluated for indicators of pain, or history of pain.The pain measurement scales of 0 - 10 or the Wong-Baker FACES facial pain scale will be used measuring a resident's severity of pain level. Mild pain: 1 -3; Moderate pain: 4 - 6; Severe pain: 7 - 10. In addition to an initial pain assessment.a pain assessment shall be completed.when a resident is exhibiting behaviors that may be caused by pain.The Wong-Baker FACES Foundation, originator of the Wong-Baker FACES Pain Rating Scale (a tool created and adapted for use to facilitate communication and improving assessment for pain management), date unknown, states in part: This self-assessment tool must be understood by the patient, so they are able to choose the face that best illustrates the physical pain they are experiencing. It is not a tool to be used by a third person.healthcare professionals, or caregivers, to assess the patient's pain. R5 was admitted to the facility on [DATE] and has diagnoses that include aphasia following cerebral infarction (inability to verbally communicate due to a stroke in the brain), restless leg syndrome, insomnia, repeated falls, retention of urine, fracture of unspecified part of neck of left femur, vascular dementia with behavioral disturbance. R5's Minimum Data Set (MDS) assessment, dated 11/21/2025, indicated that R5 has a Brief Interview for Mental Status (BIMS) score of 8/15 which means moderate cognitive impairment. R5 has an activated power of attorney for healthcare decisions. R5's care plan, initiated on 09/09/2025 with a target date of 02/20/2026, states in part: Potential for Pain. Interventions include.monitor physical symptoms - use the same assessment tool consistently - use 0/10 pain scale or use verbal description (mild, moderate, severe, very severe/horrible) - [NAME] FACE scale. R5's care plan, initiated on 09/09/2025 with a target date of 02/20/2026, states in part: The resident has a communication problem related to expressive aphasia, stroke, weak or absent voice. Interventions include.monitor/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed. On 02/09/2026 at 8:45 AM, Surveyor observed R5 sitting in a wheelchair in the hallway, propelling self with his legs down corridor. R5 had an indwelling urinary catheter located beneath wheelchair. During Surveyor's observation, R5 made attempt to stand while in wheelchair, which activated a chair alarm. Staff assisted R5 to sit back down in wheelchair. Surveyor attempted to interview R5; however, R5 did not verbally respond to questions. On 02/09/2026 at 10:45 AM, Surveyor observed R5 attempting to stand from wheelchair while in hallway. Certified Nursing Assistant (CNA) F assisted R5 back to a sitting position. Surveyor interviewed CNA F regarding staff interventions for maintaining R5's safety, CNA F stated staff keep R5 in the hallway, and not allowed alone in room, because R5 often attempts to stand up, activating chair alarm. CNA F stated staff can monitor R5's safety if kept in hallway and within staff's view. CNA F was unsure why R5 attempted to stand from wheelchair, or causes of R5's restless behavior. On 02/09/2026 at 11:54 AM, Surveyor interviewed R5's wife, who was visiting R5 in his room. R5's wife stated R5 does not sleep well at night and makes several attempts to get out of bed. R5's wife stated R5 is frequently restless and (continued on next page)

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	525592	A. Building B. Wing	02/24/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	makes repeated attempts to stand while in wheelchair. Surveyor observed R5 attempt to stand from wheelchair and incoherently verbalize to wife during interview with R5's wife. R5's wife stated R5 does not verbalize needs very well due to having had a stroke and is difficult to understand. R5's wife stated it is difficult to interpret R5's needs, including if having pain. R5's wife stated R5 must have a permanent indwelling urinary catheter because of chronic urinary retention, a condition diagnosed by a provider prior to R5's admission to the facility. R5's wife feels the catheter causes discomfort for R5 because of frequent pulling on catheter tubing, at times completely dislodging catheter. R5's wife stated, I think it hurts around his penis and that is why he pulls on it. R5's wife informed Surveyor of R5's history of falls, one which resulted in fracture of left femur. R5's wife was unable to interpret if R5 was having pain during interview. On 02/10/2026 at 7:44 AM, during interview with Registered Nurse (RN) D, RN D stated R5 is up all night most nights and repeatedly attempts to exit the bed. RN D stated it is unclear to cause of R5's restlessness. Record review of R5's medical record indicated the following: R5 suffered falls while residing at facility on 09/21/2025, 11/12/2025 and 10/15/2025. The fall R5 had on 10/15/2025 resulted in a left femur fracture, requiring surgical intervention. On 09/09/2025, physician orders state: Ask resident if having presence of pain, aches or discomfort OR non-verbal indicators of pain (facial expressions, protective body movements, posture etc.) using the pain measurement scale of 0 -10 or FACES pain rating scale. Document appropriate number. On 11/14/2025, physician orders state: Acetaminophen (medication for pain/fever) tablet 325mg, give 2 tablets one time a day for chronic pain. On 01/30/2026, order was discontinued. R5's TAR for January 2026 and February 2026 include directions that state: Ask resident if having presence of pain, aches or discomfort OR non-verbal indicators of pain (facial expressions, protective body movements, posture etc.) using the pain measurement scale of 0 -10 or FACES pain rating scale. Document appropriate number. R5's TARs indicate pain assessment was done twice daily. R5's TARs have no time of day documented when assessments were done. R5's TARs do not have number indicators of R5's pain levels documented. Daily pain assessment include check marks with initials of staff. On 12/03/2025 at 4:35 PM, nursing documentation in R5's medical record states in part, Foley catheter placed causes discomfort to resident, resident attempts to pull catheter out frequently. R5's medical record for December 2025, January 2026 and February 2026 showed several chart entries by nursing staff for behavior/mood of R5 exhibiting restless behaviors at night with attempts to get self out of bed. R5's frequently pulled at catheter tubing and at times pulled it entirely out. No documentation for pain assessment found in R5's record. On 12/10/2025 at 12:00 PM, interdisciplinary team charting stated in part: Resident throughout the month of November continued to have daily behaviors of pulling at lines (i.e. catheter), attempting to get out of chair or bed. Resident's wife visits nearly every day and aids with behaviors and reorienting resident. On 01/17/2026 at 6:49 AM, R5's medication administration record (MAR) indicates Acetaminophen 325mg 2 tablets was administered. No pain level or reason for administration of pain medication was documented. On 02/11/2026 at 8:35 AM, Surveyor interviewed MDS coordinator/Director of Nursing (DON) B regarding what staff expectations were for assessing and documenting pain on residents who are unable to communicate verbally. MDS/DON B stated nonverbal residents are assessed for pain using the FACES scale, and it is documented utilizing the number conversion in a resident's medical record.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility did not have a comprehensive system for ensuring residents received and/or were offered pneumococcal immunizations for 1 of 5 sampled residents (R) (R6).The facility did not have any documentation R6 was offered the pneumococcal vaccine, was educated on the risk and benefits of the vaccine, or that R6 declined the vaccination. Findings include:On 2/10/26, Surveyor reviewed Pneumococcal vaccination for R6 and noted: R6 had no Pneumococcal vaccination on record and Wisconsin Immunization Registry (WIR) stated, Recommended and overdue 08/17/86. Facility did not have any documentation of R6 declining the vaccination, nor documentation of follow-up regarding educating R6 on the risks and benefits of the vaccination.On 02/10/26 at 9:04 AM, Surveyor interviewed Infection Preventionist (IP) C and asked what the expectation is for providing pneumococcal vaccination to residents in the facility. IP C reported to Surveyor that the facility no longer offers pneumococcal vaccinations. Surveyor asked IP C to explain IP C's process for making sure the facility is offering pneumococcal vaccines or educating residents on the risks and benefits of pneumococcal vaccination. IP C reported the facility does not offer the vaccination or complete education. IP C stated, If residents come to us wanting Pneumococcal vaccination, we refer them to the clinic to have that done. Surveyor asked if IP C asks or updates vaccination status per resident upon admission and annually. IP C reported to Surveyor that IP C did not realize the facility had to offer pneumococcal vaccinations or offer education, so IP C stated to Surveyor, This is not being completed, and I will talk with Nursing Home Administrator (NHA) A going forward. Surveyor asked IP C if R6 is up to date on the pneumococcal vaccinations. IP C reported R6 is not up to date on pneumococcal vaccination, and IP C does not have any declinations for R6 refusing the pneumococcal vaccination since it was not offered to R6.