STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525611	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timber Ridge Health and Rehabilitation	825 Whiting Ave Stevens Point, WI 54481

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and record review, the facility did not ensure food was stored and served in a safe and sanitary manner. This practice had the potential to affect 44 of 44 residents residing in the facility. Staff did not store food in a manner to ensure food safety, including proper labeling and dating practices. Staff did not accurately test parts per million (PPM) of the sanitizing solution or accurately complete testing logs. Kitchen equipment and food services areas were not in clean and condition. Staff did not follow safe food cooling protocols. Staff did not appropriately test and maintain dishwasher temperatures. In addition, staff engaged in an unsanitary dishwashing process. Staff did not wear hair restraints consistently throughout the kitchen. Staff did not complete appropriate hand hygiene.Findings include: On 5/4/26 at 9:08 AM, Surveyor and [NAME] (CK)-G began an initial kitchen tour and were joined by Kitchen Manager (KM)-F. On 5/5/26 Nursing Home Administrator (NHA)-A indicated the facility follows the Food and Drug Administration (FDA) Food Code. Food Labeling/Storage: The 2022 FDA Food Code documents at 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food (TCS), Date Marking: (A) Except when packaging food using a reduced oxygen packaging method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 Celsius (C) (41 Fahrenheit (F)) or less for a maximum of 7 days. The day of preparation shall be counted as day 1. The 2022 FDA Food Code documents at 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food (TCS), Disposition: (A) A food specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or package that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3-501.17(A). The facility's Date Marking for Food Safety policy, dated 3/1/26, indicates: .2. Food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. 4. The marking system shall consist of a color-coded label, the day/date of opening, the day/date the item must be consumed or discarded .6. The head cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. The dietary manager, or designee, shall spot check refrigerators weekly for compliance, and document accordingly . During the initial kitchen tour with KM-F and CK-G that began at 9:08 AM on 5/4/26, Surveyor observed numerous food storage concerns including the following examples: Dry Storage:~ An open bag of penne pasta that was not sealed shut and did not contain open or use-by dates.~ A unlabeled bulk container of bread crumbs (per KM-F) with no open or use-by dates. Surveyor and KM-F observed a scoop in the container.~ An unlabeled gallon container of an unidentified substance with no open or use-by dates. KM-F initially indicated the substance was salt, but then thought it was seasoning. KM-F stated the container had been on the counter as long as KM-F could remember. ~ Three unlabeled containers of oats (per KM-F) with no (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CK-G then stated CK-G cleaned the microwave that morning. CK-G did not know when the stovetop/range was last cleaned and verified the kitchen did not look clean. Food Cooling Temperatures: The 2022 FDA Food Code documents at 3-501.14 Cooling: (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. (B) Time/temperature control for safety food shall be cooled within 4 hours to 5 C (41 F) or less. The 2022 FDA Food Code documents at section 3-501.15 Cooling Methods: (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of food being cooled: (1) Placing the food in shallow pans; (2) Separating the food into smaller or thinner portions; (3) Using rapid cooling equipment; (4) Stirring the food in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. The facility's Dietary Department Policy and Procedure (Rapid Cooling of Foods), dated 3/1/26, indicates: Potentially hazardous foods should be cooled rapidly. Proper cooling of hot foods to a safe temperature minimizes the growth of microorganisms that may result in food contamination. 1. Rapid cooling is defined as cooling from 135ˆF to 70ˆF within two hours and then to a temperature of 40ˆF or below within the next four hours. The total cooling time between 135ˆF and 40ˆF is not to exceed six hours. During the initial kitchen tour that began at 9:08 AM on 5/4/26, Surveyor and KM-F observed a food cooling log posted in the kitchen. The log contained 23 food items for cooling. Seven of the items had not been cooled to 40 degrees or less. Examples of final logged temperatures included: ~ Ham - 50ˆ~ Soup - 109ˆ~ Chili - 66ˆ~ [NAME] - 64ˆ~ Sausage - 145ˆ Surveyor interviewed KM-F who indicated food should be cooled to 40 degrees. KM-F indicated staff should document the food cooling progress on the log all the way through to 40 degrees or less. Dishwasher Temperatures: The 2022 FDA Food Code documents at 4-302.13 Temperature Measuring Devices, Manual Warewashing: Water temperature is critical to sanitization in warewashing operations. This is particularly true if the sanitizer being used is hot water. The effectiveness of cleaners and chemical sanitizers is also determined by the temperature of the water used. A temperature measuring device is essential to monitor manual warewashing and ensure sanitization. Effective mechanical hot water sanitization occurs when the surface temperatures of utensils passing through the warewashing machine meet or exceed the required 71 C (160 F). Parameters such as water temperature, rinse pressure, and time determine whether the appropriate surface temperature is achieved. Although the Food Code requires integral temperature measuring devices and a pressure gauge for hot water mechanical warewashers, the measurements displayed by these devices may not always be sufficient to determine the surface temperatures of utensils are reaching 71 C (160 F). The regular use of irreversible registering temperature indicators provides a simple method to verify the hot water mechanical sanitizing operation is effective in achieving a utensil surface temperature of 71 C (160 F). The 2022 FDA Food Code documents at 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures: The temperature of hot water delivered from a warewasher sanitizing rinse manifold must be maintained according to the equipment manufacturer's specifications and temperature limits specified in this section to ensure surfaces of multi-use utensils such as kitchenware and tableware accumulate enough heat to destroy pathogens that may remain on such surfaces after cleaning. The surface temperature must reach at least 160 degrees F as measured by an irreversible registering temperature measuring device to affect sanitization. When the sanitizing rinse temperature exceeds 194 degrees F at the manifold, the water becomes volatile and begins to vaporize reducing its ability to convey sufficient heat to utensil surfaces. The lower temperature limits of 165 degrees F for a stationary rack, single temperature machine, and 180 degrees F for other machines are based on the sanitizing rinse contact time required to achieve the 160 degree F utensil surface temperature.The 2022 FDA Food Code documents at 4-302.13 Temperature Measuring Devices, Manual and Mechanical Warewashing (B): In hot water mechanical warewashing operations, an irreversible registering (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	they needed to review policies for education. Surveyor observed the following policies on the counter for staff to read and sign: ~ Food Safety Requirements~ Sanitation Inspection~ Dishwasher Temperatures~ Date Marking for Food Service On 5/6/26 at 12:11 PM, Surveyor interviewed Registered Dietician (RD)-E who indicated kitchen staff should be aware of and follow all policies related to food preparation, storage, safety, cleanliness, and serving. On 5/6/26 at 12:27 PM, Surveyor interviewed KM-F who indicated cooked and opened food should be clearly marked with the name of the food, the date it was made or opened, and the use-by date. KM-F indicated staff should clean food storage areas and remove out-of-date foods. KM-F indicated nursing staff are responsible for maintaining temperature logs for unit kitchenette refrigerators/freezers. KM-F wasn't aware the sanitizing solution needs to be at a certain temperature to test for efficacy and verified the testing log did not include the temperature of the sanitizing solution. KM-F verified staff aren't cleaning the kitchen as indicated on the daily cleaning checklist and deep cleaning list and indicated it may be due to staff burnout. KM-F stated the state of the kitchen is embarrassing and verified staff should not sign the daily cleaning log for tasks that aren't completed. KM-F verified cooked food should be cooled to 40 degrees or below. KM-F stated staff should put food in shallow pans and/or in ice baths to cool and should document cooling temperatures until the food reaches a temperature of 40 degrees or below. KM-F thought the facility had a high temperature dishwashing machine but stated KM-F was told by NHA-A it was a low temperature chemical sanitizing machine and the low temperatures were fine. KM-F was aware information on the dishwashing machine indicated the temperature should reach a minimum of 155ˆ for the wash cycle and 180ˆ for the rinse cycle and reported the low temperatures to NHA-A. KM-F stated it is an old machine and two repairman have been there to address low temperatures in the past two months. KM-F stated one of the repairmen indicated the machine is faulty because it isn't properly ventilated. KM-F stated the temperature testing puck does not work and shows lower temperatures than the dishwashing machine gauges. KM-F verified KM-F did not order a new testing puck. KM-F confirmed staff should remove aprons and wash hands prior to touching clean dishes when moving from dirty dishes to clean dishes. KM-F stated every person who enters the kitchen needs to wear a hairnet and beard restraint (if applicable). KM-F stated KM-F put a box of hairnets by the kitchen entrance so staff can put one on prior to entering the kitchen. KM-F verified KM-F should have worn a hairnet to cover the hair coming out of KM-F's hat. KM-F also confirmed CK-G should have cleansed hands between glove changes. On 5/6/26 at 3:29 PM, Surveyor interviewed NHA-A who indicated kitchen staff should be aware of and follow policies related to food preparation, storage, safety, cleanliness, and serving. NHA-A stated NHA-A was told the dishwashing machine was a chemical sanitizing machine. After Surveyor indicated information on the dish machine indicated the wash temperature should reach 155ˆ and the rinse temperature should reach 180ˆ, NHA-A confirmed the dishwashing machine is a high temperature machine. NHA-A confirmed the dishwashing machine needs to be fixed or replaced because of the consistently low temperatures.

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Timber Ridge Health and Rehabilitation	825 Whiting Ave Stevens Point, WI 54481

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure meals were served at a safe and appetizing temperature and prepared in a way to conserve nutritive value. This practice had the potential to affect more than 4 of the 44 residents residing in the facility. Staff did not follow a recipe when preparing pureed food in order to conserve/ensure the nutritive value of the food. Staff did not appropriately temp meals served to residents. Food was served outside the designated temperature range. Findings include: The facility's Puree Food Preparation policy, revised 3/1/26, indicates: It is the policy of this facility to provide pureed food that has been prepared in a manner to conserve nutritive value, palatable flavor, and attractive appearance .1. Each resident must receive and the facility must provide food that is prepared by methods that conserve nutritive value, flavor, and appearance .5. Do not use water as an additive to prepare puree foods .6. Residents receiving pureed diets should always receive portions equivalent to those served on the regular or therapeutic diet .7. Pureed Food Preparation Guidelines per serving (more or less may be used depending on the consistency of the cooked food): Meats: add 1 teaspoon of beef broth or beef gravy; Poultry: add 1 teaspoon of chicken broth or chicken gravy; Fish: add 1 teaspoon mayonnaise; Noodles: add one teaspoon margarine; Vegetables (leaf, stem, or flower): add 2 teaspoons mashed potato flakes; Vegetables (root, tuber): add 1 teaspoon margarine . The publication All About Recipes, Part II from the College of Agriculture, Biotechnology and Natural Resources [NAME], A., and [NAME], S. 2021 indicates: It is important to follow a recipe to ensure accurate nutrition content, which is important for schools, hospitals, and nursing homes. Modifying a recipe by adding water lowers the nutritional quality of the food. Pureed Foods: On 5/5/26 at 11:42 AM, Surveyor observed [NAME] (CK)-G puree food in a food processor. CK-G stated CK-G was pureeing two servings of carrots with approximately 4 pumps of Simply Thick (a thickening agent). CK-G indicated two residents (R2 and R10) receive pureed food. Surveyor also observed CK-G puree seasoned ground beef with 4 pumps of Simply Thick. CK-G stated CK-G did not follow a recipe for the pureed carrots or seasoned ground beef. CK-G indicated the residents were having tacos (seasoned ground beef, cheese, lettuce, tomato, sour cream, and tortilla shell), refried beans, and carrots. Surveyor observed a container in the food prep area that CK-G stated contained two scoops of breadcrumbs and water mixed together for R2 and R10. CK-G stated CK-G did not measure the water or follow a recipe. CK-G indicated CK-G was giving R2 and R10 the breadcrumb mixture instead of a tortilla and stated residents on a pureed diet don't receive a taco; they receive meat and moistened breadcrumbs. When asked if that is what R2 and R10 wanted, CK-G was not sure. CK-G then put two plates of pureed meat and carrots into an unheated/cold oven. On 5/5/26 at 11:53 AM, Surveyor observed CK-G remove the plates of pureed food from the cold oven and use a whisk to place an undetermined amount of the breadcrumb mixture on each plate while leaving some in the dish. Surveyor noted R2 and R10 did not receive refried beans, a tortilla, or taco toppings, including cheese and sour cream. Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including dysphagia (difficulty swallowing) oropharyngeal phase, dementia with psychotic disturbance, anarthria (inability to speak) and dominant side paralysis after a stroke. R2 had an order for a regular diet, pureed texture, honey thick consistency. Surveyor was unable to interview R2. Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including dysphagia, quadriplegia, dementia, and Bell's palsy. R10 had an order for a no salt added diet, pureed texture, nectar thick consistency. Surveyor was unable to interview R10. On 5/6/25 at 11:51 AM, Surveyor observed CK-G serve lunch. CK-G had already pureed items for R2 and R10. CK-G stated the meal was turkey pot pie, carrots, and cranberries. CK-G stated CK-G pureed two servings of pot pie with 1 to 2 pumps of Simply Thick. CK-G also pureed 2 servings of carrots with 1 to 2 pumps of Simply Thick. CK-G was not sure the exact quantity of the items that were added. CK-G indicated CK-G did not follow a recipe. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/6/26 at 11:56 AM, Surveyor asked Kitchen Manager (KM)-F for pureed food recipes for the meals on 5/5/26 and 5/6/26. KM-F indicated KM-F doesn't have pureed food recipes. KM-F stated staff make the food and puree it with Simply Thick. When asked if R2 and R10's food should be made to the same consistency, KM-F indicated one should be nectar consistency and one should be honey consistency; however, K-F likes to make them mashed potato consistency. KM-F stated KM-F likes to double up on the thickening agent and use a liqid thickening agent (Simply Thick) as well as a couple scoops of a powdered thickening agent. KM-F showed Surveyor the powdered thickening agent and indicated the kitchen goes through thickening agents quickly because they are used often. On 5/6/26 at 12:02 PM, Surveyor asked CK-G why residents received carrots instead of brussel sprouts as indicated on the menu. CK-G stated CK-G didn't know. KM-F stated KM-F forgot the brussel sprouts. On 5/6/26 12:11 PM, Surveyor interviewed Registered Dietician (RD)-E who stated staff should follow a recipe to prepare pureed food. When asked if staff know where to find recipes, RD-E indicated staff do not have access to pureed food recipes which are located on the menu software. RD-E stated staff need to request the information from RD-E. RD-E verified staff should not use water to puree food as it has the potential to negatively impact the nutritional value. RD-E indicated staff should follow the menu. Residents on pureed diets should be offered the same food that's on the menu unless it's not a food that can be safely pureed. RD-E stated the issues have been on the facility's radar to fix. RD-E stated RD-E wants to ensure kitchen staff offer what is supposed to be offered so residents get the nutritional food they are supposed to receive. On 5/6/26 at 3:29 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated kitchen staff should be aware of and follow all policies related to food preparation and serving. Food Temperatures: Surveyor requested the facility's policy for food temperatures at serving and palatability and received the following: The facility's Dietary Department Policy and Procedures, dated 3/1/26, indicates: Food service employees shall prepare and serve food in a manner that complies with safe food handling practices .1. The danger zone temperatures that promote pathogenic microorganism growth that cause foodborne illness are between 41ˆahrenheit (F) and 135ˆ .7. Mechanically altered hot foods must stay above 135ˆ during preparation . On 5/5/26 at 11:42 AM, Surveyor observed CK-H prepare hot and cold beverages. CK-H did not temp the beverages. Surveyor observed the facility's beverage temperature logs and noted missing entries, including one meal on 5/3/26, two meals on 5/4/26, and two meals on 5/5/26. On 5/5/26 at 11:53 AM, Surveyor observed CK-G plate food at the beginning of meal service. CK-G did not temp any food items on the steamtable. Surveyor reviewed the temperature log and noted there were no temperatures for the meal. On 5/5/26 beginning at 11:53 AM, Surveyor observed CK-G serve lunch. CK-G removed plates of pureed food for R2 and R10 from a cold oven. CK-G put the plates on trays and gave them to CK-H to put on the cart. CK-G did not temp the food on the plates. Before CK-H put the trays in the cart, Surveyor asked CK-G to temp the plates of pureed food. The taco meat on one plate was 82.4ˆ and the carrots were 93.2ˆ. CK-G did not temp the wet breadcrumb mixture and did not reheat the food to the appropriate serving temperature of 135ˆ or higher. After temping the pureed food on one plate, CK-G put a cover on the plate and sent it back to CK-H who put the plate on the cart to be served. On 5/5/26 at 12:06 PM, CK-G verified CK-G did not take food temperatures and indicated CK-G would take food temperatures before the next meal. All of the food on the steamtable temped appropriately at 135ˆ or higher except the hamburger patties (protein alternative) which temped at 122ˆ. CK-G continued lunch service and served all the hamburger patties (even though they were not at a safe food temperature of 135ˆ or higher). CK-G did not temp the grilled cheese sandwiches. Near the end of room tray service for the 300 wing, Surveyor requested a test tray. Surveyor noted room trays left the kitchen at 12:43 PM. KM-F stood next to CK-G while CK-G temped the items on the tray. KM-F did not provide assistance to CK-G when CK-G reported the temps to Surveyor. On 5/5/26 at 12:48 PM, Surveyor observed a family member exit a resident's room with coffee from a food tray that was just served on the 300 wing. The family member told staff the coffee wasn't hot and heated the coffee in the microwave. On 5/5/26 at 12:54 PM, Surveyor received a test (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tray and immediately took food temperatures which were as follows: ~ Soup - 127 degrees F~ Beans - 143.2 degrees F~ Taco - 147.2 degrees F~ Carrots - 137.2 degrees F~ Coffee - 112.2 degrees F~ Juice - 58.4 degrees F~ Milk - 55.4 degrees F Surveyor noted the soup, carrots, and coffee were not at a safe serving temperature of 135ˆ. Surveyor noted the milk and juice were served above the safe serving temperature of 41ˆ. On 5/6/26 at 12:11 PM, Surveyor interviewed RD-E who stated food and beverages coming from the kitchen should be served at the required temperature. RD-E confirmed pureed food should also be served at the appropriate temperature. RD-E verified kitchen staff should temp all food and drinks prior to service.On 5/6/26 at 12:27 PM, Surveyor interviewed KM-F who stated staff should know and temp every type and texture of food, including regular, ground, and pureed meat. KM-F stated drinks should be temped also. KM-F indicated staff should record the temperatures on the appropriate log.On 5/6/26 at 3:29 PM, Surveyor interviewed NHA-A who stated kitchen staff should be aware of and follow the facility's policies related to food temperatures.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection. This practice had the potential to affect more than 4 of the 44 residents residing in the facility. R3 had open wounds on both feet and had an order for enhanced barrier precautions (EBP). R3's room entrance did not contain an EBP sign or other EBP protocol. R3's care plan did not indicate R3 was on EBP. R8 had open wounds on the buttocks. R8's room entrance did not contain an EBP sign or other EBP protocol. R8 did not have an order for EBP. R8's care plan did not indicate R8 was on EBP. R34 had a surgical wound and drain. R34's room entrance did not contain an EBP sign or other EBP protocol. R34 did not have an order for EBP. R34's care plan was not resident-specific for the surgical wound/drain and did not indicate R34 was on EBP. Staff carried soiled linens against their clothing and bare skin. Findings include: The facility's Enhanced Barrier Precautions policy, dated 2/1/26, indicates: It is the policy of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms (MDROs). EBP refers to an infection control intervention designed to reduce the transmission of MDROs that employs targeted gown and glove use during high-contact resident care activities .1. a. All staff receive training on EBP upon hire and at least annually and are expected to comply with all designated precautions .c. The facility will have discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities .An order for EBP will be obtained for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds .) and/or indwelling medical devices .even if the resident is not known to be infected or colonized with an MDRO .ii. Infection or colonization with a Centers for Disease Control and Prevention (CDC) targeted MDRO when contact precautions do not otherwise apply: .4. High-contact resident care activities include: a. Dressing; b. Bathing; c. Transferring; d. Providing hygiene; e. Changing linens; f. Changing briefs or assisting with toileting; g. Device care or use .h. Wound care; any skin opening requiring a dressing . 1. On 5/4/26, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including cellulitis of right lower limb, cellulitis of left lower limb, and type 2 diabetes. R3's Minimum Data Set (MDS) assessment, dated 4/16/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R3 had intact cognition. On 5/4/26 at 12:32 PM, Surveyor observed the entrance to R3's room which did not contain an EBP sign or a receptacle near the door for disposal of personal protective equipment (PPE). Surveyor observed a PPE cart in the hall near the room entrance that contained gloves and gowns. On 5/4/26 at 12:34 PM, Surveyor interviewed R3 who stated R3 had open wounds on both feet which required daily dressing changes. R3's medical record contained the following wound care orders: ~ Wound care to bilateral feet and right toes 1, 2, and 3: Carefully remove old dressing. Use clean water or wound cleanser. Moisten gauze with cleanser and cleanse the wound in a circular motion starting from the center of the wound and working toward the edge of the wound. Pat dry. Apply betadine-moistened gauze to all wounds, cover with an ABD, and secure with Kerlix. No compression. No ace wraps. Change twice daily. R3 had an order for EBP related to chronic wounds on R3's bilateral lower extremities. R3's care plan, dated 4/10/26, indicated R3 had an infection and wounds to both feet but did not indicate R3 was on EBP. On 5/5/26 at 4:33 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated all residents on EBP should have an EBP sign near their door, an EBP care plan, an order for EBP, and designated receptacles inside the room for PPE disposal. On 5/6/26 at 1:12 PM, Surveyor observed an EBP sign near R3's door but not a receptacle near the door for PPE disposal. 2. On 5/4/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including type two diabetes, diabetic (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	retinopathy, fracture of right pubis, and fracture of multiple ribs. R8's MDS assessment, dated 4/16/26, had a BIMS score of 15 out of 15 which indicated R8 had intact cognition. On 5/4/26 at 1:37 PM, Surveyor observed the entrance to R8's room which did not contain an EBP sign, a receptacle near the door for PPE disposal, or a PPE cart. On 5/4/26 at 1:37 PM, Surveyor interviewed R8 who indicated R8 had open wounds on the buttocks which required dressing changes. R8 saw a physician for the wounds. R8 indicated staff wear gloves but not gowns during wound care. R8's medical record contained wound care orders for a pressure injury on R8's left and right buttocks. R8 did not have an order for EBP. R8's care plan did not indicate R8 was on EBP. On 5/6/26 at 1:34 PM, Surveyor observed the entrance to R8's room which did not contain and EBP sign, a receptacle near the door for PPE disposal, or a PPE cart. On 5/5/26 at 4:33 PM and 5/6/26 at 2:52 PM, Surveyor interviewed DON-B who indicated residents on EBP should have an EBP sign near their door, an EBP care plan, an order for EBP, and designated receptacles inside the room for PPE disposal. DON-B confirmed R8 had an open wound. DON-B stated R8's family asked that PPE receptacles near R8's room exit be removed because it was cluttered. DON-B indicated the receptacles needed to stay there otherwise there was no place for staff to remove PPE appropriately. 3. On 5/4/26, Surveyor reviewed R34's medical record. R34 was admitted to the facility on [DATE] and had diagnoses including morbid obesity and obstructive sleep apnea. R34's MDS assessment, dated 5/1/26, had a BIMS score of 13 out of 15 which indicated R34 had intact cognition. On 5/4/26 at 12:11 PM, Surveyor observed the entrance to R34's room which did not contain an EBP sign. There was a PPE cart near the door and other residents on EBP nearby. On 5/4/26 at 12:11 PM, Surveyor interviewed R34 and observed a drain with pink fluid that hung out the bottom of R34's shirt. R34 stated R34 had surgery and a wound with a surgical drain. R34 stated staff wear gloves to care for the wound and drain but do not wear gowns. R34's medical record did not contain an order for EBP. R34's care plan did not indicate R34 was on EBP and was not individualized related to the wound and drain from R34's surgical procedure. Sections of the care plan contained blank areas intended for staff to enter resident-specific information tailored to R34's needs. On 5/5/26 at 4:33 PM, Surveyor interviewed DON-B who indicated there should be an EBP sign near the entrance to R34's room. DON-B confirmed R34 should have an order for EBP. DON-B verified R34's care plan should indicate R34 is on EBP and should be individualized to R34's needs. DON-B stated night shift staff often update and individualize care plans, however, it's everyone's responsibility. On 5/6/26 at 1:14 PM, Surveyor interviewed Registered Nurse (RN)-K who indicated staff know a resident is on EBP because there is a sign outside the resident's room. RN-K verified EBP should be included on a resident's care plan. RN-K stated a resident on EBP should have receptacles inside their room designated for PPE disposal and should have an EBP order on their Medication Administration Record (MAR) or Treatment Administration Record (TAR). RN-K stated nurses should post EBP signs and ensure PPE carts and disposal receptacles are in place. On 5/6/26 at 2:28 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-J who stated CNA-J knows a resident is on EBP due to a sign outside the resident's door. CNA-J indicated EBP should be reflected on a resident's care plan. On 5/6/26 at 2:52 PM, Surveyor again interviewed DON-B who indicated residents with open wounds and/or MDROs should be on EBP. When Surveyor asked how staff know if a resident is on EBP, DON-B indicated an EBP sign is posted on or near the resident's door and the resident's care plan and Kardex will indicate the resident is on EBP. DON-B also stated there is a PPE cart outside the resident's door and receptacles near the exit of the room for PPE disposal. DON-B indicated the resident should have an order for EBP which is what staff use to set up the rest of the precautions. 4. On 5/6/26 at 2:46 PM, Surveyor observed Housekeeper (HK)-L exit a resident's room with an armful of soiled linens that were in contact with HK-L's clothing, bare forearms, and hands. HK-L put the soiled linens in a drop off room and returned to the resident's room. On 5/6/26 at 2:48 PM, Surveyor interviewed HK-L who stated HK-L was helping deep clean the resident's room. HK-L verified Surveyor's observation and indicated it was probably not an appropriate way to transport linens. On 5/6/26 at 3:29 PM, Surveyor interviewed Nursing Home (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administrator (NHA)-A who indicated staff should be aware of and use EBP. NHA-A indicated EBP should be included on a resident's care plan (if appropriate) which should be resident-specific. NHA-A also indicated staff should follow infection control practices with linens and resident cares.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not provide appropriate care and services to prevent urinary tract infections (UTIs) for 1 resident (R) (R1) of 4 sampled residents. R1 had urinary catheter valve also known as a Flip-Flo (R) that was not reflected in R1's plan of care. R1's care plan did not reflect R1's current care needs and R1's orders were not up to date. In addition, staff did not measure R1's urinary output and did not empy or clean R1's catheter bag. Findings include: The facility's Indwelling Catheter Use and Removal policy, dated 2/1/26, indicates: .Indwelling urinary catheters are catheters that remain in the bladder to assist with urinary elimination. The use of indwelling catheters for managing incontinence is not appropriate and increases the risk of urinary tract infections .1. The facility will conduct ongoing assessments for residents at risk for urinary catheterization and for residents with indwelling catheters .If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to: .Insertion, ongoing care, and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures .Appropriate indications for indwelling catheter use include: a. Acute urinary retention or bladder outlet obstruction; b. Need for accurate measurements of urinary output . Urinary Catheter Relias training indicates: .Many of the people you provide care for will have a urinary catheter. Unfortunately, urinary catheters often lead to infections and complications .Regular catheter care is important to prevent infection and other complications. Microbes, which cause infection, can enter the body through: .Portions of the equipment that touch a non-sterile surface, such as the floor .Follow your organization's policy on catheter care. Here are the steps to follow to provide basic catheter care: .11. Position and secure the drainage bag. The bed frame is a good place to hang the bag while the person is in bed. The drainage bag should be kept below the level of the person's bladder at all times. Do not place it on the floor. Once a bag touches the floor, it is contaminated. Place a bag cover over the bag to preserve the person's privacy . On 5/4/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including resistance to multiple antibiotics, retention of urine, and presence of urogenital implants. R1's Minimum Data Set (MDS) assessment, dated 4/10/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. On 5/4/26 at 1:24 PM, Surveyor observed the entrance to R1's room and noted an enhanced barrier precaution (EBP) sign. Surveyor also observed a cart with personal protective equipment (PPE) nearby. Surveyor observed two receptables inside the door of R1's room; one labeled linens and the other labeled garbage. A pile of folded cloths was on top of the linen receptacle. On 5/4/26 at 1:24 PM, Surveyor interviewed R1who stated R1 had a catheter with a plastic open and close attachment that R1 operated independently. R1 stated R1 went to the bathroom approximately every 2 hours and opened the valve to urinate. R1 stated R1 did all of R1's catheter care and staff did not assist. R1's medical indicated R1 had Foley catheter and contained the following orders: ~ Enhanced Barrier Precautions: PPE required for high-resident contact care activities. Indication: Foley catheter every shift for peripherally inserted central catheter (PICC) line with multidrug-resistant organism (MDRO) history (order date: 4/28/26) ~ Foley catheter: 16 French size, 10 milliliter (ml) balloon size. Diagnosis: urinary retention one time a day every 28 day(s) for chronic Foley for urinary retention (order date: 3/30/26) ~ Monitor Foley output every shift for (specify) Monitor output (order date: 4/22/26) ~ Change Foley catheter as needed (PRN) based on clinical indications of infection, obstruction, leakage, or if the closed system is compromised. PRN for Foley catheter (order date: 3/30/26) R1's Treatment Administration Record (TAR) for Foley output monitoring indicated staff recorded output on every shift of 250 ml to 2550 ml. An entry on the 5/1/26 PM shift indicated R1's (continued on next page)

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	525611	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timber Ridge Health and Rehabilitation	825 Whiting Ave Stevens Point, WI 54481

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	output was 0 ml. R1's care plan did not contain information about R1's catheter, Flip Flo valve, catheter care, output monitoring, or EBP. R1's progress notes indicated R1's catheter was patent (clear, without kinks, flowing properly) and intact and catheter care was provided. A note on 4/30/26 at 9:54 PM indicated a catheter shunt was in place and R1 had been emptying on R1's own every 2 to 3 hours. R1 used a catheter bag at night. On 5/6/26 at 1:14 PM, Surveyor interviewed Registered Nurse (RN)-K who indicated R1 had a regular catheter. RN-K was not aware R1 had a Flip Flo valve and emptied R1's bladder during the day via the valve. RN-K stated R1 was probably wearing a regular catheter and emptying R1's Foley or leg bag. RN-K indicated a catheter and EBP should be reflected on a resident's care plan. When Surveyor asked if RN-K was familiar with R1's care plan, RN-K stated RN-K didn't know how to access a care plan. RN-K stated the facility switched to a new electronic documentation system approximately three months prior which is why things may be missing from R1's care plan. On 5/6/26 at 1:28 PM, Surveyor interviewed R1 who indicated R1 still had a Flip Flo valve and not a regular catheter. R1 stated staff had not assisted with the catheter since R1 had the Flip Flo installed during a urology appointment on 4/29/26. R1 stated staff had not emptied R1's catheter because R1 emptied it every 2 to 3 hours during the day and put on a catheter bag at night before bed. R1 stated R1 removes the Flip Flo device, rinses it with water, and lets it sit by the sink. In the morning, R1 drains the catheter bag and hangs it in the closet. Surveyor observed the bag in R1's closet which contained amber-colored urine in the bottom. R1 stated R1 had never cleaned the bag and sometimes urine remains in the bag. R1 stated staff do not clean the bag, change the bag, or measure R1's output. R1 also stated staff do not ask about R1's output at night or the Flip Flo valve during the day. On 5/6/26 at 1:45 PM, Surveyor informed RN-K that R1 emptied R1's catheter via a Flip Flo device. During the conversation, RN-K asked Certified Nursing Assistant (CNA)-M if R1 had a Flip Flo valve. CNA-M stated R1 no longer had a traditional catheter and used a spigot device. Surveyor asked CNA-M if staff helped clean the device or R1's catheter bag. CNA-M indicated staff previously cared for R1's traditional catheter by measuring output and completing catheter care, cleaning, and disinfecting; however, R1 does it on R1's own now. On 5/6/26 at 2:36 PM, CNA-M approached Surveyor and indicated CNA-M contacted R1 and R1's spouse to teach them how to clean the Flip Flo device and catheter bag. CNA-M stated R1 and R1's spouse were not aware they could use vinegar to clean and disinfect the Flip Flo and catheter bag. CNA-M was not aware R1 wasn't cleaning the catheter bag and was hanging it in the closet. When asked if cather care should be included in R1's plan of care, CNA-M indicated yes. On 5/6/26 at 3:03 PM, Surveyor discussed R1's Flip Flo valve with Director of Nursing (DON)-B who had not heard of the device and looked up the device on a computer. DON-B indicated R1 used to have a traditional catheter and DON-B was not aware it was changed to Flip Flo device. DON-B indicated catheter care and the Flip Flo device should be included in R1's care plan. DON-B indicated staff should clean and disinfect the catheter bag and Flip Flo device. DON-B didn't know how staff could chart the output for a Foley catheter when R1 didn't have a Foley catheter and emptied R1's bladder and catheter bag themself. DON-B also indicated EBP should be reflected on R1's care plan. On 5/6/26 at 3:05 PM, DON-B asked Assistant Director of Nursing (ADON)-N to join the conversation. ADON-N was also not aware R1 had a Flip Flo device and was doing R1's urinary cares, including emptying R1's bladder and cathether bag. ADON-N agreed the Flip Flo device and the care surrounding it should be on R1's care plan. ADON-N didn't know why staff documented R1's output when they were not providing catheter care.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not provide the necessary respiratory care and services for 2 residents (R) (R16 and R34) of 2 sampled residents. R16 was on continuous oxygen. The nasal cannula and tubing for R16's room concentrator was not changed as ordered. R34 had sleep apnea and expressed the desire to use a continuous positive airway pressure (CPAP) machine. The facility did not obtain an order for the machine or assist R34 with using the machine. Findings include: The facility's Oxygen Concentrator policy, dated 2/2026, indicates: The purpose of this policy is to establish responsibilities for the care and use of oxygen concentrators .5. Care of the Concentrator: .C. Nurse responsibilities: i. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. The facility's Oxygen Administration policy, revised 2/1/26, indicates: .4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: a. The type of oxygen delivery system. b. When to administer, such as continuous or intermittent and/or when to discontinue. c. Equipment setting for the prescribed flow rates. d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered. e. Monitoring for complications associated with the use of oxygen .Types of delivery systems include: .d. CPAP mask - This mask is part of a system that allows a resident to receive continuous positive airway pressure CPAP), with or without an artificial airway. The system is comprised of a mask, tubing, and a machine that generates a constant flow of air pressure. Machines have different settings . 1. On 5/6/26, Surveyor reviewed R16's medical record. R16 was admitted to the facility on [DATE] and had diagnoses including chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea. R16's Minimum Data Set (MDS) assessment, dated 4/23/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R16 had intact cognition. R16's medical record indicated R16 was hospitalized from [DATE] through 3/17/26 for acute hypoxemic respiratory failure. R16 had an order to change R16's oxygen tubing every week and if soiled and store the tubing in a plastic bag when not in use (dated 5/6/26). On 5/6/26 at 9:35 AM, Surveyor observed R16 in a wheelchair with a nasal cannula and tubing (dated 5/6/26) connected to a portable oxygen tank set at 3 liters. R16's room concentrator was off and had a nasal cannula and tubing (dated 4/22/26) that was on R16's bed. On 5/6/26 at 9:35 AM, Surveyor interviewed R16 who indicated R16 would be on continuous oxygen for life after R16's most recent hospitalization. R16 indicated the tubing attached to the portable oxygen tank was changed that morning. R16 indicated R16 uses the room concentrator when in bed and the portable tank when in a wheelchair. On 5/6/26 at 10:33 AM, Surveyor interviewed Registered Nurse (RN)-D who confirmed R16's portable tank oxygen nasal cannula and tubing were changed that morning. RN-D verified the nasal cannula and tubing (dated 4/22/26) attached to R16's room concentrator should be changed at least weekly. On 5/6/26 at 10:40 AM, Surveyor interviewed Director of Nursing (DON)-B who verified oxygen tubing (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be changed at least weekly. 2. On 5/6/26, Surveyor reviewed R34's medical record. R34 was admitted to the facility on [DATE] and had diagnoses including heart failure with ejection fraction, morbid obesity, and obstructive sleep apnea. R34's MDS assessment, dated 5/1/26, had a BIMS score of 13 out of 15 which indicated R34 had intact cognition. On 5/4/26 at 12:11 PM, Surveyor interviewed R34 and observed an unplugged CPAP machine on R34's bedside table. Parts of the machine were in a plastic bag. R34 indicated R34 would like to use the CPAP machine but staff won't put it on. R34 stated R34 used to use the CPAP machine at home every time R34 slept. R34 indicated staff say they cannot put the CPAP on R34 because they don't have the specifications for when to put it on. (Of note: R34's care plan and Kardex (an abbreviated care plan used by nursing staff) did not indicate R34 used a CPAP machine. In addition, R34 did not have an order for CPAP use.) On 5/5/26 at 4:23 PM, Surveyor interviewed DON-B who indicated the facility has a standing order for CPAP machines. DON-B stated if a resident is admitted with a CPAP machine, staff can use the standing order until they get a specific order. DON-B indicated if the resident hasn't received individualized orders prior to the respiratory therapist's monthly visit, DON-B ensures the respiratory therapist gets the settings in place. DON-B indicated there should be a physician order for CPAP use which should also be indicated on the resident's care plan. When Surveyor informed DON-B of R34's desire to use the CPAP machine, DON-B thought R34 had been refusing the CPAP machine. Surveyor and DON-B reviewed R34's progress notes which did not contain any documented refusals for CPAP use. On 5/5/26 at 4:36 PM, Surveyor noted R34's CPAP machine was not plugged in and some of the parts were in a plastic bag. Surveyor interviewed R34 who indicated staff had not offered to assist R34 with CPAP use. R34 indicated no one had approached R34 about setting up the machine or entering the operational settings. R34 indicated R34 had sleep apnea and wanted to use the machine. On 5/6/26 at 1:10 PM, Surveyor noted R34's CPAP machine was not plugged in and some of the parts were in a plastic bag. Surveyor interviewed R34 who indicated R34 still wanted to use machine. R34 indicated staff had not asked if R34 wanted to use the machine or offered to assist with set up. On 5/6/26 at 3:29 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated a resident's care needs should be care planned and a resident should receive therapy as ordered.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not provide pharmaceutical services to ensure the accurate administration of medication for 1 resident (R) (R6) of 8 sampled residents. R6 had an order for acetaminophen. Staff attempted to administer the medication on 5/5/26 but R6 was unavailable. Staff returned the medication to a stock bottle of acetaminophen. Findings include:The facility's Medication Administration policy, dated 3/2026, indicates: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection . On 5/5/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including compression fracture of T5/T6 vertebra. R6's Minimum Data Set (MDS) assessment, dated 4/29/26, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R6 had intact cognition. On 5/5/26 at 11:37 AM, Surveyor observed Nurse Tech (NT)-C obtain two 325 milligram (mg) tablets of acetaminophen from a stock bottle and put them in a medication cup for R6. NT-C attempted to administer the medication but R6 was unavailable. NT-C returned to the medication cart and poured the acetaminophen tablets back into the stock bottle. On 5/5/26 at 11:40 AM, Surveyor interviewed NT-C who indicated NT-C was told if a stock medication does not enter a resident's room, the medication can be returned to the original container. On 5/5/26 at 11:57 AM, Surveyor interviewed Registered Nurse (RN)-D who stated the facility's policy indicates medications that are undeliverable should be wasted so as not to create an opportunity for the medication to be returned to the wrong bottle. On 5/5/26 at 4:00 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated undeliverable medications should be wasted.