STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525613	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Marina Health and Rehab Ctr	35 N 28th St Superior, WI 54880

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, interview and record review, the facility did not prepare, distribute and serve food in accordance with professional standards for food service safety for 64 of 64 residents resulting in possible contamination of all residents' food.Facility staff did not wear gloves during preparation and serving of food,Facility staff did not perform hand hygiene and don new gloves after touching contaminated surfaces. This is evidenced by:The facility policy titled, Handling Raw Foods, updated 06/25/2012, states in part, Plastic food service gloves will be worn .when hands will be in direct contact with food and for preparing food to eat .Single use gloves will be used for only one task, used for no other purpose and discarded when damaged, soiled or interruptions occur in operation. Regulations also state in part: Cross-contamination can occur when harmful substances, i.e., chemical or disease-causing microorganisms are transferred to food by hands (including gloved hands), food contact surfaces, sponges, cloth towels, or utensils that are not adequately cleaned .Food preparation or service area problems/risks to avoid include .handling food with bare hands .staff distributing meals without first properly washing their hands.On 09/16/2025 between 7:34 AM and 8:00 AM, Surveyor observed:Dietary [NAME] (DC) H distributed food into dishes wearing a glove on right hand only, while left hand remained gloveless. DC H touched utensils, clean bowls and kitchen counter surfaces with both hands during food distribution. DC H walked around kitchen touching several countertop and equipment surfaces and returned to distributing food into dishes without removing contaminated glove, performing hand hygiene, or donning new gloves. During breaks in serving food, DC H wiped surrounding kitchen surfaces with a dish cloth while wearing same glove on right hand. DC H used both hands while wiping surfaces with dirty dish cloth. DC H did not remove contaminated gloves or perform hand hygiene prior to resuming food distribution into clean dishes. DC H touched clean dishes with both hands. DC H grabbed muffins with ungloved hand and placed on plates. DC H coughed into ungloved hand and then resumed serving food without performing hand hygiene and donning new gloves. DC H walked away from food distribution area, grabbed a pan of potatoes, opened oven door and placed potatoes in oven while wearing same glove on one hand. No hand hygiene was performed prior to returning to food distribution, and DC H was wearing same contaminated glove.During food distribution, DC H moved to stove and cracked eggs into a frying pan while wearing same glove. DC H did not perform hand hygiene before or after food preparation and returned to food distribution. DC H removed glove and left kitchen, walked into dining area to talk to a resident, touched resident on shoulders, then went back into kitchen without performing hand hygiene or donning new gloves to resume food preparation and serving. On 09/17/2025 at 3:25 PM, Surveyor interviewed Dietary Manager (DM) I and asked what dietary staff expectations are during food preparation and serving. DM I stated staff should always perform hand hygiene and wear gloves on both hands when prepping and serving foods. DM I stated gloves should be changed and hand hygiene performed if any surface area other than the food, or dishes food is placed into, is touched.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(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 - Some	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 maintain an infection prevention program designed to provide a safe and sanitary environment to prevent the transmission of communicable disease and infection. This had the potential to affect 9 of 64 residents. (R3, R32, R14, R43, R48, R58, R12, R46 and R51) Staff did not perform hand hygiene during water pass and in between residents. This had the potential to affect 7 of 7 residents (R) observed during water pass (R3, R32, R14, R43, R48, R58, R12). Staff did not maintain a clean environment during dressing change. This had the potential to affect 1 out of 2 residents (R) observed for wound care (R46). Observation of medication administration for 1 (R51) of 3 residents found the facility did not implement appropriate infection prevention and control practices during medication administration which could have caused contamination of a medication bottle upon opening. Example 1 Findings include: Facility's policy titled, Handwashing/Hand Hygiene states in part, Indications for Hand Hygiene 1. Hand Hygiene is indicated: .e. after touching the residents' environment. On 9/15/2025 at 2:06 PM, Surveyor observed Certified Nursing Assistant (CNA) G delivering fresh clean water cups and removing used water cups, without performing hand sanitization in between rooms and/or clean to used cups. CNA G passed clean water cups and removed used cups in R3, R32, R14, R43, R48, R58, and R12's rooms before Surveyor stopped her. Surveyor interviewed CNA G, who reported she usually does practice hand hygiene in between residents and forgot. CNA G explained she has worked 5 days in a row. On 9/17/2025 at 9:58 AM, Surveyor interviewed Registered Nurse (RN) C, who stated the expectation would be hand hygiene be performed after touching used (dirty) water cups and before touching/delivering clean water cups and after entering a resident's room before going into the next resident room. Example 2 Facility's procedure document titled, Dressings, Dry/Clean, which states in part, 1.Establish a clean field. 2. Place the clean equipment on the clean field .11. Using clean technique, open other products. R46 was admitted on [DATE] with diagnoses including, in part, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, unspecified fall, subsequent encounter, muscle weakness (generalized). R46's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15/15 indicating R46 is cognitively intact. R46 required substantial (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assist from staff for some activities of daily living (ADLs). R46's orders include, in part, Wound care to right knee (Wound #1) . Change daily. Wound care to left second Toe (Wound #2) . Change three times weekly. RN C reported R46's wounds to knee and toes are a result of trauma following a fall in her home prior to admission. On 9/16/2025 at 8:34 AM, Surveyor observed wound care performed by Licensed Practical Nurse (LPN) F with RN C present. LPN F removed R46's dressing. Surveyor noted wound bed with red granulation tissue, edges defined, and no signs or symptoms of infection. LPN F cleansed wound. Surveyor observed LPN F apply ointment to the wound bed with a tongue blade, which was not kept in clean environment and not wrapped to keep the applicator in a clean environment. During R46's dressing change, Surveyor observed LPN F set the hand sanitizer bottle and wound cleanser bottle directly on the floor, and after setting bottles in the unclean area, continued to touch the bottles with clean gloves to continue with R46's wound care. On 9/16/2025 at 9:05 AM, Surveyor interviewed LPN F about setting bottles used during wound care directly on floor. LPN F stated she realized there was cross contamination when using her clean gloves to touch the hand sanitizer bottle and then continuing to provide R46's wound care. Surveyor observed tongue blades are kept uncovered and on the outside of the medication cart for that entire wing. LPN F reported she did ask for individually wrapped tongue blades and has not yet received them. LPN F verbalized agreement that there is a potential for contamination to the uncovered tongue blades left out on the medication cart. On 9/16/2025 at 9:14 AM, Surveyor interviewed Infection Preventionist, RN C. RN C stated she did see the sanitizer bottle and wound wash be placed directly on the floor and verbalized this is considered an unclean surface. RN C stated her expectation would be that a clean environment be maintained during wound cares. Surveyor interviewed RN C about the tongue blades that are left uncovered on medication cart and used to apply ointment directly onto R46's wound. RN C verbalized the potential for infection, and shortly after interview, RN C returned with individually wrapped tongue blades and replaced the open ones on the medication cart. Example 3 Facility policy, titled Handwashing/Hand Hygiene under Promoting Healthy Hand Skin and Fingernails, updated 10/2023, states in part, Personnel with direct-care resident responsibilities should maintain short, natural fingernails .fingernails should not extend past the fingertips. Facility policy also indicates all personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. On 09/17/2025 at 7:43 AM, Surveyor observed LPN E administer medications to R51. LPN E performed hand hygiene, then proceeded to prepare R51's medications. LPN E opened and distributed medications from the medication cart for R51. LPN E retrieved R51's Lactulose (a laxative medication (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	given for constipation) from a medication drawer that contained medications in larger bottles. The Lactulose for R51 was in a new, unopened bottle. The opening of the Lactulose bottle contained a foil seal covering, as packaged by the pharmaceutical company for safety. LPN E attempted to remove foil seal by peeling it back with fingers. LPN E was not successful in removing foil seal. Without performing a repeat hand hygiene, LPN E used own thumbnail to puncture foil seal on bottle opening. LPN E's thumbnail was approximately one half inch longer than its nailbed and entered part ways into bottle, touching the remaining foil seal and rim of bottle. Remnants of foil seal remained on Lactulose bottle. LPN E poured Lactulose through foil seal remnants into a medication cup. LPN E administered the Lactulose to R51. On 09/17/2025 at 2:15 PM, Surveyor interviewed Infection Preventionist, RN C, and asked what the facility standard is for opening a new medication bottle containing a foil seal to maintain infection control practice and avoid contamination. RN C stated that if unable to peel back a foil seal with fingers, RN C would suggest using bandage scissors which have been wiped down with an alcohol wipe and allowed to air dry and puncture the foil seal with them. After doing hand hygiene, RN C stated then if needed, remove any remaining foil with fingers while avoiding entering bottle, or touching rim of bottle.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not provide Notice of Bedhold, Notice of Transfer and/or did not notify the Ombudsman of a resident who was transferred from the facility to a hospital for 3 of 4 residents (R) (R4, R11 and R76). Evidenced by:The facility provided Surveyor with a one-page document titled Notice of Transfer or Discharge, which is a blank document that is provided to the residents/resident representatives upon transfer or discharge that explains the reason for transfer/discharge and an area for resident/representative signature and indicated this was the facility's policy. On 05/15/25, R76 was admitted to the facility and discharged home on [DATE]. R76 received a Notice of Transfer, but the Ombudsman was not notified of the discharge. On 08/04/25, R11 was admitted to the facility and discharged home on [DATE]. R11 received a Notice of Transfer, but the Ombudsman was not notified of the discharge. On 08/20/25, R4 was admitted to the facility and was transferred to the hospital on [DATE] for change in condition. Record review shows that R4 declined a bedhold, but did not receive a Notice of Transfer. On 09/16/2025 at 1:46 PM, Surveyor interviewed Nursing Home Administrator (NHA) A and Social Services Director (SSD) D, regarding supportive documentation of Notice of Transfer and Ombudsman Notification being completed for above residents. NHA A stated she was unable to provide supportive documentation or information requested. NHA A stated transfer/discharge information was being sent to Ombudsman at this time.